University of Cape Town

An Exploration of How Working-Class Substance Users in the Western Cape Understand Their Addiction

Masters in Clinical Psychology

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Abstract

The study aims to explore how substance users from poor and working-class backgrounds in the Western Cape, South Africa, understand the development of their patterns of substance use. Using a mono-method qualitative research design under an intersectional theoretical framework, 11 face-to-face interviews were conducted. The interviews were transcribed and analysed using thematic analysis. Six themes were identified: addiction and agency; substance use as a coping mechanism; unmet attachment needs; societal factors influencing substance use; the psychology of active addiction; and recovery. The results of this study correspond to existing literature on substance abuse; however, this study is unique in that it relates problematic substance use to violence and poverty, through the mechanism of shame, in a South African context. Future research should aim to conduct interviews in participants' home languages to aid in capturing more nuanced narratives. Moreover, a more gender-balanced sample should be interviewed which would allow the female voice to come through more consistently.

Contents

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Introduction

On both a global and national scale, problematic substance use is a major public healthcare burden. A study conducted on a representative South African community sample showed high lifetime prevalence (13.3%) and early onset (21 years) of substance use disorders (Stein et al., 2008). In the Western Cape, this is particularly notable where the extent of alcohol and other drug (AOD) use disorders, and the associated social consequences, are notably higher than the national average (Peltzer & Ramlagan, 2009). Within the Western Cape, poor and working-class communities are the most severely affected by AOD use (Sorsdahl, Stein, Carrara, & Myers, 2014). To better address problematic substance use within these communities, understanding how poor and working-class substance users make sense of their addiction is important.

This research aims to explore the experiences of poor and working-class substance users in the Western Cape, South Africa. In the opening section, key definitions will be covered, including class, poverty, race, and substance use disorders. The literature review moves to a discussion about substance use in South Africa, focusing on the various explanations provided for substance use, followed by an exploration of the substances that are most popular amongst the poor and working classes. Thereafter, substance abuse and its association with violence in lower socio-economic status (SES) communities is explored. Finally, the psychological mechanisms surrounding substance use among working-class users, again in relation to violence and poverty, will be examined.

Definitions

Class.

Class divisions result from competition over what are defined as socially valued resources (Cobb, 1972; Fattore & Fegter, 2019). In South African society, an elite minority enjoy the power to define and control the distribution of these resources (Cobb, 1972; Fattore & Fegter, 2019). The class divisions that result symbolise this power, and higher status individuals are able to exert control over those who are less powerful (Cobb, 1972). At an ideological level, class stratifications limit freedom by legitimizing deprivation and the unequal allocation of resources (Cobb, 1972). When the unequal distribution of power is seen as legitimate, poor and

working-class individuals internalise normative structures enforced by the powerful minority (Cobb, 1972) and they find themselves trapped in transgenerational cycles of low income, poor access to basic (and often dysfunctional) facilities, exposure to crime and violence, and material poverty (Haushofer & Fehr, 2014).

Race (and its overlap with class).

In South Africa, class systems are undeniably intertwined with racial politics. The racial categorisations developed during apartheid do not refer to inherent characteristics (Parry, Plüddemann, Louw, & Leggett, 2004; Wechsberg et al., 2008), but rather to specific demographic markers (Plüddemann, Flisher, McKetin, Parry, & Lombard, 2010; Wechsberg et al., 2008). Due to their historical significance, the categorisations (White, Black[1], Indian, Coloured, and Other) are still used as they allow researchers to monitor various sociocultural markers among sub-populations (Plüddemann et al., 2010; Seedat, Van Niekerk, Jewkes, Suffla, & Ratele, 2009; Wechsberg et al., 2008). Since the apartheid regime sought to prevent people of colour from socio-economic advancement, a distinctive race-class overlap developed. Marais (2013) illustrates that as the National Party came to power, individuals classified as White were guaranteed higher paying jobs and social security, whereas individuals classified as 'non-White' were offered low paying jobs with no social security or labour rights. Over the years, this pattern has largely persisted. The highest income earners are primarily comprised of the White population and a small segment of the population of people of colour, whereas, the lowest income earners comprise primarily Black and Coloured populations (Marais, 2013; J. May & Govender, 1998; Van Der Berg, 2011).

Substance use disorders.

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.) states that the hallmark of any substance use disorder is a collection of physiological, cognitive, and behavioural symptoms demonstrating that the individual continues substance use despite numerous substance-related issues. Diagnosis of substance use disorders is based on a pathological pattern of behaviours related to substance use (American Psychiatric Association, 2013). This includes: weakened control over substance use; a desire to cut down use that may include reports of unsuccessful efforts to regulate use; spending a great deal of time obtaining, using, and recovering from the substance's effects; a strong craving to use the substance; failing to

[1] Black refers to Black African in this dissertation.

fulfil occupational or personal obligations; continuing substance use despite recurrent social or interpersonal issues caused or exacerbated by the effects of substance use; discontinuing or reducing important social, occupational, or recreational activities in favour of substance use; withdrawing from one's family to use substances; recurrent substance use in hazardous situations; continuing substance use despite knowing that substance use is likely to have caused or aggravated prolonged health problems; tolerance to the substance's effects; and withdrawal syndrome upon ceasing substance use (American Psychiatric Association, 2013). Substances may refer to alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, anxiolytics, stimulants, tobacco, and other unclassified substances (American Psychiatric Association, 2013).

Substance Use in South Africa

Explanations for Substance Use.

There have been many proposed explanations for substance use. One reason for drug use proposed by many, and the focus here, is the self-medication hypothesis. The self-medication hypothesis proposes that problematic substance use is associated with psychopathology (Khantzian, 1987). The psychoactive effects of substances interact with psychiatric disturbances and negative affect, making them appealing to vulnerable individuals (Khantzian, 1987). The short-term effects of substance use helps individuals cope with distressing mental states and an external reality otherwise experienced as unmanageable.

For example, mood and anxiety disorders are found to co-occur with substance use disorders. Several proposed explanations for this comorbidity include: a shared familial risk, vulnerability to a secondary disorder caused by the primary disorder, depression triggered by problematic substance use, and individuals attempting to self-medicate anxiety and depression with substances (Davis, Uezato, Newell, & Frazier, 2008). In the South African context, exploring the interface of mood and anxiety disorders with substance use disorders has been the focus of an increasing body of research (Morojele, Saban, & Seedat, 2012), with some research highlighting the association between depression and risky substance use in Cape Town (Sorsdahl et al., 2014).

Substance use as a coping mechanism may also be relevant in the context of dealing with the stressors of living in poverty. Among lower income earners in Cape Town, Watt and colleagues (2014) found that participants reported that "tik" (methamphetamine) had a numbing effect on their experiences of emotional pain. Another study examining initiation into methamphetamine in low income communities in Cape Town supports these findings

(Hobkirk, Watt, Myers, Skinner, & Meade, 2016). Participants reported experiencing multiple stressful life events that contributed to their tik initiation—not just one—which suggests an accumulation of stressful and traumatic events over time.

Moreover, gender inequalities in South Africa have resulted in some of the highest rates of violence, particularly in lower income communities (Norman et al., 2010). Experiences of abuse can make initiation into substance use easier, as a strategy for managing symptoms of traumatic stress (Meade et al., 2012). In Cape Town, Black and Coloured women report substance use as a coping mechanism to deal with interpersonal conflict, and physical, sexual and emotional abuse (Wechsberg et al., 2008). This is supported by findings in Gauteng where participants reported initiation into alcohol consumption due to a previously or currently abusive relationship, and dysfunctional family structures (Morojele et al., 2006).

Women have also reported that alcohol abuse was often precipitated by experiences of childhood abuse (Morojele et al., 2006). This is supported by Jewkes and colleagues (2010, as cited in Norman et al., 2010) who have shown that, in South Africa, the risk of alcohol abuse is much greater for individuals who have experienced child sexual abuse. Another study, in the Western Cape, found that individuals with child sexual abuse histories were at greater risk for drug use (Berg, Hobkirk, Joska, & Meade, 2017).

Unemployment and boredom are also mentioned as factors that precipitate substance use. Men in Gauteng attributed their heavy alcohol use in part to the lack of employment and recreational activities (Morojele et al., 2006). In Cape Town, tik was appealing to youth as it provided excitement and an escape from boredom in a community where future prospects were lacking (Hobkirk et al., 2016; Watt et al., 2014). Moreover, adolescents in Cape Town who reported higher levels of boredom at the beginning of the eighth grade were significantly more likely to report using substances than those who reported participating in healthy leisure activities (Sharp et al., 2011). Boredom due to unemployment and a lack of recreational activities led to curiosity about drug use and methamphetamine initiation (Hobkirk et al., 2016).

Another reason for substance use is the sense of belonging it provides. In Gauteng, alcohol consumption seemed to foster a sense of identity and camaraderie among male peers (Morojele et al., 2006). This is supported by qualitative studies conducted in the Western Cape (Sawyer-Kurian, Wechsberg, & Luseno, 2009; Watt et al., 2014). Similar results were also found by Hobkirk and colleagues (2016) in which most participants reported knowing tik users before they began using themselves, with many of their friends smoking before them, eliciting a desire to please and impress. The perceived popularity of tik use was reported to push participants toward using in order to acquire a sense of belonging among peers. Additionally,

the perceived normality of substance use made it difficult to avoid the social pressure of experimenting because of the sense of social connection that substance use conferred (Hobkirk et al., 2016).

The normalisation of substance use in some communities goes hand-in-hand with the widespread availability of substances. Shebeen goers in Gauteng explained that men were inclined to partly attribute their heavy alcohol consumption to the plethora of drinking spots available (Morojele et al., 2006). Elsewhere, among tik users in Cape Town, Hobkirk and colleagues (2016) found that tik was consistently described as an ever-present feature of their community, with participants stating that it was easily accessible. Given the availability and ease of access to tik, initiation into drug use was regarded as almost inevitable.

Individuals may also use drugs in order to reduce nervousness and enhance courage to participate in criminal activity (Goldstein, Brownstein, Ryan, & Bellucci, 1989). This is supported by research demonstrating that 10% of arrestees in Cape Town and Durban indicated that they used substances to assist them in committing criminal acts (Parry et al., 2004). This applies to many types of criminal activity, including sex work. Among men who have sex with men (MSMs) in South Africa, many reported using substances to deal with the nature of their work (Parry, Petersen, Dewing, et al., 2008). Female sex workers reported substance use for the same reason (Wechsberg, Luseno, & Lam, 2005). Drug use helped sex workers escape from the guilt of engaging in sex work (Needle et al., 2008; Parry, Petersen, Dewing, et al., 2008; Wechsberg et al., 2005). Indeed, for many sex workers drugs form part of their daily lives, largely because substance use can augment sexual encounters (Parry, Petersen, Carney, Dewing, & Needle, 2008), with rapid assessments reporting that a variety of sex workers use drugs to increase confidence and energy for sex work (Parry, Petersen, Dewing, et al., 2008).

Associations of Race and Class with Problematic Substance Use.

In the Western Cape, substance use is a significant problem, where the prevalence of substance use disorders is higher than the national average (Peltzer & Ramlagan, 2009). South Africa has been a key marketing and distribution platform for methamphetamine, cocaine, cannabis, hashish, opium, and other illicit drugs (Maiden, 2001; Wechsberg et al., 2008). During apartheid, the country was politically isolated from global trade and, with illicit drug trade difficult, it was therefore relatively free of hard drugs (Maiden, 2001; Myers, Louw, & Fakier, 2008). However, with the transition to democracy in the 1990s, South Africa's global trading increased, and illicit substances started entering the country through organised crime

syndicates, subsequently leading to an increase in local substance use (Maiden, 2001; Myers et al., 2008; Parry, Petersen, Dewing, et al., 2008; Plüddemann, Myers, & Parry, 2008).

Parry and colleagues (2004) suggest that there are divergent patterns of substance use among populations groups in South Africa, although race as a variable does not independently define substance use patterns, being intertwined with factors such as socio-economic status (SES). In particular, as a result of racial segregation during the apartheid years racially specific market chains evolved in South Africa, and post-apartheid trends appear to bear this out. Research has indicated, for example, that White arrestees had the highest proportion of persons testing positive for cocaine and opiates, while Coloured arrestees had the highest proportion testing positive for methaqualone (Parry et al., 2004). Additionally, most methamphetamine users pursuing treatment are Coloured men and women, usually younger than 20 years old, from poorer communities (Hobkirk et al., 2016; Meade et al., 2012; Morris & Parry, 2006). However, research has noted high rates of methamphetamine use in women from densely populated Black communities in the Western Cape too (Hobkirk et al., 2016; Myers et al., 2013; Wechsberg et al., 2010).

Income levels also influence substance use patterns. In the aforementioned research, most White arrestees came from the highest income level group, 43% tested positive for cocaine, and 10% of arrestees in the highest income level tested positive for cocaine compared to 5% overall (Parry et al., 2004). By way of contrast, alcohol and cannabis are the substances of choice in the South African workplace, particularly in industries that employ large numbers of unskilled workers (Maiden, 2001). As per the previously cited research, cannabis appeared to be a substance that arrestees with lower incomes were more likely to use in major metropolitan cities (Parry et al., 2004).

Alcohol use in historical context.

The overlap between race and class is clear when looking at the history of alcohol use in South Africa in particular. According to Mager (2004), narratives of problematic alcohol use demonstrate that, despite diverse understandings of excessive drinking, racially-inflected explanations are instructive. During apartheid, for example, the state endorsed an association between specific drinking habits and particular racial groups. The (ideological) naturalising of Black individuals as heavy drinkers allowed the state to justify selling liquor to Black individuals while denying them access to treatment for the associated consequences.

In the Western Cape, a similarly racist discourse took hold. Coloured farmworkers were, supposedly, more effectively managed through regularly supplying them with crude

wine, instead of wages. This was termed the "dop"/tot system of payment (Gossage et al., 2014; Mager, 2004). Mager (2004) demonstrates that workers were regularly supplied with a "dop" of crude wine, often at the beginning and end of every working day (Gossage et al., 2014). Subsequently, payment in crude wine led to pervasive alcohol abuse on wine farms.

Among labourers in the mining industry, too, rewarding workers with beer for physical labour, and the notion that drinking was an appropriately masculine activity, persisted (McAllister, 1993). Stripped of their traditional status as household heads and prevented from residing with their families, workers had little choice but to spend their recreational time at beer halls (Mager, 2004; Maiden, 2001). Drinking was the primary leisure activity provided for mine workers, and excessive grain beer consumption became, as it were, part of the job description (Mager, 2004; Maiden, 2001).

Mager (2004) continues, however, that the problem was not restricted to the labour sector. Medical professionals began describing problematic alcohol use in the homelands. Increased alcohol use in the homelands was partly explicable in terms of the widespread availability of beer and the introduction of urban drinking patterns (Lekgetha, 1972), with the '76 generation in particular constructing new drinking practices. By the mid-1990s, it was widely recognized that alcohol misuse exacerbated the stress of living in poverty, highlighting once more the socio-economic and political dimensions informing the complex relationships between race, class, and substance use in South Africa (Steyn, 1996; Van Der Spuy, 1994).

Associations of Crime and Violence with Problematic Substance Use

The "dop" legacy and contemporary urban drinking patterns are an important factor when exploring the increasing body of research highlighting the substance use-violent crime nexus (Parry et al., 2004). The relationship between substance use and violence involves both broad socio-economic forces as well as biological processes, with one theory presented by Boles and Miotto (2003) providing three explanations for the connection between general substance use and violence. First, violence can be perpetrated due to substance intoxication, termed "psychopharmacological violence," with the most relevant substances involved in psychopharmacological violence including alcohol, stimulants (cocaine and amphetamines), phencyclidine and barbiturates (Goldstein, 1985). Cognitive, emotional, hormonal and/or physiological functioning can be altered or hindered by substance use and may serve to encourage violence (Baskin-Sommers & Sommers, 2006; Boles & Miotto, 2003; Reiss & Roth, 1993; Tyner & Fremouw, 2008). The disinhibiting effect of certain substances may permit the

expression of violent impulses by reducing an individual's ability to use various coping devices in threatening situations (Fagan, 1990).

The second type of violence related to substance use—"systemic violence"—refers to violent patterns of interaction within the substance distribution system (Goldstein, 1985; Tyner & Fremouw, 2008). Systemic violence includes drug distributors' use of violence in territorial disputes or disputes with police, violent retribution for providing "bad" drugs or for being an informant, aggressive enforcing of rules, and substance users fighting over drugs or drug paraphernalia (Goldstein, 1985; Roth, 1994).

The third type of violence—"economic compulsive violence"—refers to violence in the context of acquiring substances (Goldstein, 1985). Economic compulsive violence occurs as a result of substance users engaging in violent crimes in order to support their addiction (Boles & Miotto, 2003; Tyner & Fremouw, 2008). Overlap between the three types of violence often occurs (Boles & Miotto, 2003; Tyner & Fremouw, 2008) and various studies have found evidence of all three types of substance-related violence occurring simultaneously (Goldstein et al., 1989).

