# Exploring Lay People's Understanding of Substance Abuse

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# ABSTRACT

South Africa has been identified as one of the drug centres of the world (UNODC, 2016). Substance abuse has been implicated in violent crimes and accidental deaths, as well as in the increasing the risk of communicable and non-communicable diseases (Harker Burnhams & Parry, 2015; Pasche & Myers, 2012; van Heerden et al., 2009). Even though substance abuse is evidently a challenge facing South Africa, there is currently a paucity of literature exploring how substance abuse is understood, specifically among lay people. Research indicates that there is a clear need for qualitative inquiry on lay people's understanding of substance abuse (Keatley et al, 2017; Lang & Rosenberg, 2017; Sorsdahl et al., 2012 ). Available South African research in this area centres on trends, attitudes and perceptions of substance abuse (Sorsdahl, Stein, & Myers, 2012). Previous studies indicate that professionals often define substance abuse according to observable indicators, as well as the type of substance used (APA, 2013). Research shows that lay people tend to lean towards moral models of understanding, in contrast to professionals who align with the medical models. Located within social constructionism, this study provides insight into how the understanding of substance abuse is shaped by society (Gergen & Gergen, 1996). This study aims to explore how lay people understand substance abuse and use, and whether this understanding confirms or contradicts that of professionals/DSM. The study made use of an exploratory research design. The sampling procedures used was a combination of purposive and snowball sampling. A total of 50 participants were recruited and twelve focus groups were conducted. The information was analysed using thematic analysis. Six themes emerged: severity of substance abuse; use, abuse and dependence; functionality; loss of control; gateway substance use and experimenting; and mental health literacy. The findings of this study indicate that lay peoples' understanding of substance abuse centres on the impact that

substance use and abuse have on peoples' lives. Further suggested by the findings is that, lay people often associate poor interpersonal relationships, functionality or lack thereof and loss of control with substance abuse problems. This view is consistent with that of professionals and the DSM5 (APA, 2013). The findings of this research indicate that there are similarities in the views of lay people and those of professionals regarding substance abuse problems.

Keywords: dependence, DSM, lay people, lay understanding, social constructionism, substance abuse, substance use, substance use disorder, qualitative research, thematic analysis

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# LIST OF ACRONYMS

| | |
|---|---|
| SUDs | Substance Use Disorders |
| DSM | Diagnostic and Statistical Manual of Mental Disorders |
| UNODC | United Nations Office on Drugs and Crime |
| SACENDU | The South African Community Epidemiology Network on Drug Use |
| WHO | World Health Organization |

# CHAPTER 1: INTRODUCTION

## 1.1. Introduction

South Africa has been identified as one of the countries with the highest rate of substance abuse in the world (United Nations Office on Drugs and Crime [UNODC], 2016). Within South Africa 28% of the population is reported to consume alcohol, while cannabis use among adolescents range from 2% to 9%, and 2% among adults (Peltzer, Ramlagan, Johnson, & Phaswana-Mafuya, 2010; Peltzer & Ramlagan, 2007). Furthermore, 0.3% of the South African population uses cocaine, 0.3% sedatives, 0.2% amphetamines, and 0.1% use inhalants, hallucinogens and opiates (Human Sciences Research Council [HSRC], 2005). Global trends, on the other hand, indicate that cannabis is the world's most widely used drug with 183 million people estimated to have used this substance in 2014 and amphetamines being the second most widely used substance (UNODC, 2016). Also, the prevalence of cannabis and amphetamine use is reported to be high among younger people (UNODC, 2016).

The South African Community Epidemiology Network on Drug Use (SACENDU) monitors trends in substance use and the associated consequences on a six monthly basis from specialist substance abuse treatment programmes (SACENDU, 2015). SACENDU reported that for the first half of 2016 the Gauteng and Eastern Cape regions had the highest prevalence rate of cannabis at 77% and methamphetamine at 33% misuse respectively, for those under the age of 20 (Dada, Harker Burnhams, Erasmus, Parry, Bhana, Timol, & Fourie, 2016). For the first quarter of 2017, these two regions still recorded the highest prevalence of substance use for those under the age of 20 (Dada, Harker Burnhams, Erasmus, Parry, & Bhana, 2018). But a slight increase to 82% for cannabis misuse and a decrease to 25 % of

methamphetamine misuse for this population group in Gauteng and Eastern Cape regions respectively were noted (Dada et al., 2018). Other substances that contribute to the high rates of substance use among the youth in South Africa is nyaope or whoonga because it is easily accessible to the youth due to its low cost (Mokwena & Huma, 2014).

Though substance use trends vary according to geographical location and population, the rates of polysubstance use remains on the rise in South Africa, with between 32% and 45% of the patients in a treatment programme reporting more than one substance of abuse (Plüddemann et al., 2010). This study is located within the Eastern Cape province, and in this region an increase in the number of admissions in treatment centres for cannabis was noted during the first quarter of 2017 when compared to the other regions (Dada et al., 2018).

Substance abuse has been implicated in violent crimes and accidental deaths, as well as in increasing the risk of communicable and non-communicable diseases (Harker Burnhams & Parry, 2015; Pasche & Myers, 2012; van Heerden et al., 2009). The trend of alcohol consumption was found to be that of binge and hazardous drinking (Pasche & Myers, 2012). Similarly, during the first quarter of 2015 alcohol was found to be the dominant substance of abuse across all treatment centres who are registered with the department of health (SACENDU, 2015). Furthermore, an increase in the number of patients admitted for substance abuse treatment was reported (SACENDU, 2015). This seems to indirectly suggest that substance abuse is a problem in South Africa by highlighting the challenge of a shortage of government operated treatment centres for substance abuse problems and the increased demand for such services, particularly for the youth (Myers, Harker, Fakier, Kader, & Mazok, 2008; Parry, 2005; Pasche & Myers, 2012). A decade ago, Stein et al. (2008) reported that approximately 13% of the South African population will experience a substance abuse problem.

While alcohol is a commonly abused substance among the general adult population within South Africa, cannabis on the other hand is commonly abused by the youth (Peltzer & Ramlagan, 2007; Tshitangano & Tosin, 2016). The trend seems to be continuing with SACENDU (2017) showing that cannabis was still a popular substance among the youth.

In attempting to understand substance abuse within the South African context, it is also important to acknowledge the growing trend of illicit drug manufacturing and distribution (Kalula & Nyabadza, 2012). South Africa has become one of the largest markets for illicit drugs in the world (Peltzer et al., 2010). One of the newer substances that has been exclusively manufactured in South Africa is nyaope or "whoonga" (Grelotti et al., 2014) which is often found in Black Townships and its origins can be traced to Pretoria and sorrounding areas (Mokwena & Huma, 2014). This drug is reported to be a mixture of illicit substances such as dagga, methamphetamine and/or heroin, household products and antiretroviral treatment (Dada et al., 2016; Mokwena & Huma, 2014).

Peltzer and Ramlagan (2009) found that the more marginalised communities within South Africa tend to be more at risk for substance abuse problems. This high prevalence of substance abuse among these communities is one of the many legacies of the apartheid regime (Otu, 2011). Otu (2011) suggests that one of the strategies that was used by the apartheid government to fight back opposition to apartheid policies by Black people was to purposefully promote drugs amongst the Black and Coloured communities. The terms Black and Coloured refer to people of African and mixed (African, European and/ or Asian) ancestry respectively, and are demographic markers which do not signify inherent characteristics (Parry, Pluddemann, & Myers, 2005).

Due to the dire drug abuse situation in South Africa, national government devised various strategies in order to address this problem. One of these strategies included the revision of existing policies and a proposal for a more integrated way of dealing with substance misuse (Department of Social Development [DSD], 2013). The commonly applied strategies to achieve this, as reflected in the National Drug Master Plan 2013–2017 are: reduction of the demand, supply reduction and a localised version of harm reduction. However, other organisations such as the UNODC and the WHO advocate for a shift towards primary prevention, a bottom up approach as apposed to the usual top down approaches of solving social problems, as well as devising more individualised approaches based on communities' needs rather than the "one size fits all" approach (DSD, 2013). The Drug Master Plan (2013–2017) also recognises that substance use may promote crime, poverty, unemployment, dysfuctional family life and the spread of diseases such as HIV, which then explains the focus on prevention. A further negative consequence of the high rates of substance abuse is that South Africa has been identified as having one of the highest rates of foetal alcohol syndrome (FAS) in the world (May, Gossage, Marais, Adnams, Hoyme, Jones, Robinson, Khaole, Snell, Kalberg, Hendricks, Brooke, Stellavato,Viljoen, 2007). A 1997 research study conducted in a wine growing region in the Western Cape among grade 1 learners found that the prevalence of FAS was 41–46 per 1000 learners (May et al.,2007). However, this number increased to 65–74 per 1000 grade1 learners in 1999 (May et al., 2000), whereas the rate of 26 per 1000 learners was found in Gauteng in a non-wine growing region (Viljoen, 2003). These rates continued to increase to per 1 000 in Upington 64, Kimberly 74.7 and De Aar 119.4, in the Northern Cape respectively (Olivier, Curfs, & Viljoen, 2016). It is worth noting that the aforementioned areas are wine producing regions and this potentially has an impact in on these rates of FAS. Similar studies conducted globally report a lower prevalence of FAS