The association between substance use and violent behaviour is supported by several empirical studies (Parry et al., 2004). Substance abuse has been shown to be a key factor in homicide, robbery, sexual violence (Abrahams, Jewkes, Hoffman, & Laubsher, 2004; Dunkle et al., 2004; Seedat et al., 2009), and other predatory crimes (Baskin-Sommers & Sommers, 2006; Parry et al., 2004). In South Africa, among arrestees charged with violent offenses or arrested due to family-related violence (rape, homicide, weapons charges, substance-related charges), almost half tested positive for substance use (Parry et al., 2004). In the case of alcohol—the substance of choice for many working-class users—laboratory and empirical studies support the possibility of a causal relationship between alcohol use and violent behaviour (Boles & Miotto, 2003). Research suggests that the most widely accepted mechanism for alcohol-related aggression is through pharmacological violence, where the anxiolytic effect of alcohol inhibits fear (Baskin-Sommers & Sommers, 2006; Lavine, 1997) and decreases one's ability to plan actions in threatening situations (Boles & Miotto, 2003).

However, most real-world studies indicate that the relationship between substance use and violence is complex, and is moderated by a host of personal and environmental factors (Baskin-Sommers & Sommers, 2006; Reiss & Roth, 1993). These include exposure to violence, poor parental care, aggressiveness in family relationships, prior substance use within the family, and poverty-related factors (Boles & Miotto, 2003). Moreover, in working-class communities which have high rates of unemployment due to the social challenges created by

poverty and inequality, men may be stripped of typical symbolic markers of success, such as high income, tertiary education, and employment (Seedat et al., 2009). Here, men often construct their masculine identity around respect and recognition, and its opposite—shame—becomes a key factor in manifestations of substance use and violence. Indeed, one of the emotional consequences of living in relative poverty is shame, which, along with humiliation, can serve as important triggers for violence and can encourage substance use (Long, 2021; Wilkinson & Pickett, 2010). The disinhibiting effect of using substances, coupled with feelings of inadequacy, can facilitate the displacement of anger onto more vulnerable and marginalized individuals and groups (Baskin-Sommers & Sommers, 2006).

Another explanation for how substance use can influence violence in working-class individuals is through differential association (Baskin-Sommers & Sommers, 2006). Increasing involvement in substance use, that is, seems to shift behaviour from experimentation to addiction and, concomitantly, a commitment to violent patterns of conduct (Baskin-Sommers & Sommers, 2006). Within the Western Cape, increased contact with gang members through drug use may expose individuals to more violence (Sawyer, Wechsberg, & Myers, 2006; Wechsberg et al., 2008), particularly systemic violence, with the insertion of substance use into this situation entrenching violent behaviour further (Mager, 2004).

For example, drug marketing and distribution are closely linked to gang membership and activity in the Western Cape. Youths may join gangs due to the availability of substances and/or the financial gains from gang-related activity (Hobkirk et al., 2016). In these poor and working-class communities, individuals involved in the distribution of drugs may become involved in gang activities (or vice-versa), which tend to be associated with some form of violence. Such individuals are at a higher risk for perpetrating violence, particularly if combined with substance use. The relationship between substance use and violence is highly contingent, being mediated by personal factors, social context, and the type of substances consumed (Baskin-Sommers & Sommers, 2006).

Psychological mechanisms in the lives of poor and working-class people

Thus far, the various relationships between substance use, the race-class nexus and violence have been explored. In turn, these relationships may be influenced by—and influential in shaping—specific psychological mechanisms. One psychological mechanism particularly important to this discussion is shame, which is related to relative poverty (i.e. income inequality), violence, and substance abuse in various ways. Shame involves a range of painful emotions including feelings of foolishness, stupidity, inadequacy, incompetency, vulnerability,

and insecurity (Fattore & Fegter, 2019; Wilkinson & Pickett, 2010). It is rooted in the processes through which people internalise how they believe others perceive them. Individuals seek recognition and respect (Long, 2021), but when they fall short of others' standards, failing to earn recognition and respect, they feel ashamed.

In South Africa, the material and ideological subjugation of native, enslaved and labouring populations during the colonial and apartheid eras involved also, at a psychological level, the denigration and shaming of all Black people (Long, 2021). A generation into democracy, however, the lives of many are still mired in poverty and, with little chance of socio-economic improvement in a highly unequal society, the shame of poverty becomes overwhelming (Long, 2021; Marais, 2013). Specifically, the shame around living in poverty serves as a strong motivator for substance use, and committing acts of violence (Wilkinson & Pickett, 2010).

Indeed, violence within contexts of inequality and poverty is often triggered by threats to one's pride—situations in which people feel looked down upon or disrespected (Fattore & Fegter, 2019; Wilkinson & Pickett, 2010). James Gilligan (1996, as cited in Wilkinson & Pickett, 2010) argues that the exercise of violence in these situations is often an attempt to ward off feelings of shame and humiliation and replace them with their opposite, namely, pride.

Where poverty is rife and aspirations are hindered, men tend to be highly competitive about power and status (Seedat et al., 2009; Wilkinson & Pickett, 2010). Interpersonal violence in defence of honour or for status occurs frequently (Seedat et al., 2009). Young men, too, have a strong incentive to achieve and maintain a high social status, with their success in sexual competition in part determining this status. Wilson and Daly (as cited in Wilkinson & Pickett, 2010) suggest that this not only explains why feelings of shame are widely regarded as common triggers for violence, but also explains why most violence occurs between men. Moreover, this explains why violence among men is most common in lower SES communities (Seedat et al., 2009). Stripped of ordinary symbols of success (employment, income, car, house) due to poverty and inequality, these men feel ashamed that they cannot fulfil traditional aspects of a masculine identity (Wilkinson & Pickett, 2010).

In an unequal society, shame is inescapable, especially for the poor and working classes who feel they have failed to acquire the material standards of success set by society (Fattore & Fegter, 2019; Long, 2021). For some of these individuals who experience high levels of shame, the experience of having less than what qualifies as success partly shapes their sense of self (Fattore & Fegter, 2019). Substance use becomes a ready consolation to cope with feelings of shame and worthlessness (Long, 2021; Meehan, O'Connor, Berry, Weiss, & Acampora, 1996).

Indeed, compared to the general population and individuals with mental health issues, individuals who engage in problematic substance use behaviours have higher levels of shame (Meehan et al., 1996). This may be the case for users from poor and working-class backgrounds who feel they have failed to meet the standards of success in an unequal society, their own standards of a fulfilling life, and the exercise of self-restraint concerning substance use (Flanagan, 2013).

In other words, a cyclical relationship exists between shame and addiction in which individuals with higher levels of shame are more prone to addiction problems, which exacerbates in turn the initial feelings of shame (Wiechelt, 2007). Moreover, the shame of poverty can serve as a trigger to both substance use and violence. The relationships between poverty, problematic substance use and violence are, again, complex, but partly mediated by experiences of shame.

Research Aims

In the foregoing literature review, substance use was explored through the self-medication hypothesis, particularly as a coping mechanism for poverty-related factors. This was followed by an exploration of the racially specific drug markets that have developed in South Africa. For example, alcohol and cannabis are the most popular drugs among low-income individuals. Moreover, substance abuse was considered in relation to violence via the concepts of pharmacological, systemic, and economic compulsive violence. Finally, a major psychological mediator—shame—was discussed in relation to the connections between poverty, violence, and substance use. The environment that inequality creates, that is, and the shame surrounding this form of poverty, can act as a trigger to violence and problematic substance use.

It is clear from the existing literature that substance abuse in South Africa has mainly been quantitatively studied (Plüddemann et al., 2008; Rehm et al., 2003; Simbayi et al., 2006). However, very little qualitative literature explores how people from poor and working-class backgrounds understand their substance use (Hobkirk et al., 2016; Watt et al., 2014). Although research by Hobkirk and colleagues (2016) has explored the factors contributing to initiation into substance use in the Western Cape, they focused solely on methamphetamine. In light of South Africa's unique social and political history, studies conducted in other countries cannot easily be transferred to local communities. Accordingly, the central research question in this study was:

How do substance users from poor and working-class backgrounds in Cape Town, South Africa understand the development of their addictions?

Given the salience of contextual considerations in the extant literature, sub-questions that were also addressed, included:

- How do various identity markers (e.g. race, gender, class) feature in participants' understandings of their substance use?
- How do these identity markers intersect with each other in participants' accounts of their substance use?

Theoretical Framework

Intersectionality theory, as coined by Kimberlé Crenshaw, has its groundings in Black feminism and critical race studies (Cho, Crenshaw, & McCall, 2013; Crenshaw, 1989; Nash, 2008), but has since been globally adopted by other disciplines (Cho et al., 2013). While intersectionality is a scientific theory, it cannot be used to predict human behaviour or mental processes (Syed, 2010), as it has no core variables to be operationalised and tested (Bowleg, 2012). Intersectionality is best perceived as a theoretical and analytic framework that assumes that multiple social locations (race, gender, sexual orientation, class) converge at the micro-level of individual everyday experience to reflect multiple interlocking systems of privilege and oppression at the macro-level (racism, sexism, heterosexism, classism) (Bowleg, 2012; Hankivsky, 2014). Therefore, while definitions of intersectionality vary, most definitions agree that social locations which act as organizing features of social relations, mutually constitute, reinforce, and naturalize each other (Shields, 2008).

The goal of an intersectional approach in this thesis was to allow for a closer reading of the lived experiences of poor and working-class substance users (Griffith, 2012). Specifically, the aim was to better capture the intersection of their multiple positionings in their everyday lives and relate these to the broader social context (Phoenix & Pattynama, 2006). To achieve this, the following assumptions were made: individuals are multidimensional and complex; specific social locations (categories) are linked and ever-changing; the importance of any social category is not predetermined as individuals can simultaneously experience privilege and oppression; multilevel analysis is needed; the social positioning(s) of the researcher must be considered; and the aim of intersectional research must be transformation.

Adopting an intersectional approach means that individuals cannot be reduced to single categories: people's lives are multi-dimensional and complex, shaped by multiple categories operating together (Hankivsky, 2014; Shields, 2008). Perceiving individuals in this way better captures the complexity of people's lived experiences and makes it possible to relate these experiences of multiple social locations to the broader power structures that challenge or perpetuate the inequalities and/or privileges experienced (Larson, George, Morgan, & Poteat, 2016; Shields, 2008). It cannot be assumed that the same collection of social locations will produce the same lived experiences—identities must be understood within their specific contexts (Yuval-Davis, 2006). Correspondingly, individuals have unique personal biographies.

Since individuals' lived experiences are multidimensional and complex, it is important to note that intersectionality sees social locations as mutually constituted and interdependent (Bowleg, 2008, 2012; Larson et al., 2016). This implies that any single category of identity takes its meaning, as a category, in relation to other categories (Shields, 2008). Therefore, intersectional identities are not constellations of discrete identities: they emerge and are defined in relation to one another (Shields, 2008). Categories are permeated by other categories, always in the process of creating and being created through power relations (Anderson, Teicher, Polcari, & Renshaw, 2002; Cho et al., 2013). Social locations compound each other in specific, complex ways (Solanke, 2009). At a point of intersection, categories mutually adapt, each changing the other, but not destroying each other: each remains visible, although changed (Walby, Armstrong, & Strid, 2012). Seeing social categories as relational and intertwined allows for research to highlight the fluidity and interconnectedness of the structures of power that create them (Larson et al., 2016; May, 2014; Phoenix & Pattynama, 2006).

This brings us to a common issue within intersectional research: finding a balance between the stability and fluidity of social categories (Walby et al., 2012). Some identity categories are found across historical periods and cultures; however, the social meanings attached to the category varies depending on how and to whom the identity category applies (Shields, 2008). Categories are ever-evolving: as social institutions change, so does the environment within which social locations are negotiated and experienced (Walby et al., 2012). However, at any one moment in time, categories have some stability because of their institutionalization which provides a degree of relative stability to lived experiences (Walby et al., 2012). Thus, research must recognize that concepts need to have their meaning temporarily stabilized at the point of analysis, even while recognizing that their social construction is a product of ever-changing interactions (Walby et al., 2012). Identities are fluid and changing;

at the same time, however, they are experienced as stable, giving the self a sense of continuity across time and place (Shields, 2008).

This brings the thesis to the next important principle of intersectionality. It is widely agreed that intersections create experiences of both oppression and opportunity simultaneously (Hankivsky, 2014; Shields, 2008). People can be members of some dominant groups but simultaneously be a member of other subordinate groups depending on the social context (Bowleg, 2008; Hankivsky, 2014). In other words, individuals may be disadvantaged relative to one group but advantaged relative to another (Shields, 2008). In this way, intersectionality also describes the ways in which privilege and oppression intersect, informing subjects' experiences (Nash, 2008). Intersections of social locations combine to produce a web of experiences, highlighting variations of experience across individuals and social groups (Nash, 2008).

Since intersectionality assumes that individuals can experience privilege and oppression simultaneously (Shields, 2008), the importance of any one category cannot be predetermined. This is because an individual's relative privilege and/or disadvantage is context dependent (Hankivsky, 2014; Larson et al., 2016). The categories and their importance must emerge during analysis (Hankivsky, 2014). Therefore, intersectionality does not make a priori presumptions about the importance of one category over another (Mburu et al., 2014).

Another important principle of intersectional research is its preference for multiple levels of analysis (Bowleg, 2012). There are two levels at which intersectionality operates (Syed, 2010). First, intersectionality can be used as an analytic tool for understanding structural oppression, while the second level is consistent with the traditional individual focus of psychology. Intersectionality aims to understand the effects between and across various levels in society, including the macro-, meso-, and micro-levels (Hankivsky, 2014; May, 2014). Intersectionality is concerned, therefore, with how multiple social identities at the individual level of experience (micro-level) intersect with multiple social inequalities at the structural level (macro-level) (Bowleg, 2012).

Multi-level analysis bridges the theoretical gap between conspiracy-theory levels of structural research and pathologizing individual-level analyses (Hancock, 2007). Macro- and micro-level research pursued in isolation lacks utility in addressing social issues (Hancock, 2007). Both levels must be considered simultaneously to truly understand how intersecting identities shape individuals' experiences (Syed, 2010). This will result in a more accurate depiction of the social realities of inequality and power, while not losing sight of individual experiences that reflect, shape, and construct those social structures (Bowleg, 2012).

Since the researcher is the primary tool of analysis, there needs to be a recognition that all knowledge is socially positioned (Grineski, Hernández, & Ramos, 2013). Researchers must consider their own social location, role and power in relation to the group of study when taking an intersectional approach (Grineski et al., 2013). Researchers have their own individual perspectives, rooted in their social positions, which must be acknowledged and reflected upon during the knowledge generation process (Grineski et al., 2013). Reflexivity acknowledges the importance of power at the micro-level of the self and in interpersonal relationships, as well as at the macro-level of society (Hankivsky, 2014), by acknowledging multiple truths and a diversity of perspectives, while focusing on voices typically excluded (Hankivsky, 2014). Practicing reflexivity requires the researcher to commit to ongoing reflections concerning implicit, personal, professional, or organizational knowledges and their influences on data analysis (Hankivsky, 2014).

Moreover, intersectionality aims to bring the often hidden complexity of social categories to the forefront (Carbado, Crenshaw, Mays, & Tomlinson, 2013). Understood this way, intersectionality aims to initiate social change (Carbado et al., 2013; Hankivsky, 2014). Intersectional research prioritizes an agenda for positive social change, reflecting a belief that science can be beneficial to society and that researchers must assume the responsibility to study issues that affect real people's lived experiences (Sen, Iyer, & Mukherjee, 2009). To achieve this goal, giving precedence to the perspectives and worldviews of marginalised individuals can be used to challenge power structures that also dominate the production of knowledge (Hankivsky, 2014).

While the principles of intersectionality theory provide an adequate framework and language for this research, intersectionality is critiqued for its lack of well-defined methodologies. Here, however, qualitative methods are taken to be compatible with the theoretical language and purpose of intersectionality (Sen et al., 2009), embracing the notion of emergent phenomena. Intersectionality theory, by virtue of its description of the multidimensional nature of identity, makes investigation through qualitative methods seem both natural and necessary (Sen et al., 2009). Intersectionality speaks to the importance of knowledge in empowering oppressed people (Collins, 2002), providing a unifying language and theoretical framework for research already engaged in investigating intersections of social locations (Bowleg, 2012). Therefore, intersectionality embraces rather than avoids the complexities and nuances of social inequalities that make up human lives (Bowleg, 2012; Hankivsky, 2014).