namely, 10–15 per 1 000 in the USA, 10 per 1 000 in Canada; 35 per 1 000 in Italy; 18 per 1 000 in France; 20 per 1 000 in Poland; and 12 per 1 000 in Croatia (Olivier et al., 2016).

### 1.2. Rationale and Research Questions

Since South Africa has been identified as having one of the highest rates of substance abuse in the world (UNODC, 2016). However, there is currently a paucity of literature exploring how substance abuse is understood specifically among lay people. Available research in this area centres on trends, attitudes and perceptions of substance abuse (Sorsdahl, Stein, & Myers, 2012). Pienaar and Savic (2016), in their review of the National Drug Master Plan (2013–2017) also alluded to the paucity of South African research in the field of substance abuse and its effects on the population. This paucity of research in this area has sparked an interest in the researcher to conduct the current study. This research hopes to address this gap in South African literature related to the understanding of substance abuse. The researcher aimed to explore the understanding of substance abuse among lay people and whether this understanding confirms or contradicts that of professionals. For the purposes of this study the term "lay people" refers to individuals with no formal medical or psychological professional training, knowledge or experience in the treatment of addiction (Furnham & Thomson, 1996). As seen in literature (Klingemann & Bergmark, 2006; Williams & Calnan, 1996; Zulewska-Sak & Da_browska, 2005) the way that lay people understand and construct substance abuse is important, because firstly lay people either have personal experience of addiction and dependence therefore are likely to be aware of the complexities of the addiction and the factors that prevent change or treatment seeking. Thus, obtaining a lay understanding would firstly provide helpful information in providing effective substance abuse treatments. Secondly, lay people's understanding of the causes of substance abuse is likely to assist policy makers in developing public health interventions (Keatley, Ferguson, Lonsdale, &

Hagger, 2017). The DSM construction of SUD on the other hand does not demonstrate the extent of problems experienced by people with substance abuse problems (Zafarghandi, Khanipour, & Ahmadi, 2018).

The study's research question is as follows: how do lay people understand what constitutes substance use and abuse?

### 1.3. Overview of Chapters

In the following chapter (Chapter 2), the researcher reviews the available relevant literature, both local and international, on substance use and abuse. The researcher begins the chapter by discussing literature on how the DSM or professionals and lay people define substance abuse, following that is a discussion of substance abuse trends within the South African context. Thirdly, the researcher discusses gateway substance use and experimenting. The different models of understanding substance use and abuse are then discussed, followed by a discussion of lay people's perceptions of social problems and mental illness. A discussion on stigma and substance abuse and use concludes this chapter.

Chapter 3 provides an overview of the theoretical framework and the detailed outline of the research methodology guiding the research process. The discussion includes an outline of sampling techniques employed in this research, the demographics of the participants are also included, the data collection methods, the research procedure and the data analysis. Furthermore, the researcher discusses the ethical considerations adhered to during the research process, such as reliability and validity, with a focus on trustworthiness and reflexivity.

Chapter 4 provides an analysis of findings. In this chapter the researcher outlines the main themes and sub-themes that were generated from the analysis.

Finally, Chapter 5 concludes this thesis by providing a summary of findings, limitations of the study and recommendations for future research.

# CHAPTER 2: LITERATURE REVIEW

## 2.1. Introduction

Substance use occurs along a continuum, levels of use are generally identified as use, abuse and dependence (Breshears, Yeh, & Young, 2009). It is important to note that not everyone who uses a substance becomes addicted or dependent on the substances (Breshears, Yeh, & Young, 2009). This chapter provides a discussion and review of the relevant and current literature, both local and international, on the topic of substance abuse. The researcher begins this chapter by reviewing literature on how professionals and lay people define substance abuse. This is followed by a discussion of the trends of substance abuse within South Africa. A discussion of Gateway substance use and experimentation follows this. Following this is a discussion of the various models of understanding substance abuse, with a focus on the contrasting views of professionals and those of lay people. This is followed by a discussion of available literature on lay people's perceptions of social problems and mental illness. The researcher concludes this chapter by discussing stigma and substance use and abuse, with a focus on the stigmatising attitudes demonstrated by professionals who are involved in the treatment and care of those with SUDs.

## 2.2. Defining Substance Use and Abuse

### 2.2.1. DSM/professional definition of substance abuse

Professional understanding of substance abuse is documented in the DSM 5. The DSM 5 defines SUD as clinically significant impairment or distress manifested by two or more of the following 11 symptoms occurring within a 12 month period: (a) Using the substance in larger amounts or over a longer period than was originally intended; (b) Unsuccessful efforts to cut

down or regulate use of substance; (c) A significant period is spent trying to obtain, using or recovering from the effects of the substance; (d) Craving or strong urge to use the substance; (e) Recurrent substance use may result in a failure to fulfil major role obligations at work, school, or home; (f) Continued use of the substance despite having recurrent social or interpersonal problems caused or exacerbated by the effects of the substance; (g) Decreased or increased social, occupational, or recreational activities due to substance use; (h) Substance use in hazardous or dangerous situations; (i) Persistent use despite physical or psychological problems; (j) Tolerance (the need for increased amounts of substance to achieve the desired effect or diminished effect if using the same amount); and (k) Withdrawal (development of substance specific syndrome due to the cessation of use that can be serious and prolonged) (APA, 2013). In the DSM 5, two categories of SUDs (substance dependence and substance abuse) that were used in the previous version (DSM-IV-TR) (APA, 2000) of the DSM are integrated into a single category of SUD (Sher, 2016). Substance dependence is defined as the physiological and psychological state in which a substance user has developed a dependence on substances such as alcohol, tobacco, opiates or amphetamines (Qi, Tretter, & Voit, 2014).

In the DSM-IV-TR, a diagnosis of substance abuse was given to an individual who used a substance and suffered adverse consequences, yet did not display dependence (Jones, Gill, & Ray, 2012). The individual would have to meet at least one of the following criteria to be diagnosed with substance abuse: failure to fulfil major role obligations at work, home, or school; use in physically hazardous situations (e.g., drunk driving); substance-related legal problems; and continued use despite recurrent substance-related social or interpersonal problems (APA, 2000). A diagnosis of substance dependence, on the other hand, would be given if a person met at least three of the following seven dependence symptoms: tolerance;

withdrawal; using larger amounts than intended; unsuccessful attempts to stop or control substance use; spending a great deal of time obtaining, using, or recovering from the effects of the substance; important activities given up or reduced because of substance use; and continued use despite substance-related physical or psychological problems (APA, 2000). The changes in the DSM 5 were brought about due to several factors. Some of these were: questions regarding the validity and reliability of the diagnosis of substance abuse, which was found to be significantly low; concerns relating to diagnosing substance abuse disorder based on the presence of only one symptom; the hierarchical view of dependence and abuse; the view of abuse as milder than dependence even though criteria indicate clinically significant problems; and finally, individuals who meet one or two criteria for substance dependence but do not have alcohol related consequences – these individuals were known as "diagnostic orphans" (Hasin et al., 2006). It is suggested that these individuals are similar to those with alcohol abuse disorder but they do not qualify for either abuse or dependence (Jones et al., 2012; Ray, Miranda, Chelminski, Young, & Zimmerman, 2008; Ridenour, 2013). The DSM classifies SUD according to observable indicators and the type of substance that has been abused (APA, 2013). Though this kind of classification is sufficient for diagnostic purposes, it does not demonstrate the extent of problems experienced by the person with a substance abuse problem (Zafarghandi, Khanipour, & Ahmadi, 2018). Furthermore, there are many differences between individuals who may be addicted to the same type of substance (Windle & Scheidt, 2004). This implies that these individuals would present differently though abusing the same substance.

Room (1998) demonstrates that there have been numerous concepts or definitions proposed in international classification systems to define substance abuse. Heavy substance use overtime was one of the ways that was used to define a substance use disorder (Rehm, et al.,

2013). Furthermore, heavy substance use is associated with negative effects on work perfomance (Gmel & Rehm/, 2003). Family problems and criminal law problems were reported to be common specifically among males (Gmel, Rehm, Room , & Greenfield, 2000). In other instances unemployment, the risk for academic failure, involvement in criminal activities and overall poor quality of life have been associated with substance use and abuse (Sloboda, Glantz, & Tarter, 2012). The extent of the negative effects of substance use on family, work, physical health, mental health has also been used to determine the severity of the substance use problem (Zafarghandi, Khanipour, & Ahmadi, 2018). Also, the severity of the substance abuse problem has been regarded as a main factor for classifying the different types of substance use disorders (Cardosa , Barbosa , Ismail, & Pombo , 2006; Henderson & Galen, 2003).