Intersectionality theory, therefore, is suitable for this study, which aimed to look at how social locations, and the intersection of these social locations, factor into individuals' understandings of their substance use. It is important to explore how the intersection of social locations influences narratives of substance use, as individuals do not experience their social locations as independent, separate entities, nor do they act in the world independently of these social markers. Rather, individuals' experiences are informed by social locations that are intertwined and interactive. For example, the literature review examined the distinct overlap between class and race in South Africa and its relationship to substance use, implying that race and class are not experienced as separate entities; rather, individuals experience the intersection of these identities in a way that race or class discourse alone cannot account for. Intersectionality theory proposes that the individual variables contributing to substance use will intersect to form unique, nuanced lived experiences that cannot be accounted for by examining them as independent, separate entities.

Methods

Research Design

This research was a mono-method, exploratory, qualitative study. It aimed to better understand how working-class people understand their addictions and did not aim to quantify aspects of participants' lived experiences. Therefore, a qualitative study was appropriate since it required a close examination of issues pertaining to participants' social contexts. This was facilitated by using an intersectional framework, which allowed for an exploration of the intersecting social positionings occupied by participants and their relation to the broader socio-historical context.

A qualitative design allowed for an exploration of participants' subjective reality by exploring how participants understand, experience, and make sense of their substance use given their working-class backgrounds. The exploratory nature of the research ensured flexibility, allowing topics that were prominent and important in participants' narratives to be prioritised. This research design did not permit generalization of findings as the sample size was too small and not representative of the population, which had very specific social characteristics that might not be present in other communities. However, the credibility and authenticity of the analysis was prioritized through prolonged engagement with the audio recordings, transcripts, and supervisor feedback.

Sample

This study made use of nonprobability sampling in which individuals do not have an equal chance of being selected for the sample. Rather, participants who fit certain criteria and were willing and able to participate were more likely to be chosen (Laher & Botha, 2012). This strategy was pertinent to the study, which aimed to capture the experiences of a specific group of substance users who met certain criteria, including psychiatric diagnosis of a substance use disorder, being over the age of 18, and coming from a poor or working-class background in the Western Cape. Accordingly, the sampling method makes use of purposive sampling as participants had to meet specific selection criteria in order to participate (Laher & Botha, 2012).

A sample size of 12 to 15 participants was sought: this was considered an ideal size as the research aimed to obtain an in-depth understanding of specific phenomena rather than generalise findings. While 14 interviews were conducted, only 11 interviews were used. Two interviews were discarded due to participants not speaking English fluently, and one interview was discarded as the participant was experiencing a psychotic episode making the data unreliable. Since data collection was delayed by 6 months and data collection procedures restructured due to the pandemic, a sample of 11 participants was considered adequate, especially considering the timeline and scope of the research. Basic demographics for this sample can be found in Table 1. The small sample size allowed for a more in-depth analysis that focused on examining how working-class substance users in the Western Cape understood their addictions. Access to this sample was gained through the Cape Town Drug Counselling Centre (CTDCC), a public, not-for-profit treatment facility located in Observatory, Cape Town.

The Western Cape's poor and working-classes are constituted predominantly—both historically and currently—by the Black and Coloured communities. Substance abuse has been identified as a major social problem within these communities, many of which are characterized by dysfunctional primary services, gang violence, crime, neighbourhood disorder, poor social relations, high unemployment, gender-based violence, low levels of education, and other poverty-related factors. Moreover, the home language for the majority of individuals from working-class backgrounds is isiXhosa or Afrikaans, with English often being their second or third language. With some of the highest rates of illicit substance use, these communities provide a suitable space to better explore problematic substance use among poor and working-class individuals who are reliant on state-funded or non-profit—rather than private—facilities for treatment.

Demographics	Sub-categories	Total
Sample Size	-	11
Sex	*Males*	9
	Females	2
Race	*Coloured*	7
	Black	2
	Indian	1
	White	1

Table 1: Table to show the basic demographics of the sample.

Data Collection

This study collected data through face-to-face interviews, abiding by all Covid-19 safety protocols including social distancing, wearing masks, and sanitizing regularly. The interviews were semi-structured and lasted approximately one hour. The semi-structured approach encouraged participants to expand on topics important to them, adding to the depth and complexity of the research. Additionally, the semi-structured interview allowed for flexibility within the interview, yet still maintained enough structure to ensure all aspects of the research question were addressed. Open-ended questions allowed participants to respond in their own terms of reference, which helped capture the nuances of the topic, in contrast to most existing studies that have tried to quantify the problem or certain aspects of substance abuse in the Western Cape.

The interview schedule was adapted from Hobkirk and colleagues (2016) who conducted a qualitative study exploring the factors that contributed to methamphetamine initiation in a low-income community in the Western Cape. To ensure that the interview schedule was appropriately sensitive to the topics of discussion, pilot interviews were conducted. In light of these pilot interviews, the sections concerning HIV and sexual relations were removed from the interview schedule as participants did not feel comfortable discussing these topics openly. The original interview schedule can be found in Appendix 1 (Hobkirk et al., 2016), while the final adapted version that was used can be found in Appendix 2.

Procedure

Ethics clearance was sought from the University of Cape Town's Psychology Department ethics committee and the participating treatment facility, CTDCC. Once ethics clearance was obtained, advertisements (found in Appendix 4) were posted in the waiting area and at CTDCC reception. Pilot interviews and data collection then began. Interested parties scheduled

interviews with me through the facility's receptionist. Interview times were scheduled directly after group therapy sessions for participants' convenience.

Initially, pilot interviews were conducted to assess and appropriately adapt the interview schedule. I also observed an interview conducted by my supervisor during this pilot phase to familiarise myself with the interview format and improve my interview style. When participants arrived, they were taken through to a private room where the consent process was explained in detail. Once participants agreed to volunteer for the study, they received participant information sheets and were asked to sign informed consent forms (Appendix 3).

Interviews were audio-recorded using an app called *VoiceRecorder* on my cellular device. Basic demographic questions were asked initially in order to build trust and rapport. Prompts were used to ensure that participants understood questions or to encourage more detailed answers. Once the interviews were completed, participants were thanked, debriefed, and given food packages as compensation for the time spent participating in the study. Participants were provided with both my contact information and helpline contact details in the event that interviews were experienced as distressing.

Data Analysis

As this was a qualitative study focused on exploring how individuals from poor and working-class backgrounds understood their substance use, thematic analysis (TA) was used to analyse the data (Braun & Clarke, 2006). TA is a method for identifying, analysing and reporting themes within a data set by organizing and describing the data in rich detail (Alhojailan, 2012; Braun & Clarke, 2014). However, it often goes further by interpreting various aspects of the research topic (Alhojailan, 2012). TA allowed me to organise and interpret data to gain a better understanding of individuals' experiences by looking for patterns of meaning that emerged from their subjective perceptions (Alhojailan, 2012; Braun & Clarke, 2006). TA is relatively flexible in terms of theory and epistemology and could therefore be utilized in this intersectional study (Alhojailan, 2012; Braun & Clarke, 2006, 2014). Additionally, TA is useful for understanding the meaning people give to their experiences that produce certain behaviours (Braun & Clarke, 2006)—in this case, understanding the meaning a group of working-class individuals gave to experiences related to problematic substance use.

Braun and Clarke (2006, p. 10) note that, in TA, "a theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set." For the purposes of this study, then, themes aimed to capture prominent aspects of the data set relating to participants' understandings of their

substance use. When it is not theoretically focused, however, utilising TA can result in a lack of focus on complex features of the data set. In this study, therefore, a deductive TA was performed given the centrality of its intersectional approach, and because the generation of themes via coding was done in relation to the existing literature (Braun & Clarke, 2006). Moreover, the analytic focus was on semantic themes, that is, themes were identified as per the explicit meanings of the data and were not formulated on the basis of any latent meanings in participants' accounts (Braun & Clarke, 2006).

The following steps are essential in TA, as set out by Braun and Clarke (2006). Initially, the data was transcribed verbatim from audio recordings. Since this was not a discourse analysis, some aspects of the data were excluded such as the length of pauses between speech and intonation. While most of the interviews were conducted in English, participants did use colloquial language, some of which included Afrikaans. These sections were translated by participants during the interview. The transcripts were then checked for errors (Braun & Clarke, 2006).

I read and re-read the transcripts to familiarise myself with the material and, while reading, I noted down initial ideas (Alhojailan, 2012; Braun & Clarke, 2006). Instead of using coding software such as Atlas 8, initial codes were generated manually, which involved identifying aspects of the data that related to participants' understanding of their substance use and noting them down in a Microsoft Excel spreadsheet (Braun & Clarke, 2006). Data that related to these generated codes were placed in the corresponding columns.

Based on the codes, I searched for themes to uncover patterns relevant to the research topic (Alhojailan, 2012; Braun & Clarke, 2006). Care was taken to remain consistent in how themes were chosen, keeping in mind the research aims (Alhojailan, 2012). The themes were reviewed, refined (and discussed in supervision) to ensure their correspondence to the coded data and research aims (Braun & Clarke, 2006). In order to cross-check the findings, the data was displayed using different techniques to ensure that it had been coded correctly (Alhojailan, 2012). This included tabulating the findings in Microsoft Excel and manually highlighting relevant excerpts from the transcripts that were used to formulate the themes (Alhojailan, 2012).

Thereafter, themes were defined and named by describing what was unique and specific about each of them (Braun & Clarke, 2006). This helped direct me in defining the focus and boundaries of the study to ensure that the themes represented the data as a whole (Alhojailan, 2012). The analysis chapter in this thesis was then produced by selecting and commenting on

representative examples of data extracts, while relating them back to the research question and literature (Alhojailan, 2012; Braun & Clarke, 2006).

Reflexivity

Media portrayals of substance abuse in Cape Town have been heavily influential in my previous understanding and perception of substance users. Only after engaging with the literature concerning substance use have I come to realise the complexity of this social ill. It has proven disheartening, in retrospect, to learn that the most adversely affected individuals and population groups are also portrayed as the cause of problematic substance use and the associated drug market. When looking at poor and working-class communities, it is easy to draw conclusions about these groups, which include excessive substance use and gang activity. Upon closer inspection, though, the individuals in these communities are the ones most negatively affected by these activities. They are also the victims of the very crimes relatively affluent sectors of society accuse them of perpetrating. In this way, I find myself sensitized to the day-to-day challenges of life in these communities.

I should mention that gender, class and race considerations were important to reflect on in this study, for theoretical, methodological, and also personal reasons. As an Indian, middle-class, English-speaking, educated female, participants may have perceived me as a professional who was far removed from their experiences. The responsibility was on me to acknowledge and negotiate these issues as they arose in the interview process. During the piloting of the interview schedule, it became apparent that male participants felt uncomfortable discussing sexual violence and HIV/AIDS with me, perhaps because of my gender and relative youthfulness. After consultation with my supervisor, we decided to remove this section from the interview schedule to avoid participants feeling uncomfortable and exposed.

I attempted to equalize—to the extent possible—any power imbalances between myself and my participants by offering them the opportunity to access the study's findings, thereby promoting the transparency of the research process. During the interviews, participants were advised to contact CTDCC reception if they wanted to access the study's findings. If participants contacted CTDCC reception, copies of the completed thesis would be left at CTDCC for them to collect at their convenience. This was also accomplished during interviews by explicitly stating that this was their space, not mine, and that I was conducting this research because their insights and experiences were valuable. My reflexive process took the form of journal entries following each interview, as well as weekly entries during data analysis to

ensure consistent reflection throughout the research process. Moreover, debriefing with my supervisor took place on a monthly basis.

Ethical Considerations

There were various ethical matters that needed to be considered in the collection of primary data for this study. For one, permission to conduct the study was obtained from the UCT Psychology Department, the participating treatment facility (Cape Town Drug Counselling Centre), and the individual participants. The anonymity of the participants was guaranteed as all identifying information was masked to protect the identities of participants. Confidentiality of the interviews was ensured, with only my supervisor and myself permitted access to the transcripts. Interview recordings and transcripts were kept in a password-protected computer and cell phone, while printed transcripts were kept in a secure apartment. Participants were provided with information sheets and were asked to sign both informed consent and audio-recording forms (Appendix 3). The interviews may have brought difficult experiences and memories to mind for participants; accordingly, the contact details for suitable helplines and therapeutic services were provided.

Participants were given my contact details if they had any follow-up queries or concerns. Moreover, all participants were informed of their rights as voluntary participants, allowing them to refuse participation or withdraw from the study at any time. Additionally, participants were informed of their right to refuse to answer any questions they were not comfortable answering. Participants were reassured that they would not be penalised for withdrawing from the study, refusing to participate, or refusing to answer certain questions, nor would their relationship with their treatment facility be affected. To compensate participants for the time spent participating in this study, food parcels worth R100 were provided to each participant upon completion of the interview.

Results and Discussion

Theme 1: Addiction and Agency

A common theme across the data was participants' understandings of addiction in relation to agency. Many participants discussed how substance use was a personal choice:

> *"I had to deal with the fact, man, that this is not my father's addiction man, you know? Everybody has a- you know, God gave us a will man. That's what*

I understand. We all have choices that we can make. So, I had to take ownership of the choice I made, you know, because there's a lot of people that maybe have the same story like me, like their father wasn't there but they turned out well, you know what I'm saying?" (Caleb)

"It was personal [drug use]. Ja, it was personal because I decided, because I wanted. I always wanted to know, this tik drug." (Cullam)

The idea of substance use as a personal choice indicates participants taking ownership of their addiction. To be sure, addiction as a choice versus addiction as a disease has been an ongoing debate, although many believe that substance use is an act of free-will (Holton & Berridge, 2013). There are several reasons why participants may view addiction as a personal choice. Participants' understanding of addiction as a choice may reflect the beliefs of their healthcare professionals, as clients often adopt the beliefs of their treatment providers (Koski-Jannes, 2004, as cited in Russell, Davies, & Hunter, 2011). Some studies have shown that many practitioners hold the view that addiction is a choice (Russell et al., 2011; Schaler, 2002), which may influence participants' understanding of their addiction. However, this seems unlikely among this sample as practitioners at the participating treatment centre—CTDCC—do not ascribe to the so-called 'moral model' of addiction.

Since the moral model of addiction sees drug use as a choice, it views addicts as responsible and blameworthy—potentially deserving of stigma (Pickard, 2017). For many in the recovery process, taking responsibility for one's addiction is a key part of treatment, not because they felt deserving of the stigma, but rather because not taking responsibility for their addiction may feel disempowering. By taking ownership of their addiction, addicts develop a sense of agency and control in their lives. Subsequently, this promotes the belief that future choices, such as recovery, are within their control (Pickard, 2017). It is possible that participants' belief in addiction as a choice has less to do with them feeling that they made the conscious choice to be an addict, and perhaps more to do with them trying to take ownership of the shortcomings and past failings associated with their substance use in order to make better decisions in the future.

It is interesting to note that despite participants perceiving their addiction as a choice, they also demonstrated a more medicalised understanding of addiction as a disease:

"You have from the best paid people who are now superstars, to the worst, it's an alcoholic, you know? Um, and we all have a sickness. So, that is it." (Cameron)

"I mean, my wife also said, 'Yeah, you're sick. You got a disease. You got a-' and it hurt, you know, because I'm thinking, 'Yeah, I know have- I'm not sick, you know? I'm not crazy' but to her it became that way and that is how it seemed to her, or how it was, how it was yeah." (Shaun)

This speaks to participants having a more medicalised understanding of addiction as a disorder that people have little control over. Here, it is understood as an illness that impairs one's decision-making and impulse control, thereby revealing an understanding that addiction is not a choice, but rather a disorder that requires medical treatment (Maté, 2008). Brain imaging studies support this view: research has revealed an underlying disruption to brain regions that affect motivation, decision-making, and reward and inhibitory control, providing a basis for addiction as a disease of the brain with clear biological dimensions (Bartzokis et al., 2002; Kalivas, 2004; Maté, 2008; Volkow & Li, 2004). Additionally, the perception of addiction as a disease may lessen the moral judgement that is associated with addiction as an act of free-will; however, the diminished moral judgement still enforces the imperative that the sick person take responsibility for their condition and seek treatment (Hammer et al., 2013).

The foregoing excerpts also indicate participants' understandings of addiction as a disorder that can affect anyone. Since it is a disease, it can affect any individual irrespective of class, gender, status, race, or any other demographic markers. It alters the perception of addiction from a reflection of one's weak moral character or lack of abilities, as assumed by the moral model of addiction, to an illness that anyone is susceptible to.

Another interpretation of participants referring to addiction as both a choice and a disease is that they may be highlighting that, while initial substance use was a choice, the subsequent addiction was not (Russell et al., 2011). This is indicated by participants' perceptions of addiction as a disease that is only recognized and/or acknowledged when it has become firmly established in one's life and is already problematic:

"Um, they don't know that they have an addiction up until it's almost too late." (Keith)

"You don't realize as time goes on that it's starting to affect your brain, starting to affect your thinking." (Rafik)

This reflects participants' more nuanced understanding of addiction as neither a disease nor a personal choice. It is clear that the progression from substance use as a choice to substance use as a compulsion is blurry (Henden, Melberg, & Rogeberg, 2013). This is supported by research suggesting that addiction cannot fit neatly into to the disease-choice dichotomy; rather, addiction is a complex, messy, mutually constructed relationship between the user's biology and environmental factors, which subsumes elements of the disease and choice models without contradiction (Maté, 2008; Russell et al., 2011). In short, participants may be pointing to an understanding of addiction as a multi-faceted condition.