Vederhus, Clausen, and Humphreys (2016), assessing the understandings of SUDs among Norwegian treatment professionals, patients and the general public, found that treatment professionals have a different understanding of SUD to that of lay people. They deduced that the way SUD is understood could possibly influence whether people seek treatment or not, therefore the beliefs of the general public about SUD are of critical importance (Vederhus, Clausen, & Humphreys, 2016).

Furthermore, Copoeru (2014 ) postulates postulates that in order to adequately assist individuals with SUD, professionals and lay people require a way of defining SUD that does not make reference to failure or judgement of people. Rather, this author encourages that addiction should be defined in a way that has at its core the idea to empower those individuals with SUD, as well as of reconstructing their capacity to take decisions about their own lives (Copoeru, 2014 ).

### 2.2.2. Lay people's definition of substance use and abuse

The common theme in the literature (Keatley et al, 2017; Lang & Rosenberg, 2017; Sorsdahl et al., 2012 ), seems to be that there is a clear need for qualitative inquiry on lay people's understanding of substance abuse, as most South African studies on substance abuse have either focused on trends, or assessed attitudes, beliefs or perceptions of substance abuse. Global trends also indicate that there is a paucity of literature on lay peoples' understanding of substance abuse (Chassin, Presson, Rose, & Sherman, 2007). Bjòrnsdòttir, Almarsdòttir, and Traulsen (2009) explored the lay public's explicit and implicit definitions of drugs and they argue that there is a dearth of literature on lay people's understanding of drug abuse. These authors further state that culture and language influences how substance abuse is understood, therefore, in order to understand lay people's view of substance abuse, it is important to establish a point of reference when using the term substance abuse (Bjòrnsdòttir et al., 2009). Similarly, Lee, Law, and Eo (2004), further emphasised the crucial role played by culture and individuality in understanding substance abuse. They also found that cultural influences such as shaming the family and perceptions of the nature of substance abuse problems impact on help seeking behaviours (Lee et al., 2008).

Hadjicostandi and Cheurprakobkit (2002) found that minority populations' views and definitions of substance abuse emphasise the impact of the substance on individuals, as well as how they contribute to social ills such as crime and violence. These authors further emphasise that how and why drugs are used differs across social groups and that this understanding is socially constructed. They further explain that one of the common ways of defining drugs in the United States is their legality, where legal drugs such as caffeine are not regarded as drugs as they are considered harmless while licit and illicit substances are

recognised as drugs due to their perceived degree of danger (Hadjicostandi & Cheurprakobkit, 2002).

Chassin, Presson, Rose, & Sherman (2007) investigated adolescents' and adults'definitions of addiction and related these to the perceived addictiveness of cigarette smoking. This study found that both adolescents and adults view addiction as multifaceted, including appetitive (liking the taste of cigarettes like other enjoyable things) and compulsive (behaviour that is maintained by the aversive impact of deprivation that is suffering negative physical effect and psychological effects) facets. The were some differences noted though in how the adults and the adolescents in the study defined addiction. For adolescents, the appetitive and compulsive dimensions were equally important, whereas the adults found the compulsive aspect more important in the definition of addiction (Chassin et al., 2007).

A study aiming to compare assumptions informing New York Rockefellar drug laws and views of substance users in New York, found that participants defined or classified substance use according to the effects of specific substances, as well as the consequences of using such substances (Windsor & Dunlap, 2010). Furthermore participants described use as functional, as long it does not affect the user's ability to meet their personal obligations (Windsor & Dunlap, 2010). These participants also differentiated between functional and dysfunctional substance use, they further determined that some substances have harmful effects (Windsor & Dunlap, 2010).

Klingemann (2011), examined lay and professional conceptualisation of addiction and found that professionals' conceptualisation of substance abuse aligns with the medical model. Lay people on the other hand conceptualise addiction in terms of the medical-moral model and also described dependence as a sympton of maladapive social functioning (Klingemann,

2011). Furthermore, perceived curability of addiction was another major difference in views between lay people and professionals (Klingemann, 2011). As professionals view addiction as a chronic condition, while lay people believe that an individual is able to recover from substance addiction even though it is difficult (Klingemann, 2011). Lay people in this study saw willpower as a significant factor that plays a role in recovery from substance abuse or addiction. Furthermore, lay people in this study view substance dependence as a sign of social dysfunction. And that recovery is likely to take place when one is aware of their role in society and makes an effort to comply with social expectations (Klingemann, 2011).

### 2.3. Substance Abuse Trends within the South African Context

In terms of understanding trends of substance abuse, gender is also an important factor worth considering. According to Peltzer and Ramlagan (2009), in developing countries like South Africa the predominant trend of drinking tends to be that of infrequent heavy drinking, specifically among men. A pattern of hazardous drinking  was also identified by WHO (2002) in developing countries. This pattern of consumption of alcohol is one that places the individuals at risk of health related problems (Reid, Fiellin, & O'Connor, 1999). Over the years, these hazardous patterns of alcohol consumption have been consistently found to be high amongst men when compared to women, regardles of age (Peltzer & Ramlagan, 2009). Van Heerden et al. (2009) also showed that males were found to be eight to nine times more likely than females to use all drug types. In a recent publication, SACENDU reported a similar pattern, where the majority of patients admitted across all sites treating SUDs were male (Dada et al., 2016).

Within South Africa, race appears to be a significant factor that influences substance use. Parry, Plüddeman, and Myers (2005) found a higher prevalence of substance use among

“Coloureds” and “Whites” when compared with “Blacks” and “Indians”. These trends were found in urban populations, however there appears to be a change in these trends in recent times. SACENDU recently reported that in most treatment centres across the country the majority of patients admitted below the age of 20 years were Black African (Dada, et al., 2016).

### 2.4. Gateway Substance use and abuse

Substance use is said to follow a particular sequence or a pattern, beginning by the use of licit substances such as alcohol or tobacco and then progressing to the use of illicit substances such as cannabis, cocaine, etc. (Choo, Roh ,& Robinson, 2008; Kandel, 2002; Kirby & Barry, 2012). This is known as the “Gateway Hypothesis” or “Gateway Theory” (Choo et al., 2008; Kandel, 2002; Kirby & Barry, 2012). The Gateway Hypothesis was previously known as the Stepping Stone Hypothesis and Multiple Stage Progress Theory (Chen , Unger , Palmer ,et al., 2002). This theory holds that an individual typically progresses from non-use of any substance as a child, to use of licit substances such as alcohol and or cigarettes in early adolescence, this is then potentially followed by the use of illicit substances such as cannabis and or cocaine (Choo et al., 2008; Kandel, 2002).

This theory suggests that alcohol and or tobacco serve as a “gateway” toward use of illicit substances (Choo et al., 2008). This implies that alcohol use increases the likelihood that other licit (tobacco/cigarettes) and illicit (cannabis, cocaine, narcotics, etc.) substances would be used (Kirby & Barry, 2012). Cannabis is often the first illicit substance used and it is typically preceded by alcohol and tobacco use (Degenhardt et al., 2010). Though this progression is common, licit drug use however, does not always predict later illicit drug usage (Kirby & Barry, 2012). In essence, this theory implies that substance or drug

involvement often begins with the socially acceptable substances namely, alcohol and cigarettes (stage1), then proceeds to cannabis use (stage 2), and finally leading to illegal substances (stage 3) (Howell, 2010).

Gateway substance use, specifically adolescent tobacco and alcohol use have also been associated with paternal substance abuse history and disruptive behaviour disorders, these are risk factors for substance abuse problems (Cadoret, Yates, Troughton, Woodworth, & Steward, 1995). Research also indicates that the earlier the age of substance use initiation increases the likelihood of substance use and abuse in the future (Woodcock, Lundahl, Stoltman, & Greenwald, 2015). Others have also linked the early onset of alcohol use to alcohol abuse and dependence in adulthood (Hawkins, et al.,1997; Maggs & Schulenberg , 2005).

Substance use progression is associated with the Gateway Hypothesis, however progression that is not consistent with this hypothesis is attributed to environmental factors such as greater access to drugs in the neighbourhood and inadequate parental supervision specifically in young people (Tarter, Vanyukov, Kirisci, Reynolds, & Clark, 2006). Furthermore, gateway hypothesis inconsistent substance use pattern has been linked to the greater likelihood of progression of substance use to substance dependency (Degenhardt et al., 2009; Sartor, Kranzler, & Gelernter, 2014).