The slow progression from voluntary use to compulsive use makes it difficult for addicts to recognize when their substance use became problematic and, in this way, addiction was understood as a trap:

"She don't know from the room that I'm trapped in. You know, I want to stop. Maybe I don't know how, until now." (Shaun)

"It's the only jail cell with the keys on the inside." (Jacque)

Addiction was seen as an internal prison, that, once was embedded in it, was inescapable. Despite wanting to recover, the compulsion to use substances was far larger. This is supported by evidence showing that repeated drug use leads to long-lasting changes in the brain that undermine voluntary control (Volkow & Li, 2004). As such, once substance use alters parts of the brain responsible for decision-making (Volkow & Li, 2004), the prospect of a life without substance use seems unrealistic and surreal to addicts.

Since participants' voluntary control was impaired (Maté, 2008; Volkow & Li, 2004), their compulsion to use substances meant that they placed more value on substance use than on other aspects of their lives (Maté, 2008). As a result, their actions adversely affected the lives of those around them. Participants understood that their addiction was not a disease that affected only themselves:

"And you believe that you're doing it to yourself, man. I'm only harming myself. I'm doing it to myself. Everyone else will be okay. And it's not like that. It affects all of them." (Shaun).

"I've stolen 30 years of my life and of my family's life." (Jacque)

Participants understand that their addiction influences the lives of those around them. This is in contrast to the commonly held belief that addiction is a condition that lies within an individual, and as such, the individual is the source of the problem. However, literature indicates that addiction is often an issue of trans-generational trauma (Maté, 2008). Addiction is a disease that is influenced by many factors, including one's relationship with their family and loved ones, and there is a need for family and social circles to be recognised as both influencing, and influenced by, the addictive process (Maté, 2008). Addiction can be seen as a family disease, not only because addicts' behaviours adversely affect those around them, as demonstrated by participants' understanding of addiction, but also because the family dynamic itself has potentially contributed—and will continue to contribute—to addicts' substance use (Maté, 2008). This speaks to the need for addiction to be seen as a socially and environmentally influenced disorder in order for it to be comprehensively understood.

Another way in which addiction is a socially influenced disorder is through its relationship with shame. Shame is a public emotion, as a result of which redemption from shame relies on 'public amnesia' (Long, 2021, p. 40). For participants who live in a country characterised by stark inequality, being Black and coming from a working-class background can result in intense experiences of shame (Long, 2021). It is not absolute poverty that generates this shame but, rather, relative poverty. Shame and a felt lack of agency (when living in a supposedly meritocratic society that does not easily allow for upward social mobility) can lead to substance use as a way to deal with these painful emotional experiences (Long, 2021). Indeed, research indicates that the relationship between shame and substance use is mutually reinforcing, with substance use shielding one against intense experiences of shame but also eliciting more feelings of shame (Long, 2021).

Theme 2: Substance Use as a Coping Mechanism

First and foremost, numerous participants made a connection between their mental health and substance use:

"Yes anxiety. And the first time it happened to me, it just happened out of the blue. I was coming from buying a bottle and I thought maybe I wanted to cry because it was so real. But when I saw I was sitting on the road and actually- Oh, it was terrible. It's a horrible feeling. And I thought there was something terribly wrong. And when I went to the hospital, they told me it was an anxiety attack, and it didn't stop at that." (Romy)

"Yes, I did, I've tried to swallow, I swallowed a whole bottle of [inaudible] which is 30 tablets [interviewee attempted suicide], and I woke up the next morning and, uh, I can honestly say that I wasn't happy." (Jacque)

Suicidal ideation, depression, and anxiety: almost all participants made a link between their substance use and their compromised mental health. This is supported by both international (Davis et al., 2008; Latkin, Williams, Wang, & Curry, 2005; Lyons et al., 2006) and local work (Morojele et al., 2012; Sorsdahl et al., 2014) on the self-medication hypothesis. According to this hypothesis, problematic substance use is associated with psychopathology as individuals attempt to medicate themselves (Khantzian, 1987; Maté, 2008). However, it remains unclear whether substances serve as the catalyst for mental health difficulties or if pre-existing mental health difficulties make substances more appealing.

According to Maté (2008), mental health issues and addiction are inseparable, both originating from some form of trauma. Interestingly, some participants in this sample felt that their substance use caused their mental health difficulties and not vice versa. Many participants who spoke about mental health issues felt that mental illness differed from experiences such as unemployment or relationships ending. These participants believed their substance use was a coping mechanism for adverse life experiences rather than mental illnesses. Such substance use subsequently led to the mental health difficulties they struggled with, and this was particularly the case with anxiety:

"I think- when I think about it. when I weigh the scales, now, that I've been clean for, so, almost four months. I think it was my alcohol that brought on the anxiety." (Romy)

"I think that it's, uh, when I'm, when I'm not using, I'm, I'm, um, the drugs is, is caused-. Tik has caused a severe, severe anxiety damage to me. I have anxiety all day." (Jacque)

As such, it is clear that some participants did not perceive their substance use as a form of self-medication for their mental health issues, as proposed by the literature. Other participants, however, did refer to substance use as a coping mechanism for negative emotional states or pain:

"Ja, people tell you 'ja, you can stop anytime'. It's easy to say but if you are that person, you don't know what that person, maybe he's been through things. It's hard for them to stop." (Callum)

"So, just to stop all of the anger you have inside, its better I smoke." (Themba)

"Um, you start- because you want to forget about the pain." (Waheed)

"No, it just made me forget about my problems." (Keith)

"The drugging was mostly just a form of escaping reality, you know? From all the painful memories and our current situation that we find ourselves in. Like numbing the pain." (Caleb)

This idea of numbing negative feelings and pain relates back to the self-medication hypothesis. Addicts are known to struggle to tolerate feelings—they are unable to express their emotional states—and hence they turn to substances to help them deal with these feelings (Maté, 2008). In sum, then, participants' responses indicate a bi-directional relationship between their substance use and mental health, where substance use can both cause mental health difficulties and be a form of self-medication. This is supported by a vast body of literature suggesting a bi-directional relationship between substance use and mental health (Maté, 2008). This highlights the cyclical nature of addiction in which addicts use substances as a coping mechanism for pain, which in turn leads to more experiences of pain, which are then self-medicated with substances, and so the cycle continues.

Although the source of negative feelings differed across participants, the common thread was that these experiences all served as major stressors in participants' lives. Several described experiencing traumatic childhood events:

> *"And then my father said, I'm sure- I don't know what happened, but the punishment that I got is that my mom beat me and my mom said to me, I must undress, and she beat me when I was naked." (Zintle)*

> *"Yeah. My dad used to- my dad used to hit me as well." (Jacque)*

> *"So, ended up staying with my uncle and the treatment was not good." (Themba)*

The fact that substances are used as a coping mechanism for people who have experienced childhood trauma is well established (Berg et al., 2017; Dube et al., 2003; Morojele et al., 2006). While these studies support the self-medication hypothesis, they also confirm that childhood trauma affects brain development resulting in consequences all the way into adulthood (Maté, 2008). In particular, the dopamine and opioid circuits, the limbic system, the stress apparatus, and the impulse control areas of the cortex cannot develop normally under such circumstances, leaving the individual vulnerable to addiction (Anderson et al., 2002; Teicher, 2000; Vythilingam et al., 2002).

For other participants, substances were used to cope with losing someone in their lives, particularly the end of a relationship:

> *"I think it's just because of my emotional, I was very heartbroken. It was the wrong thing [tik] to start off with (laughs) because- but it makes you feel so different but in fact it actually makes me the opposite of who I really am. So, but in the beginning when I started, you know, I just smoked, smoked, smoked." (Keith)*

> *Interviewer: "What led to the relapse?"*
> *Waheed: "Ahhh, problems, how can I say? Problems of the heart, problems of the heart"*

This supports work by Maté (2008) suggesting that emotional pain is at the centre of all addictive processes. Specific to this is the concept of *differentiation* in which people with less basic differentiation are more heavily reliant on relationships to maintain their emotional balance. When these relationships are threatened or fail in some way, such individuals turn to substances as an emotional crutch (Maté, 2008).

> *Keith: "I always wanted either a female companion or just- just to experience- because I genuinely actually loved her, and I didn't do anything wrong and that really like just leaves a hole. An empty hole".*
> *Interviewer: "Ja"*
> *Keith: "So, I tried to fill that constantly by surrounding myself with people. Tried to be the party animal, the favourite… that's a very dark phase. After your first 2 years in the Navy, you receive an 18-thousand-rand bonus. It just went to drugs. Drugs, friends, partying but in fact, you're making fake friends or false friends"*

> *"So, when I- drinking for me was like, when I would sit and think that every sacrifice, everything that I've done has gone down the drain. That was when I thought to myself, and you ask yourself, why, why God, why do I deserve this pain? And why did this person hurt me, hate me in this manner that he wanted to do this and everything. And so that's when I started. Like you kind of like- I wanted to block why are- because I had no answers." (Zintle)*

In these excerpts, two participants were unable to make sense of their relationship breakdowns and turned consequently to substances. These extracts also contain hints of helplessness—a connection supported by literature linking feelings of powerlessness to substance use (Maté, 2008; Newcomb & Harlow, 1986).

While participants identified differing circumstances that triggered or increased the use of substances as a coping mechanism, all these circumstances—childhood trauma, losing a loved one, a relationship ending, and feeling a sense of helplessness in one's life—can be understood as different manifestations of emotional stress in their lives. This supports work indicating a relationship between stress and substance use, with the latter serving as an attempt to relieve stress (Maté, 2008). Especially harmful stressors, moreover, include uncertainty and

powerlessness in important areas of one's life (Maté, 2008), which was reflected in some participants' accounts.

Since emotional stress can be understood as a trigger for substance use, the latter can be thought of as an avoidance-based strategy, which aligns with the self-medication hypothesis (Berg et al., 2017; Khantzian, 1987). In many ways, underlying the relationship between stress and substance use is the feeling of shame—as discussed briefly in the theme, *Addiction and Agency*. Many participants talked about experiencing feelings of shame:

> *"It's very bad. Alcoholic. Drug addict? Nah, it's no good, you know, it used to be taboo to mention that, you know, and I'm an embarrassment to my family. Um, you know, how can they go say yes, their brother is…when we such a Christian family. It's just not right." (Cameron)*

> *"The way they look at you, they, they, they judge you like, like, even with me now. Um, even though I am in recovery, even though I'm clean for so many days or whatever. Um, I'm still hesitant to tell people that I'm going to meetings, (inaudible) meetings or any meetings or whatever the case may be, because let's say they know me on this level that I haven't told him that I'm in addiction, that I haven't told them I'm in recovery. And when I do tell them I am in recovery, immediately, they have a different perspective of me." (Rafik)*

> *"Luckily, I never went- did that, but I still broke the law and I have a lot of remorse about that as well. I took someone's, I used to steal cancer patient's medication. A cancer patient." (Jacque)*

In all the excerpts above, it is clear that the participants are remorseful of, embarrassed by, and uncomfortable with their behaviour as a drug addict. There is a sense of shame surrounding their addictive behaviours, which is in keeping with literature linking shame and addiction via a shame-addiction cycle (Fattore & Fegter, 2019; Flanagan, 2013; Rahim & Patton, 2015).

It is interesting to note that, for both female participants, the shame at what they may have done when they were intoxicated was a significant source of distress and contributed to the shame-addiction cycle:

"I think, I think it had a lot to do because I started getting a lot of paranoia, especially when I was hungover because I had done so much shit. Oh, I mean, run a nightclub butt-naked. Who does that? and things like that." (Romy)

"You know, at the end of the day, when you drink today, the following morning, you're sad, more sad than when you drank. So, you need to keep up all the time. So, whatever you doing, because it may- alcohol may be there to suppress that pain, but when that alcohol gets out of your body, You come back and think, when I- what was happening and then that pain comes back, times, times, and then you thinking I can't face this. And then remember maybe you thinking we went out and what did I do? And then you thinking, Oh, gosh, I can't, I don't want to -you buy another because you don't want to think what you have done and anything. So, you buy another, so that again, you see, you mounting problems on top of one another." (Zintle)

For female participants, however, these excerpts represent an intersection between their identities as females and addicts in which societal expectations of 'respectable' women have not been met. For these women, this left them feeling inadequate and ashamed, reinforcing the shame-addiction cycle (Long, 2021).

Another way in which shame was linked to substance use in this sample was through participants' use of substances to deal with feelings of inadequacy, which were linked to low self-esteem and insecurity. As such, substances were used to build confidence, increase assertiveness, and allow for self-acceptance, albeit temporary:

"I- I- I- I like grew up in addiction, like the only way I know how to defend myself is when I'm under the influence, you know? How do I deal with? Even though it was negative, how do I deal with situations? How do I build confidence? I'm going to smoke, and I feel confident you know what I'm saying?" (Caleb)

"I would have a low self-esteem. I, I would think to myself, you know what? I don't want to have a conversation with some people. Once I have a lovely drink, we can just pow-wow the whole time, tete-a-tete and the minute I had

a drink. Oh, there I was, I was an amazing conversationalist. I was so full of humour. I was bubbly." (Romy)

"Ok first of all, the high, that euphoric feeling that you get. I talked, when I'm high I talk to people, and I'm engaged with them and I have normal conversations and, and I- because I'm feeling so good inside." (Jacque)

The use of substances to bolster one's sense of self is supported by research proposing that individuals use substances to assert themselves and increase confidence and self-acceptance (Bitancourt, Tissot, Fidalgo, Galduróz, & da Silveira Filho, 2016; Fisher, Zapolski, Sheehan, & Barnes-Najor, 2017; Wu, Wong, Shek, & Loke, 2014). Beyond the need for self-acceptance, however, participants also expressed a desire to feel a more social sense of belonging and approval, which brings us to the next prominent theme in the data set.

Theme 3: Unmet attachment needs

Many participants spoke about the difficult relationships they had with their parents. Especially prominent was the focus on absent fathers or a strained relationship with fathers, with several participants pointing to the lack of a positive relationship with their fathers causing them much distress:

"My father was very quiet. My father would keep quiet even if he didn't- like my mom would just rule over that. Even if my father disagreed, my mom, if she wanted to do something, she would do it." (Zintle)

"So, I don't know if he even regards me as his son but nothing he ever said was to build me or to mould me." (Keith)

"My father, he cheated my mother with another women and stuff like that and that build-up of feeling of betrayal. Like, he betrayed my mother so if he betrays my mother, he betrays me, you know? And um, and even the- the- the fact that now I'm- the reason why I started doing drugs because I felt rejection also, man. That- that was the biggest part of my started using drugs was." (Caleb)

Concomitantly, participants spoke about how their mothers had to play the role of both mother and father figures:

> *"So, basically like my mother was my father for me, she was like my father." (Cullam)*

> *"Ja, at that time you know? Because my father neglected me, he actually rejected me, he wasn't there. My mother like took that upon her, you know what I'm saying? Like to be mother and father. Now the part of being a mother? She does that naturally but how does a woman fulfil the duty of the father?" (Caleb)*

These extracts can be related back to a significant body of literature discussing the importance of healthy attachment in early childhood (Maté, 2008). For many participants, their fathers were present in their lives but were emotionally unavailable and psychologically absent. Research has shown that father figures of many male substance users are perceived as separated, uninvolved, weak or distant, or aggressive and brutal (Olsen, 2004; Zimić & Jukić, 2012), which is similar to how some participants perceived their fathers. Additionally, participants who felt their fathers were absent, also felt that their mothers went above and beyond in raising them, supporting literature suggesting that addicts often see their mothers as more functional than their fathers in terms of involvement, responsibility and attachment (NIDA 1999, as cited in Zimić & Jukić, 2012).

Some participants expressed their unfulfilled emotional needs in terms of lacking positive role models or feeling like outsiders in their families:

> *"But I didn't see it going like this. So, I believe I had no role models." (Caleb)*

> *"Uh, I used to be the rebel of the family, there was even times when I didn't believe I was part of the family." (Cameron)*

> *"I felt like -Like I didn't, like I was, I used to believe that my mother wasn't my own mother." (Jacque)*

Most participants felt a sense of rejection and isolation from their families during their childhood and adolescence, suggesting that their emotional needs were unfulfilled. Literature suggests that unmet emotional needs from a child's primary caregivers serves as a vulnerability to substance use (Gordon, 2002; Stattin & Kerr, 2000). Children who do not receive the attentive presence of their parents and who live in impoverished rearing environments, are more likely to have disrupted brain development (Maté, 2008). A responsive, nurturing caregiver plays a key role in the neurobiological development of a healthy stress-response (Perry & Pollard, 1998; Pohorecky, 1990). Disrupted neurobiological development leaves individuals vulnerable to addiction as they are more likely to seek out external chemical sources in response to stress. Substance use serves as a self-soothing mechanism, relating back to the self-medication hypothesis discussed in the theme, *Substance Use as a Coping Mechanism* (Maté, 2008).