### 2.5. Models of Understanding Substance Abuse

Various models of understanding substance abuse have been proposed. Traun (1993) identified three models of substance abuse which are the medical, moral and spiritual models. This author suggests that lay people tend to lean towards the moral model of attributing

substance abuse, while professionals seem to be in favour of the medical model (Traun, 1993). The moral model of substance abuse places responsibility on the individual and purports that people choose to be dependent on substances (Wakeman, 2013). More recently, Weine, Kim, and Lincoln (2016), in an attempt to understand lay people's assessments of alcohol use disorders and the stigma attached to them, found that lay people tend to understand substance abuse from a moralistic vantage point, which "blames" those who suffer from SUDs. Others have suggested that those who use substances do so because they want to and that substance use is under a person's control and a failure to discontinue use is attributed to weakness of character (Brickman, Vita, & Jurgis, 1982; Caetano, 1987; Sigelman, Gurstell, & Stewart, 1992). This view is a recurring theme in the literature, however it is significantly flawed as it does not take into consideration the biological, psychological and personality factors that may lead individuals to substance dependency. In contrast, the medical model attributes substance abuse to biological as well as genetic factors (Bliss, 2009) and here the individual is completely exempted of any responsibility for the substance abuse. This model also implies that substance abuse is a result of external factors that are out of the individual's control (Weine et al., 2016). However, this model also has certain limitations which include the failure to acknowledge the role of the social, environmental and cultural factors, and the interactional relationship among these factors in the aetiology of substance use problems (Hesselbrock, Hesselbrock, & Epstein, 1999; Polcin, 1997). Furthermore, there is a lack of acknowledgement of the holistic person-in-environment perspective that emphasises the spiritual and psychosocial aspects of alcoholism (Bliss, 2009).

A sociocultural model of understanding has also been identified as one that is endorsed by lay people (Furnham & Thompson, 1996). This model holds that SUDs arise among people

who socialise with other substance users. This model emphasises the impact of the social context, as well as the environmental influences on the development of SUDs, in contrast to the medical model. Also, the re-occurring theme in literature seems to be that professionals tend to define and understand substance abuse in terms of the medical or disease model and these definitions tend to be hegemonic since they are offered by professionals whose views are held in high regard in society (Jeewa & Kasiram, 2008; Sorsdahl et al., 2012; Truan, 1993; Weine et al., 2016). Also, professionals' views are to a large extent based on scientific knowledge and expert consensus while lay people's views are based on personal experience, media reports and other sources of knowledge (Jorm, 2000). The research conducted in this field demonstrates conflicting views among professionals and lay people regarding understanding substance abuse (Furnham & Lowick, 1984; Truan, 1993; Walters & Gilbert, 2000; Weine et al., 2016). Walters and Gilbert (2000) found that lay people, in their definition of abuse, emphasise diminished control, while "experts" or professionals place an emphasis on physical dependence. Furthermore, lay people often endorse the moral and sociocultural models of causation of substance abuse, whereas professionals tend to align with the medical model (Furnham & Lowick, 1984; Weine et al., 2016). Further, the medical attribution of substance abuse is well substantiated in literature and this contributes to its hegemony (Bliss, 2009; Clark, 2011).

## 2.6. Lay people's Perceptions of Social Problems and Mental Illness

Generally, people have different perceptions about what leads to certain social and mental health problems. According to Calnan (1987), most of the available literature on lay theories of health focuses on physical rather than mental health. Though most of the literature in this review is international articles and the findings may not be generalisable to the South African context, it is worth noting global trends in how mental health problems are perceived.

Jorm et al. (1997) introduced the concept of mental health literacy which is a conceptual framework for lay theories. Mental health literacy is defined as people's knowledge and beliefs about the diagnosis and treatment of mental illness (Furnham, Lee, & Kolzeev, 2015; Jorm, 2000). The concept of mental health literacy is multidimensional and incorporates several components: the ability to recognise symptoms of specific disorders; knowledge and beliefs about risk factors and causes; knowledge and beliefs about self-help interventions; knowledge and beliefs about professional interventions; attitudes that facilitate help seeking when necessary; and knowledge of how to seek information regarding mental health (Jorm et al., 1997). Though the present discussion focuses on lay perceptions of mental illness, it is worth noting the different components of this concept and how they impact views of substance use disorders. Lay theories are described by Furnham and Cheng (2000) as everyday personal and idiosyncratic theories that are deployed to explain phenomena. These theories suggest that psychosocial stressors are more often cited as the cause of mental health conditions than biological factors (Jorm, 2000). This conveys lay people's tendency to endorse non-medical models of social problems or mental health conditions, unlike professionals who lean towards the medical model (Angermeyer & Dietrich, 2006; Link, Phelan, & Bresnahan, 1999; Jorm, 2000; Jorm et al., 1997). For instance, a Nigerian study found that lay people have a tendency to endorse supernatural explanations and attribute mental illness to misuse of psychoactive substances (Adewuya & Makanjuola, 2008). Also, a Malaysian study found that lay people demonstrate a preference for social-environmental causes of schizophrenia to biological causes (Swami, Furnham, Kannan, & Sinniah, 2008).Both these studies convey a  consistent view regarding lay people and the way that they understand social problems..