This sense of rejection and emotional abandonment may have been further exacerbated by participants being the first person in their family to be addicted to drugs:

> *Interviewer: "Um, and let me ask you, with your stepdad and your mom and your sister, did any of them take any substances?"*
> *Themba: "No"*

> *Interviewer : "Ok ok, and tell me, your parents and your family? Um, did any of them use any substances?"*
> *Waheed: "No"*

> *Interviewer : "Ok and tell me the rest of your family, did they ever get involved in substance use?"*
> *Keith: "No, I'm the only one"*

> *Interviewer: "Okay. Um, and I just want to move to talking about the other people in your life. Um, do you have any friends or family who use substances?"*
> *Shaun: "No, no one. In the family?"*
> *Interviewer: "Yeah, in your family."*
> *Shaun: "No."*

While a minority of participants did acknowledge substance use within their family, the majority insisted that they were the first addicts in their family. This goes against a wealth of literature describing substance addiction as hereditary (Cotto et al., 2010; Edenberg & Foroud, 2014; Mary-Anne, 2013; Meyers & Dick, 2010). However, it remains unclear whether substance use disorders running within families is genetically based, environmentally based, or an interaction of both (Maté, 2008).

Being the first person in their family to be addicted to substances may have further isolated participants from feeling a sense of belonging and may have caused feelings of inadequacy and shame. Since addiction is a highly stigmatised disease (Barry, McGinty, Pescosolido, & Goldman, 2014; Earnshaw, Smith, & Copenhaver, 2013; Sattler, Escande, Racine, & Göritz, 2017), these participants felt they brought shame and embarrassment to their families:

> *"I'm hiding myself. You remember, I didn't grow up in a drinking family so that reputation, I still wanted to maintain it." (Zintle)*

> *"I could never make Sunday morning church. Well, I used to make it, but then I started realizing that, hey, I'm drunk still man. No, no, no, not right on my mother and my father that I go to church where they go to church and everybody sees me still looking very, you know?" (Cameron)*

> *"My mother came there, and she was like, really crying, 'why are you doing this?' I felt like really crap but ok, I didn't feel that much crap because I was high, and I was on a downer at the same time. Even though I did feel crap about it, that you guys, now, had to find out this way. I- it didn't make me feel very good because I disappointed them, you know, they thought I was on an ok level." (Rafik)*

Many participants felt like burdens to their families, bringing only shame, embarrassment, and disappointment to them. Shame and the addictive cycle may have been in play for these participants: a link between unmet needs for belonging and use of substances as a coping mechanism—as discussed in the theme, *Substance Use as a Coping Mechanism*—to deal with a lack of acceptance and approval is clear.

It was interesting to note how adamant participants were in their insistence that they were the first persons in their families to be addicts. It is possible that addicts felt guilty about how their addiction had affected their families, and therefore did not want to place direct 'blame' on them. Participants may have felt a need to protect their families, irrespective of the latter's role in their substance use. The narrative around substance use as a choice and taking ownership of one's addiction—discussed in the first theme, *Addiction and Agency*—may be how participants make amends for past wrongdoings and protect their family from any more harm associated with their addiction.

Despite participants' suggested desire to protect their families from further shame, their feelings of rejection and isolation were still present, and their need for a sense of belonging extended into their social circles. During childhood, many participants described being very shy or lonely:

> *"I became- probably around 15, 16, I started getting friends. I was very- I was quite a quiet child. So, mommy and daddy was my friends growing up until 15, 16." (Shaun)*

> *"Uh, the loneliness, I used to be a loner, uh, everything I do, I do on my own, I used to do electronics. Um, and I was spoiled by my father because he used to know that I was a loner." (Cameron)*

> *"No. I didn't have friends in school." (Romy)*

> *"So, I went to different schools, I had difficulty making friends and I used to be bullied. I was very small, I was very small in junior school. I was bullied quite a bit." (Jacque)*

This indicates that even among peers their own age, participants felt a sense of isolation. Research has shown that feelings of loneliness during childhood and adolescence can lead to risky behaviours, including substance use, as individuals attempt to relieve the painful experiences of loneliness and social isolation (Copeland, Fisher, Moody, & Feinberg, 2018; Niño, Cai, & Ignatow, 2016; Page, Dennis, Lindsay, & Merrill, 2011; Seil, Desai, & Smith, 2014; Stickley, Koyanagi, Koposov, Schwab-Stone, & Ruchkin, 2014).

Apart from dealing with the pain of social isolation, moreover, many participants found acceptance and approval through substance use:

> *"I don't know. Just to be in with the crowd, just to be in, man. It was nice to have everybody else but your family, to go to and go sit by like a friend and stuff like that." (Shaun)*

> *"Okay. I was about 14 years old, and I wanted to fit in with the crowd and so on." (Rafik)*

> *"From a young age, just wanted, I always felt like I wasn't part of, I wanted to be part of something, I wanted to belong. And, uh, I think the drugs made me feel like I was part of something." (Jacque)*

These participants used substances to attain a sense of belonging, a finding that is supported by local research (Hobkirk et al., 2016; Watt et al., 2014). For some, the need to feel accepted had to do with identity formation, and substance use can be an important component of a group identity (Brunelle, Brochu, & Cousineau, 2000; Morojele et al., 2006). Acceptance from peer groups may have been particularly important for participants who lacked a sense of belonging within their families. In other words, peer group acceptance served as an adaptive strategy to fulfil attachment needs that went unfulfilled by their primary caregivers during childhood (Maté, 2008). Indeed, the need for acceptance and approval from peer groups was particularly salient in this study, with almost every participant describing substance use in relation to their peer group and the experience of peer pressure:

> *"I didn't used to smoke like this tik, it's a new drug back then at that time in Cape Town. I actually didn't know about it. I didn't worry. So, my friend still gave me one hit, while we were still sitting there. I went to visit them, and they were all smoking it so I took two hits but ok, at that time, it didn't still, I didn't still like the feeling like when you can't sleep." (Cullam)*

> *"Then ja, like weekends, I work. School holidays, I work. Then there was peer pressure and a lot of stuff. Started to smoke cigarettes, smoking dagga. Then as time goes, I think 2001, 2003, started smoke mandrax." (Themba)*

"Um, I never used, I never used to pay for that time I was using, because I was still in school. And, um, the friends that I was hanging out with, they, they were always involved with drugs. They would always say, 'come, come sit with me', you know. They were always pull me and I would never pay for the drugs when I was using it." (Rafik)

"We used to do together because that is like the gang code." (Caleb)

It is interesting to note that while many participants admitted to using substances to fit in, they did not attribute their problematic substance use primarily to their peer groups. This may relate back to the idea—discussed under the theme, *Addiction and Agency*—of taking ownership for one's addiction. Instead of absolving themselves of responsibility, which is important to the recovery process, they de-emphasized the role their peers played in the development and maintenance of their substance use. This may be because these groups also provided participants with a sense of community, belonging and safety, and participants may have felt somewhat protective of them:

"I do [crime and substance use] because of a situation. I do, like, to please my friends. So, also for protection like." (Themba)

"Ja, like you know, because of the rejection neh? I- I was always- I always had that void man, in my life . Like you know, I wanted to belong and you know, where do I find that belonging. The acceptance. I mean the acceptance. So, what I did was I went out to the streets, you know, and I ended up with a group of people that they had the same background man. Amazingly, they had the same background. Like father issues, daddy issues, you know what I'm saying?" (Caleb)

"That's why I was always looking out- looking for people probably that wants to sponge off me just so that I could have people around. Be that cool guy again but that, uh, was also a stupid mistake." (Keith)

Mehl-Madrona (as cited in, Mate, 2008) states that everyone has a need to belong, to feel a part of a community. On the other hand, individuals who rely excessively on their peers for emotional acceptance are more prone to hurt and are more anxious than children who are securely attached to their caregivers. These individuals find themselves having to shut down emotionally to protect themselves, and this avoidance of feelings can greatly increase the risk of problematic substance use (Neufeld, Gordon & Mate, 2008).

Participants' unmet emotional needs can be better understood by looking at the environment in which many poor and working-class people are raised. Families in the Western Cape have experienced intergenerational forms of trauma and deprivation—from community displacement through the Group Areas Act to the legacy of poverty that has persisted within these communities. These factors make the task of child-rearing difficult (Taliep, Ismail, & Titi, 2018). Many participants spoke about the lack of role models during childhood, and particularly the lack of a paternal figure. Taking into consideration the high rates of unemployment, and the unattainable markers of success that working-class men have to meet in order to successfully fulfil their masculine identity, it is not surprising that many participants' fathers could not successfully carry out their roles (Morojele et al., 2006; Richter, Chikovore, & Makusha, 2010). The mothers of these participants, who attempted to fulfil the role of both mother and father to their children, would find themselves in impossible positions. Apart from carrying out the emotional role of both parental figures, these caregivers also had to ensure financial stability and meet their children's basic needs. This is an unviable task for anyone, but especially so in contexts of limited resources and opportunities (Wegner, Arend, Bassadien, Bismath, & Cros, 2014).

Consequently, participants' social groups became an important avenue for fulfilling their emotional needs (see also Hobkirk et al., 2016; Morojele et al., 2006)—notably, in poverty-ridden circumstances where dysfunctional family dynamics form the norm rather than the exception (Van der Westhuizen & Gawulayo, 2021). Moreover, having come from similar contexts, their shared experiences gave participants a sense of belonging and safety among their friends (see Ramson & Chetty, 2016), a feeling that may not have been apparent in their home lives where caregivers are frequently (and unavoidably) preoccupied by more pressing issues such as meeting their families' basic material needs.

Theme 4: Societal Factors influencing Substance Use

For some participants, the environment created by poverty encouraged criminal behaviour in order to meet basic needs:

> *"I was a masterful man to join them because I see the situation at home. There's no light. There's no candle. There's no paraffin. There was no electricity that time… I was living in the shacks. So, I was joining, I join the [gang] robbing Golden Arrows and doing robberies and hijackings." (Themba)*

Here, the relationship between poverty and crime is clear (Cheteni, Mah, & Yohane, 2018; Pare & Felson, 2014), and is mediated by factors such as high unemployment (Huang, Laing, & Wang, 2004; Mauro & Carmeci, 2007) and the relative poverty characteristic of city life (Fafchamps & Minten, 2006). Moreover, liberal democracies—such as South Africa—are noted for their cultures of social comparison (Long, 2021), and individuals from lower income households inevitably compare themselves to their wealthier counterparts (Cochran, Chamlin, Beeghley, & Fenwick, 2004; Pare & Felson, 2014), which can lead to feelings of envy and shame (Long, 2021). To keep up with peers and maintain one's social standing, many resort to crime.

But the link between an environment created by poverty and substance use was also evident to participants:

> *"So, I had to look after- me being the eldest, I had to look after my siblings. Make sure the house was clean and everything and (inaudible) me, I'm missing out on some practices and stuff like that. So, ja, then I, at a young age, I started smoking, just to cover that void." (Themba)*

> *"There was a family neh, in Gugulethu, this guy is-, it is a family of, I don't know, there were a lot of boys. All handsome, clean, neat, talented musically. And on Sundays, there used to be a competition and everybody at church, and they were so handsome. But because, you know, when you say, okay, after, after the competition and everything and you've won or something like that, let me just have a glass, and a glass, after another glass and all of them, they ended up being alcoholics and they were teachers, others were teachers, but all of them, they ended up down the drain. So that is the- because of exposure of alcohol in the township." (Zintle)*

"I don't want to say it's about your upbringing, I really don't want to, but I think it has, that adds a little bit to what, you know, if you kind of coming out from so-called poor household and when there's no father, or no parents, or there is parents, but they're just not there. You know, I would imagine that, that you would attach, you would- you would grab more onto the drug, than- than those that have parents, loving parents and parents that are- that are there." (Shaun)

These participants used substances as a way to deal with the stressors of living in poverty. Much research supports this view, with many studies suggesting a link between poverty and increased risk of substance use (Chen, Miller, Brody, & Lei, 2015; Karriker-Jaffe, 2011; Stimpson, Ju, Raji, & Eschbach, 2007). As discussed in the theme, *Addiction and Agency*, inequality generates much shame among the poor, particularly in democratic societies such as South Africa that are permeated by cultures of social comparison. Social resentment is rampant in South Africa—the so-called 'protest capital of the world'—as formal social equality is publicly recognised yet stark inequalities in power, education and wealth remain (Long, 2021).

For working-class individuals, such power differentials are typically explained by evaluating themselves negatively. In supposedly meritocratic societies, the dominant ideology operates in such a manner that working-class people are encouraged to interpret their failures as a reflection of their own allegedly inferior abilities. Assuming personal responsibility for societal failures leads to intense experiences of shame, which can result in people searching for consolation in substances (Long, 2021). Here, the intersection between participants' identities as working-class individuals intersects with their identity as substance users, a relationship that is mediated by experiences of shame.

Participants also drew connections between all three variables, namely, poverty, crime, and substance use:

"I was living in the shacks. So, I was joining, I join the robbing Golden Arrows and doing robberies and hijackings … So, at least we cut the shares. Then, we put together. The one we going to drink, the one we are going to smoke." (Themba)

"Um, I was working. Yes. But up until the company goes down. So that was about, I think 15 years of my working, but then three years of- before it goes

down, I was still working, and I was in addiction. Um, to get more money when I wasn't working, I would, um, I would transport the drugs, um, from place to place." (Rafik)

Some participants felt they were forced into crime due to poverty, and criminal activities also partly supported their drug habits. For others, substance use was part of a lifestyle that involved crime. This is supported by research suggesting that crime either provides individuals with money to buy drugs or it places individuals in an environment that tolerates and supports drug use (Collins, Hubbard, & Rachal, 1985; Menard, Mihalic, & Huizinga, 2001).

Again, shame comes into play as the intersections between participants' identities as gang members, working-class individuals, and substance users become apparent. The felt lack of agency that comes with being unable to improve one's material prospects through legal means, encourages the development of an alternative form of agency characterised by criminal behaviour. Indeed, poverty is associated with chaotic and unpredictable behaviour as people struggle to act rationally and exercise self-control (Sennett & Cobb, 1972). Gangs and gang membership must be contextualized within this cauldron of disorganized behaviour—not to mention the emasculation of young men—that is associated with the experience of (relative) poverty.

Some participants spoke of using substances as gang members in preparation for committing crimes:

Themba: "The feeling you have, the confident you have. Like, especially when you are in a fight. You know exactly that anytime, like the enemies will come and attack. Like you feel freer, you confident like, you always are, what can I say? You aware, like."
Interviewer: "Almost fearless?"
Themba: "Yes! Fearless, like you prepared, like, for anything. Like you feeling yourself, like you high like, like you on top. Like you know when you- let's say, you preparing yourself or at school, you did like read your notes, you are ready for your test. So, I was like on that moment like, it's like when I smoke, like, it's like I did my training session. Like I'm ready for the race like, I'm ready for the fight like. I was always aware like, even for the police, I was not scared for the police."

Caleb: "And ja, and when it gang fights, they do drugs, you know? the same reason - reason why, like, I used to do drugs, to numb because I don't believe- you either have to be a psycho to kill somebody sober minded or heavily under the influence of drugs and that is what they do- they do drugs before they go gang fight, you know?"

Participants, that is, used substances before engaging in gang-related criminal activity to reduce fear and nervousness, and to increase alertness (Brunelle et al., 2000; Parry et al., 2004). To be sure, research indicates that many offenders test positive for illicit substances at the time of their arrests (French et al., 2000; Parry et al., 2004).

However, the link between substance use and violence was not exclusive to gangsterism:

"He was saying 'look at you, your eyes, you smoked weed', but I was drinking, and I felt good about myself. I looked good. I was out in the world socially but all he could see was the negative and then he wanted to attack me. I defended myself and I accidently hit my dad." (Keith)

"Even now, she's telling lies about six years ago when we met each other, I raped her six years ago, I raped her which is not true and the part of- the abusing part which is not the whole truth it- we were in an abusive drug relationship." (Caleb)

"Uh, the reason I'm saying this is, um, is that I threatened my son once with a gun. I was drunk." (Cameron)

In these three excerpts, participants' experiences related most closely to psychopharmacological violence where the intoxicating effects of substances facilitated their violent acts (Goldstein, 1985). Participants who reported such experiences were either alcoholics or stimulant users, which accords with previous research that the most relevant substances regarding psychopharmacological violence include alcohol and stimulants (cocaine and amphetamines) (Goldstein, 1985).

Most of the narratives linking substance use to crime, violence and gangsterism were provided by male participants. Keeping in mind the impoverished contexts within which many of the participants grew up and currently live, gendered narratives emerged from the data

linking substance use to traditional constructions of masculinity. First, all male participants found ways to bring money and other symbols of success into the interview space:

> *"Ok, as I said, I had money. So, I always had money. I always had money, I was like, I always had money. It didn't matter where, I'd get it, if I didn't have it, I'd get it. I always had money on me. So, it wasn't a problem for me not to, like, get the stuff or something." (Cullam)*

> *"Being a chef in the Navy at a very young age and experiencing all that freedom, all that power, that money. You work one day, you off two days. Single. Handsome I mean, come on, I had the whole world at my feet." (Themba)*

> *"And I just started, and it became, uh, I suppose it was my thing, um, got me a lot of friends, uh, had a smart car, good car, uh, always had booze, always had money, that type of thing." (Cameron)*

> *Rafik: "So, for me, it was more of the lifestyle being in that, you know, in that crowd"*
> *Interviewer: "What, what about the lifestyle was attractive to you?"*
> *Rafik: "Um, the money, the, the girls, the, the cars, you know?"*

Male participants invariably brought talk of money, cars, easy access to substances, having a good job, having cash on hand, and women into the interviews, which may represent, as it were, a performance of masculinity among this sample of men. Bringing these traditionally masculine symbols of success into conversations was perhaps how they signalled standards of masculinity, revealing the expectations of a successful man in their communities and society at large (Seedat et al., 2009).

For these men, tangible symbols of success appeared to form part of the identity of being a successful man; this may be particularly so in the context of poverty where a lack of material symbols of success can leave men feeling ashamed at not meeting the societal expectations of a successful man (O'Neil, 2008, 2013; Seedat et al., 2009; Wilkinson & Pickett, 2010). Many of the participants felt that having these symbols of success assisted them in other areas of their

lives—such as making friends—which dovetails with the need for acceptance and approval covered in an earlier theme, *Unmet Attachment Needs*.

For many male participants, however, attaining these symbols of success was not possible due to poverty. Accordingly, pride and respect became particularly important to their masculine identities where a loss of face was a potential trigger for violence (Gebhard, Cattaneo, Tangney, Hargrove, & Shor, 2019; Vandello & Bosson, 2013) that would be aggravated further by substance use:

> *Cullam: "Um, it was basically just for me that"*
> *Interviewer: "All the violence?"*
> *Cullam: "Like I don't know. I just, like, have that streak in me"*
> *Interviewer: "Why do you think that is?"*
> *Cullam: "I don't know, probably masculine men, something about men"*

> *Caleb: "So, my reaction was I was going to kill this guy, man, because I was under the influence. I had to make a point and to prove my bad boy-ship, you know what I'm saying? Because here, like, my right hand is standing next to me, how's he going to now think that I'm a wuss, you know what I'm saying?"*
> *Interviewer: "Ja, you got to live up to your expectations."*
> *Caleb: "So, I didn't think about consequences, nothing, and I was very high and stuff. I took the gun and I cocked and I- the gun jammed I was like… that guy was also like …."*

Participants traced clear linkages between acts of violence and masculine identity. The idea of earning respect through violence was mentioned explicitly by Caleb who stated that he had to commit violence to earn his friend's respect. By the same token, other participants also identified disrespect as a trigger for violence:

> *"Ja, like don't stand on my tekkies, don't mess my tekkies up, if you mess my tekkies up and there's going to be a problem. If I see or feel a guy stand on my tekkie and I see a mark them, I'm going to bomb on him, seriously." (Cullam)*

> *"Like those things. So, just to stop all of the anger you have inside, it's better I smoke because maybe somebody will step on your toe. In that anger you have, maybe you landed up doing something, you see. Like, ended up assaulting somebody, going back to prison again. So, to get into prison is very easy, to come out there is very difficult." (Themba)*

An extensive body of research has documented how perceptions of disrespect and the resultant feelings of shame can serve as a trigger for violence among men (Bosson, Vandello, Burnaford, Weaver, & Arzu Wasti, 2009; Gebhard et al., 2019; Gilligan, 2003). To be sure, men can use aggression and hostility to lessen their experiences of vulnerable emotions such as shame (Gilligan, 2003; Jakupcak, Tull, & Roemer, 2005). This may have particular resonance for men from impoverished backgrounds where the 'code of the street'—which is all about respect—can reinforce social norms around 'toughness,' such as an avoidance of vulnerable emotions (Jakupcak et al., 2005; Long, 2021).

For poor and working-class people in an unequal society, respect is everything and the smallest provocation—whether real or imagined—cannot go unpunished (Long, 2021). The shame of poverty gets displaced from the original problem of structural violence and manifests as interpersonal violence, frequently against the most vulnerable members of society (Gilligan, 1996; Long, 2021). This is particularly so if the individual lacks other means of earning respect such as formal education, occupational skills, financial achievement, or social standing in the community. Such factors are highly influential in manifestations of violence, as the shame of relative poverty is enough to provoke displaced acts of violence (Long, 2021).

Additionally, people can feel ashamed about feeling ashamed, especially over trivial matters (Gilligan, 1996). As shame envelops shame, individuals are overcome with these feelings and what appear to be acts of unprovoked violence are actually individual attempts at restoring feelings of respect and recognition for oneself. In other words, violence can be seen as an (antisocial) attempt to regain a sense of agency in one's life (Gilligan, 1996; Long, 2021). The relationship between inequality and violent crime, in other words, is mediated by shame, which, in turn, is strongly associated with problematic substance use (Long, 2021). Indeed, the intersections of class and gender are compelling in the context of violence, gangsterism and substance use, with each or all of the latter three phenomena serving as potential avenues for performing one's masculinity successfully (Cooper, 2009).

Theme 5: The Psychology of Active Addiction

While participants spent much time discussing the many factors that contributed to their substance use, they also discussed factors that characterised active addiction. Firstly, addiction was perceived as a period of wasted time:

> *"I've wasted a lot of time and a lot of money whereas I could have done something for them as their uncle." (Keith)*

> *"And that's why. I need it for myself. I can't do it, I can't. 20 years is 20 years. It's a lifetime, you know, there's so much could have been done in that time and I wasted it using drugs." (Shaun)*

> *"Oh, my word. What- I've wasted a lot of time. I wasted a lot of time because now I have new feelings." (Romy)*

> *"I've stolen 30 years of my life and of my family's life." (Jacque)*

Participants felt that this time could have been used for more productive activities that aligned with their life goals. Research has shown that addicts are unable to maintain a regular routine as drug use often interferes with their circadian rhythms (Davies & Filippopoulos, 2015). Additionally, addicts are preoccupied with the 'now', with the future closed or experienced as extremely distant (Kemp, 2009; Ruckenstein, 2012). This distorted sense of time may partly explain participants' reflections on periods of active addiction as wasted time. Now in recovery, they may be acutely aware of the heightened value they placed on their immediate need for substances at the expense of future goals.

Despite this focus on the 'now', addicts' preoccupation with substances inhibits their connection to the present, as they remain fixated on their addiction and the subsequent guilt, regret and shame that follows (Davies & Filippopoulos, 2015; Kemp, 2009; Wyllie, 2005). As such, active addiction was also characterised by a sense of hopelessness:

> *"Ah, I was giving up in life. Like, telling myself. The thought, like I have a criminal record. I don't have a qualification, like where I'm going to get a job." (Themba)*

"Hopeless, the future was bleak. Nothing. I just threw myself away." (Zintle)

"I just gave up. I just like- I gave up. I'm like, well, there's nothing to look forward to." (Romy)

"And then over the years I have had thoughts of, how can I end my life? Can I take out an insurance policy on my life? How can I make it look like an accident? Cause I'm worth more to my children dead than I am alive. That thought has crossed my head many times." (Jacque)

Due to this sense of hopelessness, participants spoke about giving up and, as a result, felt that they might as well resign themselves to a life of addiction. Addiction is often characterised by a bleak view of the future as addicts cannot envision the real possibility of sobriety (Maté, 2008). This is supported by research suggesting a link between hopelessness and substance use (Baines, Jones, & Christiansen, 2016; Jalilian et al., 2014).

Addiction was also characterised as involving dishonesty. This dishonesty manifested in multiple ways, the first being the manipulation participants used to support their drug habits:

"But ja, because I think about a drug addict, they say a heroin addict is the most manipulative person on earth, it goes for any drug user. For any drug user. We like to manipulate things. So, it can suit us and suit our thing that we doing." (Waheed)

"I used to get everything and anything I wanted and ja, with a bit of manipulation also. That is part of the behaviour (inaudible) of a drug addict, you know? Because there is times when my mother would draw boundaries and then you know? But then I would manipulate her by saying that ja, but you know that what drugs does to a person. If- if the enabler is not going to enable me anymore, then I'm going to resort to crime man." (Keith)

"I would encourage my family to go out so that I can do my thing, so I would drop them. When last did you see Jenny? Why don't you go sleepover there, you haven't seen her? She's a school friend. Why don't you go sleep over

there, take the kids with, just so I can do my thing alone at home. You understand?" (Shaun)

"I have a gift of the gab. I manipulated. I would manipulate my children. Wasim now is [overseas], but I mean, when Wasim bought his flat… I would manipulate him with a whole lot of stories." (Romy)

Participants identified their manipulation as a way to support their habit during active addiction. This aligns with literature indicating that manipulation is a key aspect of drug addiction (Maté, 2008), with addicts using various strategies to maintain their addictions (Lex, 1990; Maté, 2008). In this study, manipulation was most commonly used against family members, demonstrating how addiction is a phenomenon that affects many people besides the user, as discussed in the theme, *Addiction and Agency*.

Another way dishonesty manifested during active addiction was through secretive substance use:

"I didn't like show people that I used to take drugs, I was always go undercover so I used to keep to myself." (Cullam)

"Um, I started using and then I started using secretly, which meant that I couldn't let anyone else in." (Shaun)

"But then when I moved to Bokaap, I, nobody was watching me anymore. I'm living alone and so on. So, every Thursday I would go to the area where I used to do my thing and I would get away with it, you know? I was smoking, like, maybe for two then I come back home, and I wouldn't smoke anymore." (Rafik)

Moreover, participants made excuses and/or lied to hide their substance use:

"So, my father noticed it and my mother noticed and I say, 'eh, I'm just tired and I'm not perfect, and I can forget." (Waheed)

"I was, it was self-denial because, you know, at the end of the day you cannot hide alcohol. So, I started like making excuse… So, I started to make excuses, not appearing for birthdays. Forgetting people's birthdays and just funny, odd behaviour, small things, neh. And then people started to notice that, I mean, this is definitely not like her, yes." (Zintle)

"Uh, so then I used to avoid going to office. I used to make excuses like left, right, and centre. Because I was drinking because I- well drinking, but more needed that drink in the morning to stabilize myself because I was shaking like this and I couldn't do a (inaudible). Okay. And I used to check myself in the morning and depending on how I shake, you know, that was it, that determines, ok, ok, here goes the lie and off goes the WhatsApp to my boss. I'm not coming in. I'm working from home, that sort of thing." (Cameron)

These acts of dishonesty may be attempts at avoiding feelings of shame. As discussed across different themes, addiction is shrouded in shame (Flanagan, 2013; Rahim & Patton, 2015)—shame that one could not refrain from using substances, shame that one was not able to meet the expectations of family or society at large, and shame about having to lie to loved ones about addiction. In order to avoid the experience of shame, dishonesty is used in its many forms as an avoidance-based strategy.

Finally, dishonesty in the form of rationalisations was used to justify the continued use of substances:

"I was very bitter and grudgy and it led me back to drugs and everything and I just had to be honest with the fact that I was just looking for a reason to drug again." (Waheed)

Caleb: "I can tell you man, I used to steal man, you know, and that was my way of- I mostly stole from people that hurt me"
Interviewer: "Ja"
Caleb: "You know?"
Interviewer: "As a form of revenge almost"

Caleb: "Yes, I always wanted to- it's like I want to draw the demons in that way. Listen here, me and you? We have issues man, you know what I'm saying?"
Interviewer: "And this is what I did"
Caleb: "And this is what I'm doing"

"Um, so then the drinking started again, um, it just got to a point back in 2002. After I had a seizure, I just collapsed one day up there, had a seizure and then I went for check-ups and all blah, blah, blah. Blamed it- never blamed it on alcohol, blamed it on the fact that I used to have seizures, convulsions when I was a baby and it's coming back quote unquote. That was my excuse." (Cameron)

"Sjoe, it went from weekends to, uh, then it- then what I would do is I would use during the day, every day, at work. Because I believed, in my mind, that I could not do my job without it." (Jacque)

Participants further rationalised their substance use as non-problematic by convincing themselves that they were in control of their substance use:

"Yes, and afterwards, we tell ourselves that you can handle this, and nobody is noticing anything. So, it's just myself and my friend, we know about it." (Waheed)

"I did not even see myself as an alcoholic, you understand. I was always trying to stop, and I'm thinking that I can, I can do this on my own because I was like, I started on my own and then I'm going to stop on my own. So, there's nothing that is going to beat me." (Zintle)

"I just couldn't understand why everyone was making such a big deal because I was doing so awesome. I thought I was doing so awesome." (Romy)

"And then I would find downers from doctors or from, or I could buy it on the street. Tranquilizers to put me to sleep so that I could maintain. I thought I was under control." (Jacque)

These rationalisations and the perceived sense of control over substance use helped participants excuse their substance use as unproblematic and justified continued use. Research indicates that addicts have been found to use defence mechanisms such as rationalisations (Bornstein, Gottdiener, & Winarick, 2010; Maté, 2008; Rinn, Desai, Rosenblatt, & Gastfriend, 2002) as a form of self-denial, and much literature suggests that denial is characteristic of active addiction as an avoidance-based coping strategy (Dean, Kohno, Morales, Ghahremani, & London, 2015; Pickard, 2016). If addicts are in denial about the negative consequences of their substance use, they do not have to acknowledge the harm it does, thereby justifying continued substance use (Pickard, 2016). Recognising one's cognitive denial system plays an important role in recovery: the first step in many recovery programmes, including Alcoholics Anonymous, is to admit one has a problem, which can be seen as the opposite of denial (Alcoholics Anonymous, 2001, in Pickard, 2016).

Participants' experiences of active addiction in this study align closely with those of other substance users described in the literature, across a range of social positions and contexts (Kemp, 2019; Maté, 2008). In other words, despite individuals' social contexts being important to understanding the development and maintenance of addiction, this study did not identify specific cognitive strategies that separate working-class substance users in the Western Cape from users in general. Accordingly, the subjective experience of active addiction, while inflected by the intersection of various identity markers, may consist of universal cognitive aspects too.

Theme 6: Recovery

Motivations to recover.

Participants discussed the various reasons they wanted to recover and, for many, the hope of achieving something in the future served as a significant motivator:

"Ok um, ok, the thing is, I'm thinking of my future now. I want to get a better future. So, for me, if I'm going to go on with my drug use, say drug use, it just going to probab-… it's not going to benefit me." (Cullam)

"So, as a young man, like myself, like I always have a dreams. Yes, I was giving up in life, I am still like in that situation but now I'm still- I'm looking up to my recovery like ja, like life." (Themba)

"Like I said, I want, I want, I want, I want my life back. I want that person who used to be a dreamer to dream again. And it's not really, yeah. I want to achieve the things that I wanted to achieve." (Zintle)

Participants felt that substance use had prevented them from achieving their goals. As such, a major incentive for recovery was the prospect of a better life with meaning and purpose. Finding purpose plays a key role in recovery (Maté, 2008; White & Kurtz, 2006) because it encourages a more positive outlook on life. For still others, relationships with their families and mending relationships that were ruined were their reasons for wanting recovery:

"So, I decided I'm going to make myself better, for my family as well." (Callum)

"My sister is raising a boy and a girl, and they so remind me of me and my sister when we were younger, and they're getting older now. And I don't want them to be disappointed at me or to be disgusted in me or to just lose respect for me. So, I need to recover right now." (Keith)

"I lost a lot of people in my life. Good friends, good family members. And I mean, I'm not hearing from them now, which I understand because I've hurt them in the past, I took advantage of them. And, um, and, and hopefully in the future those are all relationships I can still patch up again, but I've lost a lot. I've lost a whole lot." (Shaun)

"Um, I want to make friends with my ex-wife. I didn't, there's never been any arguments. She's just been very mean, and I'm just (inaudible) it, but I went to- when I see her, on the 5th, I want to ask her if we can be friends." (Jacque)

"Um, I miss my family and I don't want to lose my family." (Cameron)

The value placed on finding purpose and the focus on improving relationships may be related to the idea of shame and, more importantly, its opposite: respect. As discussed in the theme, *Addiction and Agency*, shame is an extremely public emotion (Long, 2021). As compensation through personal achievement is often not an option when one comes from an impoverished background, participants may have been wanting to replace their feelings of shame about past actions with new actions that bring a sense of pride, respect, and recognition from 'the public'—that is, from friends and family.

Moreover, mending relationships may relate back to the sense of belonging discussed in the theme, *Unmet Attachment Needs*. The prospect of losing one's family and the attendant sense of belonging was paramount for some participants seeking treatment. Of course, this could also have been part and parcel of the addictive process in which addicts look to gain their families' trust by seeking treatment in order to continue substance use. This harks back to the manipulation and deception characteristic of active addiction as discussed in the theme, *The Psychology of Active Addiction*. It is interesting to note that a need for belonging can act as a risk factor for substance use and as a protective barrier. For those who lack a sense of belonging, substance use can provide them with a feeling of acceptance and approval. Contrarily, when this need is met in prosocial ways by other people, it serves as a protective factor against substance use. This point is supported both by studies linking substance use to isolation (Copeland et al., 2018; Page et al., 2011; Stickley et al., 2014), and literature suggesting that a sense of belonging serves as a protective factor against substance use (Binswanger et al., 2012; Oxford, Oxford, Harachi, Catalano, & Abbott, 2001).

Another motivation to recover was the prospect of re-entering prison:

> *"So, for me, if I'm going to go on with my drug use, say drug use, it just going to probab-… it's not going to benefit me. I'm probably just going to go back to jail or ja. So, the main thing, going back to jail because Pollsmoor, it's not a place for people." (Cullam)*

> *"I don't want to be in that situation [prison] again, ever again because I mean, I thought I was invincible which I wasn't, and I got caught with the stupid half, man. And anything can go wrong in my life. So, it was a wake up for me." (Rafik)*

Participants who had been in prison found the experience traumatising. While it was not explicitly mentioned, when looking at the history and culture surrounding prisons in South Africa, one can make an educated guess that part of the traumatic nature of prison life relates to the violence, and specifically sexual violence, that is experienced by prison inmates at the hands of, for example, the Number gangs (Gear, 2010; Lindegaard & Gear, 2014; Steinberg, 2010).

Characteristics of recovery

Participants described recovery as having specific values and qualities, such as it being a time of newfound positivity:

> *"I feel now, now, I'm feeling good now. Like I'm thinking positive." (Themba)*

> *"So, that is- (laughs) that's the major setback in my life. Um but ja, I'm still positive." (Keith)*

> *"And also a few things you have to be forgiving and to be just, just to have a positive energy surrounding me." (Zintle)*

This optimism can be understood as the opposite of the 'hopelessness' discussed in the theme, *The Psychology of Active Addiction*. A systematic review of almost 100 papers identified hope and optimism about the future as one of five processes that are key to recovery (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). This finding may be related to the fostering of supportive relationships where feelings of connectedness and a sense of belonging give recovering addicts hope that they can lead fulfilling lives (Tew et al., 2012).

Other important characteristics of recovery that were mentioned, were honesty and openness:

> *"So, one of the things they said that I have going for me, I didn't have years before, it's the honesty factor and the open factor man." (Waheed)*

> *"Yes god, I'm just waiting that you're going to open up doors for me. And so, um, I'm so open." (Zintle)*

"And I told her, I'm now at the honesty thing. I'm entering a new place, honesty is a big, is a big thing right now. I got nothing to lose to lie right now. Do you know what I mean?" (Shaun)

"So, all I have is the clothes on my back. And, uh, and honesty, open-mindedness, and willingness." (Jacque)

Just as positivity and hopelessness are opposites, similarly, honesty can be interpreted as the opposite of 'dishonesty', which characterises active addiction. The practice of honesty is prevalent across recovery literature: working through shame to a place of self-acceptance, through the process of honesty, has been found to be essential to successful recovery (Matthews, Lorah, & Fenton, 2006; Melemis, 2015), as dishonesty wastes energy that could be focused on recovery.

Another characteristic of recovery was articulated as the need to put oneself above all else during recovery:

"So, for me most of the time, I like to be alone uh. To help myself for now." (Themba)

"Uh, but not, now that I understand what you're saying. Right now, I need to fix myself." (Cameron)

"I'm going to give it up, but this one day I decided, you know what, I'm doing it for myself, not for my children. They've grown up now and I'm doing it for me now. I can't keep ricocheting like this. I can get my act together, rather late than never. And yeah." (Romy)

"Uh, I put myself first because anything you put before your recovery, you'll lose. And I'm testament, I've lost my wife, I've lost my kids. I lost my house. Lost everything. Lost my job, lost my car. So, all I have is the clothes on my back." (Jacque)

For all participants, a key part of recovery was to prioritise their recovery above all else. Research has shown that directing compassionate curiosity towards oneself during recovery is important, as a lack of self-care is part of what contributes to—and maintains—individuals' addictions and can lead to relapses (Khantzian, 2011, 2013; Maté, 2008; Melemis, 2015). Clinical experience has shown that addicted individuals typically take less than they need and, as a result, they become exhausted or resentful and return to their addictions. Part of challenging addictive thinking is to encourage clients to see that they cannot be good to others if they are not kind to themselves first (Melemis, 2015).

Another characteristic of recovery that was emphasized, was the importance of meaning-making:

> *"Ja, it's just I lost some good friends, good friends and it's not because of anything. It was because of me. So, ja. I should have been, I'm not supposed to sit here today also. So, that's why I'm taking this chance also to really, really, really, to really make it my last time in any institution or rehabilitation programme." (Waheed)*

> *"Because I believe that um, God put me on this path. So, if it didn't happen in Saldanha, it was going to happen some or other way. And um, luckily for me I was young. I was hard-headed and I was a fool to throw myself so deep into it but after 10 years, I at least have the experience to come right now. I don't have any children so there's no kids whose lives I can actually ruin. It was just- unfortunately, I had to go through experience what I experience because maybe my life is only to teach someone else and to help someone right. I honestly don't know, I'll have to see." (Keith)*

> *"Okay, my wife and my youngest son is still up there, and my eldest son is here with me. Well not with me, he's staying by my brother-in-law and I'm living here. Um, so he was caught, and his case came up. He was sentenced to 10 years for using, uh, that was hard on us and that killed us as a family actually. But on the other side it brought us closer religiously, um, yes, we were before that had happened, myself and my wife, we sort of changed our lives towards God, more, because I had drifted away. Uh, but we, we got very*

close, and we were working our own sort of program, religious programme." (Cameron)

Some participants felt that they had to go through their addictions to reach a point of self-awareness, personal growth, and enlightenment. This finding is supported by studies showing that, for recovering addicts, meaning-making helps them attribute new significance to painful experiences, which then become aligned with their recovery journeys (Hansen, Ganley, & Carlucci, 2008; Leamy et al., 2011). Indeed, many participants made sense of their experiences through their spirituality where one's relationship with a higher power was deemed vitally important during recovery:

"Because I believe that um, God put me on this path. So, if it didn't happen in Saldahna, it was going to happen some or other way." (Keith)

"It doesn't mean I can't fall again, you know what I'm saying? That is why I'm trying to keep a structured life now, you know? Going to church and staying in the house, you know? I don't feel safe out there anymore." (Caleb)

"And so that left me with like, you know what, God help me to change my life, help me. I want to, I want to win this battle, I want to win this battle. Yes. I might have a flop. But, uh, help me to- restore me, I prayed for restoration." (Zintle)

"Um, it's helped me because God has shown me how powerful he is in my life, my family, uh, the way he's helped us through- our dedication to him." (Cameron)

"I know that I believe that God loves me. I believe that he forgives me for everything that I've done, and that in itself is something that is amazing because it's a miracle." (Jacque)

For these participants, spirituality was a way of finding a sense of acceptance and approval. Previous studies have documented how recovering addicts reported higher levels of

religious faith and affiliation (Carroll, 1993; Pardini, Plante, Sherman, & Stump, 2000) and that religious involvement was associated with lower levels of alcoholism and drug abuse (Payne et al., 1991). This may be due to spirituality giving addicts a deeper sense of purpose by increasing social support and a sense of belonging, in addition to providing them with healthy strategies for handling new stressors (Carroll, 1993; Nealon-Woods, Ferrari, & Jason, 1995). Being religious or spiritual is seen often as the antithesis of problematic substance use: one cannot be religious or filled with a sense of awe (that is not chemically mediated), and be a substance abuser. Indeed, it has been observed that addiction is fundamentally associated with spiritual deprivation (Maté, 2008) whereas greater spirituality has been found to be a protective factor against problematic substance use (Kulis, Hodge, Ayers, Brown, & Marsiglia, 2012; Lake, 2012).

Barriers to recovery

While participants' spirituality helped them navigate the recovery process, there was also mention of one prominent barrier to recovery throughout the data set, which involved both close and community relationships. For many participants, that is, the stagnation of, and damage to, these relationships were a challenge to their recovery journeys:

> *"You come back into society, you come back to the same things that you left behind maybe six months ago, three months ago like that man then- then- then even though I was equipped with tools, and this is the hardest part for me, because I couldn't understand it. I have to go through all this stuff, learn about my addiction, getting the right tools to do- to deal with certain situations that will lead to relapse and stuff but when it actually happens man, and then you find that there's more- there's more to it, man, than just facing the situation, than taking out the tools." (Caleb)*

> *"Um, I don't know. Right now, I'm battling with the fact that- that, umm, yeah, like I said, I've been three, three months clean and, and, um, but I feel like my family, are still, are still coming up [trying to work through the pain caused by his addiction and accept that his recovery is genuine and sincere], you know? They still at the start of me coming in [for recovery] because they haven't had the help yet. You know, they haven't sit down because this place,*

as well as Loaves [another treatment facility], has done miraculous things to me. You understand, but they still stuck in that." (Shaun)

"Uh, my sister-in-law's giving me a hard time, my eldest brothers wife, because they, they've been helping me, month-by-month to give me some money. And now she thinks that I've been using that money for alcohol. That's not because I- medication and they don't want to listen to me. And that gets me, it works on me, but it's not to a point where I want you to drink about it, but something that I've put behind me already. Um, I know what's the truth. I know that I did not use their money." (Cameron)

"I've been drunk for so long, she doesn't trust that I would actually sell a house and I would actually do what I say I'm doing. So, she's sceptical about me, you know, and she doesn't want me to lose totally everything." (Romy)

Participants felt that, while they had done the hard work to recover, coming back to the same environment and the same people made it difficult to maintain abstinence. A spiral into old habits was easy because nothing in their surroundings had changed. This appears to confirm an observation made in a previously discussed theme, *The Psychology of Active Addiction*: participants perceived their environment as unchanging and therefore could not see the point of recovering, thereby rationalising and justifying continued substance use. For many, the lack of change in these relationships contributed to their previous relapses. The road to recovery felt impossible because nothing about their environments had changed, keeping in mind that these environments had been influential—at least in part—in the development and maintenance of their substance use (Caprioli, Celentano, Paolone, & Badiani, 2007; Maté, 2008). This speaks to the complexity of addiction: while participants may not want to place blame on their families—as discussed in the theme, *Addiction and Agency*—addictive thinking can complicate such a sentiment.

Moreover, these excerpts highlight the impact of addicts' previous dishonesty on family relationships—also discussed in the theme, *The Psychology of Active Addiction*—as family members were now reluctant to trust them on account of past behaviour. While participants were ready to resolve their issues and move on, their loved ones were not. The lack of encouragement and acknowledgement made it difficult for them to stay motivated and, since

social support is an important aspect of the recovery process (Laudet, Morgen, & White, 2006), would likely make it harder for them to remain sober.

Conclusion

Participants attempted to take ownership of their addiction by discussing substance use as a personal choice. However, medicalised understandings of addiction were also present, highlighting participants' layered understanding of addiction as multi-faceted. Moreover, the effect of participants' addiction on their families and close social networks highlighted the need for addiction to be seen as a socially and environmentally influenced disorder, as opposed to a strictly individualised pathology.

Of particular prominence was the presence of shame in participants' narratives. It is possible that the shame of poverty can result in a lack of agency, which can lead to substance use as a way to deal with the painful emotional experiences associated with living in poverty. Shame was also revealed in relation to participants' embarrassment over their behaviour when intoxicated or when procuring substances, highlighting the salience of the shame-addiction cycle. Moreover, shame operated at the intersection of participants' identities as working-class individuals and substance users in respect of the failure to achieve material success.

Indeed, the findings of this study offer further support for the self-medication hypothesis. Substances were used to manage undiagnosed mental health issues, deal with traumatic childhood events, cope with the loss of loved ones (through death or a romantic relationship ending), cope with intense experiences of helplessness and a lack of agency over one's life, and as a response to experiences of relative poverty and the associated shame. These can all be understood as different manifestations of stress in participants' lives which was self-medicated with substances.

Another prominent finding was the relationship between participants' substance use and their need for acceptance and approval. This speaks to the unmet emotional needs and lack of healthy attachments in participants' early childhoods. Here, substance use may have served as a self-soothing mechanism, relating back to the self-medication hypothesis. Participants' unmet emotional needs are understandable when considering the numerous responsibilities their caregivers may have had to juggle. In the precarity of working-class life, it is not uncommon for caregivers to be preoccupied with meeting the basic material needs of their children, with the result that the latter's attachment needs may be placed on the back-burner.

Many male participants joined gangs to fulfil their need for acceptance and approval; however, substance use formed part of this group identity, which may have contributed to participants' struggles with addiction. Gangs and gang membership can be understood as a means of generating order amid the chaos and unpredictable behaviour that poverty encourages. Much of the narrative linking substance use to crime, violence and gangsterism came predominantly from male participants: considering the context within which many of the participants grew up and currently live, a clearly gendered narrative emerged, linking constructions of masculinity to substance use in various ways.

For many, attaining symbols of success is not possible due to poverty. In this context, pride and respect became particularly important to the masculine identity where a loss of face serves as a trigger to violence. Since respect is so intertwined with constructions of masculinity in the underclasses, substance use and gangsterism can serve as avenues for performing one's masculinity successfully. The idea of substance use as a way to perform one's masculinity can also be related back to the need for belonging. In order to feel like one successfully embodies the hegemonic masculine identity, one may feel a need for approval from those who are considered masculine, namely, fellow gang members and male peers.

In this study, active addiction and recovery were seen as occupying opposite ends of a spectrum in various ways. While active addiction was characterised as a period of dishonesty—displayed in participants' manipulation of loved ones, secretive substance use, lying to hide substance use, and rationalisation of substance use—recovery was characterised as a time of honesty and openness. The acts of dishonesty may represent an attempt to avoid feelings of shame: shame that one could not refrain from using substances, shame that one was not able to meet the expectations of family or society at large, and shame about having to lie to loved ones about addiction. Active addiction was also characterised as a time of hopelessness whereas recovery was seen as a time of newfound positivity. This optimism can be understood as the opposite of the hopelessness that characterises active addiction. Interestingly, participants' social locations were not always salient in their first-person accounts of active addiction, suggesting that there may be universal aspects to the subjective experience of active addiction.

Another important characteristic of recovery involved the creation of meaning from painful experiences. Many participants made sense of their experiences through their spirituality, which served as a means for finding a sense of belonging and for them to receive positive acknowledgement.

Participants also spoke about the barriers to recovery: most prominently, these included the environmental stagnation of their communities, social circles and relationships, which made

it difficult to remain clean and sober. Remaining clean and sober felt impossible when nothing in their environments had changed, partly because these environments were influential in the development and maintenance of their problematic substance use.

Finally, participants spoke about the various motivations to recover, including hope of achieving something in the future, wanting to mend relationships that were ruined, and not wanting to re-enter prison. The value placed on finding purpose and the focus on improving relationships can be seen to be related to the idea of shame, and more importantly, its opposite: pride and respect. Many attempted to replace their feelings of shame about past actions with new actions that brought a sense of pride, respect, recognition, and belonging.

Significance of the Study

While extensive research has been conducted on substance abuse in the Western Cape, most of it has focused on quantifying aspects of the problem. Research focused on qualitatively exploring how substance users from poor and working-class backgrounds understand their addictions is lacking. Accordingly, research in this area is important not only because it will generate new knowledge by addressing a noticeable gap in the existing literature, but because it promises a more nuanced understanding of substance-use behaviours in these communities that can aid policy development and community intervention.

To be sure, the results of this study correspond in many ways to existing literature on substance abuse. However, its contribution lies in the links it makes between problematic substance use, violence and poverty, through the mechanism of shame, in a South African context. Moreover, the study collates several aspects of participants' understanding of addiction into an integrated narrative—aspects that are ordinarily studied independently of each another.

Limitations

This study is not without its limitations. Interviews relied on the free disclosure of participants and, due to the sensitive nature of some of the questions, participants may not have felt comfortable disclosing certain information. In this respect, it is hoped that the guarantees of confidentiality and anonymity encouraged participant disclosure. Another limitation that could have affected participants' responses was the provision of food parcels as compensation for participation. Since many of the participants were homeless, participants may have felt obliged to provide answers they thought I wanted in order to obtain the food package. However,

participants were explicitly informed that the food package was guaranteed irrespective of how the interview played out.

On a different note, I was the primary instrument for interpretation, which implies the possibility of biased readings of the data set. This possibility was addressed by ensuring that data analysis was cross-checked by my supervisor to ensure the data was coded consistently and as objectively as possible. Being a student researcher, my relative lack of interview experience may have influenced the type of information participants were willing to disclose due to a lack of rapport and trust. Moreover, my nervousness may have been apparent to the first participants interviewed and may have resulted in biased data too. To mitigate this, I observed an interview with my more experienced supervisor and used the first few interviews as pilot interviews to gain confidence in the interview space.

Another issue is the small sample size: although replication and generalizability are not the aims of this study, a sample size of twelve to fifteen participants would have been ideal. The six-month delay in data collection and new safety regulations imposed by the Covid-19 pandemic made this challenging. As such, it was decided that a sample size of eleven would be adequate considering the timeline, scope and qualitative design of the research.

Perhaps the most important limitation was that of a possible language barrier. If participants could not communicate well in English, which was not always their first language, the richness of their accounts may have been somewhat compromised. Nonetheless, the preliminary pilot interviews helped guide me in anticipating and preparing for any interview-related difficulties, in addition to staying as close as possible to the terminology used by participants to ensure that their experiences were captured as accurately as possible. Relatedly, many of the participants originated from communities with a linguistic identity that I was unfamiliar with, on account of hailing from a different part of the country. With the introduction of face masks to the interview space, understanding some participants proved difficult for me, particularly in the first few interviews. This may have resulted in some misunderstanding during those interviews, which may have affected data collection. However, as my interview skills improved, I became more comfortable asking clarifying questions in moments of uncertainty.

Recommendations

Considering the limitations of the research project, there are several recommendations that are proposed. While most participants were fluent in English, they considered it their second or third language, which may have compromised the richness of the data set. As such,

future research should conduct interviews in participants' home languages, and perhaps consider the use of translators, which would only enhance the depth of the data set.

Additionally, a larger sample size should be recruited for future research to strengthen the credibility of findings. Similarly, a more gender-balanced sample is recommended for future research in order to elicit an even more diverse set of experiences. It may be valuable to conduct research that is focused solely on males or females as some of the findings in this study were strongly gendered. For men, a focus on constructions of masculinity and their relationship to substance use may be appropriate, while the shame surrounding female substance abuse could also be more closely explored.

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APPENDIX A

UNIVERSITY OF CAPE TOWN

DEPARTMENT OF PSYCHOLOGY

Original Interview Schedule

An exploration of how substance users understand their addiction.

IN-DEPTH QUALITATIVE INTERVIEW GUIDE

PRINCIPAL INVESTIGATOR:

CHRISTINA S. MEADE, PHD

CO-INVESTIGATORS:

MELISSA H. WATT, PHD

DONALD SKINNER, PHD

BRONWYN J. MYERS, PHD

M. GIOVANNA MERLI, PHD

IN-DEPTH INTERVIEW GUIDE FOR DELFT CONNECTIONS

As you are aware, we are interviewing to obtain a greater understanding of your substance use and how you have made sense of the development of your substance use patterns. We are going to ask you a range of questions about your substance use, who you use with and how it influences other aspects of your life. As we said in the consent process if this makes you feel uncomfortable at any point, you can withdraw from the interview. We also wish to state that we do really appreciate that you have made yourself available to talk to us and that what you say will really help both the research and our ongoing work to assist people who are using substance.

Some of the questions that we will be asking you to talk about are sensitive and may make you think of painful events in your life. You may want take a break at some point during the interview if the painful memories get too much. That is fine. It is also fine to end the interview early if you feel too upset. We will provide you with list of people or organisations that you can contact to help after the interview if you feel you would benefit from assistance.

Introduction

Let's start by telling me a little about yourself, like where you're from & how long you've lived in this community.

Substance use story

Can you tell me about how you started using substances?

Age, situation of life at that point

Why/how/where you started, motivations

What were the first substances you used?

Who introduced you, relationships

Other drugs used, when, why, how, where?

Others in life at that time, whether they knew about substance use

Tell me about how your substance use has changed since you started, up until now?

Changes in use of other drugs, including alcohol and cigarettes

Changes in life due to substance use, e.g., work, relationships

Any issues related to your health since using substances

Who knows about your use; who doesn't know

Tell me about your substance use prior to entering the treatment facility – how many times per week, and on the days you use, how often and how much?

Do you think your substance use is a problem? Why / why not?

How you get tik

I'd like to hear how you get the money to buy substances, or who gives them to you.

Work, stealing, selling own or family goods, begging, selling sex

Sharing of substances, what is expected when you get substances from someone

Sex for substances (e.g., "tolly for lolly")

Tik in the community

Tell me about the substance users in your community

Who uses and why: age, race, gender, other things that identify them

Black and Coloured people using together

Men and women using together

How common is use, impact of substance use on community

What could be done to reduce substance use in the community

What do you think are the substances most used in the community?

Relationships with others

Tell me about your friends and family who use substances.

Who you use with, why these people?

Family, friends who use

Family, friends who do not use

Changes in social circle with substance use

Sexual relationships

Now I'd like to hear about the relationships in your life and the people you have sex with.

Current relationship status

Types of sexual relationships, number/type of partners, how you meet partners, relation to substance use

Impact of (different) substance use on sexual desire / pleasure / behavior

Condom use, differences by partner, impact of substance use

Experience selling or buying sex, use of condoms during these acts

Experience with forced sex / violence during sex

Experiences with pregnancy / partner's pregnancy

HIV in the community

I'd like to talk to you about how you and friends feel about HIV. Have you ever been tested for HIV?

HIV testing history, how/why testing, experience, test result, reaction to HIV test

If respondent is HIV- / unknown:

Thoughts about HIV testing, benefits, barriers, reasons for not testing, willingness to test

Know anyone with HIV; thoughts about people with HIV

Who at risk, friends, other substance users

Own sense of risk and why

What would you do if you found out you were HIV+

If respondent is HIV+:

When found out, how found out, what it felt like

How got HIV, role of substances

Who you told; who you haven't told

How has life changed since HIV

HIV treatment use, telling health care providers about substance use

Experiences with gender and violence

How does substance use influence violence in this community?

General violence, criminal, gang

Violence in relationships, violence towards women, sexual violence

Own experience with violence, in community or in relationships, involvement of substances

How has violence impacted your health and emotional well-being?

Tell me about any time you have spent in jail/prison, or experiences being in a gang?

Why went to prison, for how long, violent experiences in prison

Why/when joined a gang, violent experiences related to being in gang

How prison time or gang have played a role in substance use

Mental health and well-being

In general, how would you describe your emotional well-being? What kind of mental health difficulties have you experienced?

Emotional concerns, stressors in life, difficult memories \ experiences

Influence of these experiences on substance use

Influence of substance use on mental health / well-being

Have you ever had a time in your life when you thought about killing yourself or wanted to die?

Suicidal thoughts or behaviors, descriptions and why these occurred.

Others you know who have attempted/committed suicide, role of substances

Conclusion

I want to hear your thoughts about getting treatment for substance use, or trying to stop use.

If someone wants to stop using, what are their options?

What does it mean to have a drug addiction? (medical condition, moral issue, criminality, etc)

Describe personal attempts to stop, motivations, what worked, what did not work

Personal experiences rehabs, overall views on rehab (awareness of

treatment options, challenges, barriers)

Any desire to stop now, why, possible steps you could take to stop.

What would help efforts to stop, fears and challenges

What is needed in the community to help people stop substance abuse

Thank you for talking to me about these important issues. Your input is very helpful. Is there anything you would like to add before we end?

Appendix B

UNIVERSITY OF CAPE TOWN

DEPARTMENT OF PSYCHOLOGY

Final Interview Schedule

An exploration of how substance users understand their addiction.

IN-DEPTH INTERVIEW GUIDE

As you are aware, I'm conducting interviews to obtain a greater understanding of your substance use and how you have made sense of the development of your substance use patterns. I am going to ask you a range of questions about your substance use, who you use with and how it influences other aspects of your life. As I said in the consent process if this makes you feel uncomfortable at any point, you can withdraw from the interview. I also wish to state that I do really appreciate that you have made yourself available to talk to me and that what you say will really help the research that I am doing.

Some of the questions that I shall be asking you to talk about are sensitive and may make you think of painful events in your life. You may want to take a break at some point during the interview if the painful memories get too much. That is fine. It is also fine to end the interview early if you feel too upset. I shall provide you with a list of people or organisations that you can contact to help after the interview if you feel you would benefit from assistance.

Draw connections between P's content and SU

Draw connections between P's content and the feelings it may bring up

I can hear that you've been through a lot

I can see it's bringing up a lot for you. What's coming up now? What's making you so emotional?

Introduction

Interview Number:

Date and Time:

Name:

Age:

Sex:

Race:

1. *Let's start by telling me a little about yourself, like where you're from & how you grew up.*

Area you grew up in:

Parents occupation:

Parents education level:

Your education level:

Substance use story

2. *Can you tell me about how you started using substances? How did substance use start for you?*

   Age, situation of life at that point

   Why/how/where you started, motivations

   What were the first substances you used?

   Who introduced you, relationships

   Other substances used, when, why, how, where?

   Others in life at that time, whether they knew about substance use

   What did substance use do for you? How did it make you feel?

3. *Tell me about how your substance use has changed since you started, up until now?*

   Changes in use of other drugs, including alcohol and cigarettes

   Changes in life due to substance use, e.g., work, relationships

   Any issues related to your health since using substances

   Who knows about your use; who doesn't know

Tell me about your substance use prior to entering the treatment facility – how many times per week, and on the days you use, how often and how much?

Do you think your substance use is a problem? Why / why not?

How you get substances

4. *I'd like to hear how you get substances, or who gives them to you.*

   Work, stealing, selling own or family goods, begging, selling sex

   Sharing of substances, what is expected when you get substances from someone

   Sex for substances (e.g., "tolly for lolly")

Mental health and well-being

5. *In general, how would you describe your emotional well-being? What kind of mental health difficulties have you experienced?*

   Emotional concerns, stressors in life, difficult memories \ experiences

Influence of these experiences on substance use

Influence of substance use on mental health / well-being

CAUSE -> EFFECT -> SUBSTANCE USE (does it go the other way around)

Have you ever had a time in your life when you thought about killing yourself or wanted to die?

Suicidal thoughts or behaviours, descriptions and why these occurred.

Others you know who have attempted/committed suicide, role of substances

I'd just like to move to talking about the people in your life…

Relationships with others

6. *Do you have any (friends) and family who use substances?*

Who you use with, why these people?

Family, friends who use

Family, friends who do not use

Changes in social circle with substance use

Lets zoom out a little, we've discussed your substance use and among others in your life, I want to talk about your community now…

Substances in the community

7. *What's the situation with substances in the community? Is it an issue? (go in to gender and violence from here!)*

Who uses and why: age, race, gender, other things that identify them

Black and Coloured people using together

Men and women using together

How common is use, impact of substance use on community

What could be done to reduce substance use in the community

What do you think are the substances most used in the community?

Experiences with gender and violence

8. *Do you think substance use influence violence in this community?*

General violence, criminal, gang

Violence in relationships, violence towards women, sexual violence

Own experience with violence, in community or in relationships, involvement of substances

How has violence impacted your health and emotional well-being?

Tell me about any time you have spent in jail/prison, or experiences of being in a gang?

Why went to prison, for how long, violent experiences in prison

Why/when joined a gang, violent experiences related to being in gang

How prison time or gang have played a role in substance use

Conclusion

I want to hear your thoughts about getting treatment for substance use, or trying to stop use.

If someone wants to stop using, what are their options?

What does it mean to you to have a drug addiction? (medical condition, moral issue, criminality, etc)

Describe personal attempts to stop, motivations, what worked, what did not work

Why do you want to get clean now? Why have you decided now that the substance use is a problem?

Personal experiences rehabs, overall views on rehab (awareness of

treatment options, challenges, barriers)

and why do you have a desire to stop now.

What would help efforts to stop, fears and challenges

9. What is needed in this community to help people stop substance abuse

What is needed in the communities you started and frequently used drugs in?

10. What do believe is important to understanding their addiction, or that you'd want know about your addiction? What do you believe people misunderstand about your addiction?

Thank you for talking to me about these important issues. Your input is very helpful. Is there anything you would like to add before we end?

Appendix C

UNIVERSITY OF CAPE TOWN

DEPARTMENT OF PSYCHOLOGY

Informed Consent Form and Participant Information Sheet

An exploration of how substance users understand their addiction.

Invitation and Purpose

Dear Participant

You are invited to participate in a research study about substance users' experiences in Cape Town. I am a student from the University of Cape Town conducting research for my Masters research project.

Procedures

- If you choose to participate in the study, you will take part in one individual interview. This interview will last approximately 60 minutes in a private room within your treatment centre.
- The interview will be conducted in English and will be audio-recorded.
- The information that you choose to give me will be used to write a report about the experiences of substance users in Cape Town.
- The information may also be used in an article which may be published in a psychology journal, but all identifying information will be removed.

Audio-recording and Transcription

- This study involves the recording of your individual interview. Only my supervisor and I will be able to listen to your interviews.
- Your recorded interview will be transcribed and stored safely in a password protected computer.
- The transcriptions will be used for the study. Direct quotations may be used but all personal information will be changed to protect your anonymity. Neither your name nor any other identifying information will be used in presentations or in written products resulting from the study.

- Your voice recordings will be deleted once the transcriptions have been checked for accuracy.

Participant Rights, Privacy, and Confidentiality

- Participation in this study is voluntary.
- You are free to stop participating in this study at any time. Your exit shall not result in any penalty or other consequences.
- Participating (or not participating) in this study will not affect any future treatment you may want to seek at this clinic.
- Any information you give to me is strictly confidential and you have the right to request that any information that you have given be removed from the study.
- Anonymity is also guaranteed, and you will not be identifiable in any report or publication arising out of this study.

Benefits

- The benefit of participating in this research is that you will be given a chance to voice your experiences of substance use. This may lead you to gain further insight into your substance use.
- You will receive a R100,00 food package as reimbursement for participating in the study.

Risks and inconveniences

- It may be that some of the questions asked in the study will bring about unpleasant feelings related to past experiences. You have every right not to answer any questions that make you uncomfortable.

Contact information

Should you have any questions or concerns about the study, you can contact me, Tashmira Kara: tashmirakara@gmail.com. Alternatively, you can contact Dr Wahbie Long (my supervisor): wahbie.long@uct.ac.za. If you have any issues regarding the ethics of the study, please contact Rosalind Adams Rosalind.Adams@uct.ac.za who will put you in contact with a member of the Psychology ethics committee.

Should any personal distress occur as a result of the interview, please feel free to contact:

Lifeline

Telephonic counselling (Cape Town): 021 46 1111 (9:30am-10pm Monday to Sunday)

Whatsapp Call: 063 709 2620 (9:30am-10pm Monday to Sunday)

Face-to-face counselling (Cape Town): 021 461 1113

Face-to-face counselling (Khayelitsha): 021 361 9197

Email: info@lifelinewc.org.za

South African Depression and Anxiety Group

Telephonic counselling: 011 234 4837 (8am-8pm Monday to Sunday)

24hr Helpline: 0800 456 789

For a suicidal emergency: 0800 567 567

Cape Town Drug Counselling Centre

Email info@drugcentre.org.za

Observatory: 021 447 8026

Mitchells Plain: 021 397 0103

Atlantis: 021 571 7180

Email: ashley@drugcentre.org.za

Thank you,

Tashmira Kara

Signatures

[Participant's name] _____ has been informed of the nature and purpose of the study described above, including any risks involved in the procedure. He/she has been given time to ask any questions and these questions have been answered to the best of the researcher's ability. A signed copy of this consent form will be made available to the participant.

_____ _____

Researcher's Signature Date

I have read and understood the consent form above and agree to be a part of this study.

_____ _____

Signature Date

I understand the abovementioned stipulations and agree to have my interview audio-recorded and transcribed for use in this study.

_____ _____

Signature Date

Appendix D

UNIVERSITY OF CAPE TOWN

DEPARTMENT OF PSYCHOLOGY

Advertisement to Participants

An exploration of how substance users understand their addiction.

An Exploration of How Substance Users Understand their Addiction

I am a Master's student from the University of Cape Town looking for participants for my research

Participation includes:

- A 1 hour (approximately) face-to-face interview with me
- The interview will be conducted in English
- **R100,00** food package will be available for participants
- Participation is COMPLETELY voluntary. Your participation, or refused participation, will not affect your relationship with the CTCC
- All data collected will be kept confidential and anonymous.
- You have the right to withdraw from the study at any time, and the right to deny responses to any questions you don't feel comfortable discussing.

If you are interested in participating in this study, please discuss this with your counsellor who will arrange an appointment for an interview.

Thank You!