Furthermore, various authors report that lay people often perceive those with mental health conditions to be violent and dangerous (Angermeyer & Dietrich, 2006; Hyler, Gabbard, & Schneider, 1991; Wilson, Nairn, & Coverdale, 1999; Wolff, Pathare, & Craig, 1996; Link et al., 1999). This demonstrates an over-estimation of risk with this particular group of individuals and it is influenced by media reports (Angermeyer & Dietrich, 2006; Hyler et al., 1991; Link et al., 1999; Wilson et al., 1999; Wolff et al., 1996). Similarly, those with substance abuse problems are often perceived to be violent and dangerous. However, the general public tend to hold significantly more negative attitudes toward persons with substance abuse problems than those with mental illness because of the belief held that substance abuse is to a certain extent self-inflicted (Angermeyer & Dietrich, 2006; Barry, McGinty, Pescosolido, & Goldman, 2014).

### 2.7. Stigma and Substance Use Disorders

Substance abuse problems are ranked among the highest most stigmatised health conditions in the world and this is also identified as a major barrier to treatment seeking (Corrigan, 2004; Room, 2005). Though this is not the aim of the study it is worth noting, because lay people's view of substance abuse is likely to determine whether they will seek treatment or not. Stigma is defined as the social process in which a perceived attribute marks an individual as socially sanctioned and devalued (Luoma, 2010). Stigma is divided into two domains, public stigma and self-stigma. Public stigma refers to the negative beliefs of the general public about individuals from the stigmatised group and includes stereotypes (Corrigan & Watson, 2002; Luoma, Kohlenberg, Hayes, Bunting, & Rye, 2008). Self-stigma refers to self-devaluation of individuals from the stigmatised group (Corrigan & Watson, 2002; Luoma et al., 2008).

Therefore, in any attempt to understand substance abuse it is important to understand the factors that impact treatment seeking behaviours, as this will determine the person's view of substance. Stigmatising attitudes have been found to have more adverse effects on treatment when they are demonstrated by healthcare/treatment providers (Avery et al., 2013). Psychiatrists have been found to possess more stigmatising attitudes towards those with conditions such as substance abuse and schizophrenia, than those with medical illnesses (Adams, 2008; Kreek, 2011; Nordt, Rossler, & Lauber, 2006; Rao et al., 2009; Schulze, 2007). These stigmatising attitudes can be attributed to psychiatrists' experience of working with this group of individuals as particularly unrewarding compared to other patient groups (Gilchrist et al., 2011; Howard & Holmshaw, 2010; Kreek, 2011; Livingston, Milne, Fang, & Amari, 2011; Meza, Cunningham, el-Guebaly, & Couper, 2001; Schulze, 2007).

Sorsdahl et al. (2012) examined the attitudes of the South African general population towards those who use substances and found that substance use and abuse are highly stigmatised, more so than other physical and psychiatric disorders. Among the general public, stigmatising attitudes are attributed to moral discourses, which have also been found to deter initiation of substance use (Myers, Fakier, & Louw, 2009). In addition to this, the stigma surrounding substance use is also associated with the fact that those individuals who are dependent on substances are likely to commit violent crimes (Janulis, Ferrari, & Fowler, 2013; Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999). So, perceived dangerousness and unpredictability of those with substance abuse problems appear to be contributing to these stigmatising attitudes, as discussed earlier (Crisp, Gelder, Rix, Meltzer, & Rowlands , 2000). It seems to be a reoccurring theme in literature that stigmatising attitudes arise from the belief that substance abuse problems are evidence of poor self-control (Room, 2005).

## 2.8. Conclusion

Most of the literature available on this topic is international research. This further necessitates more research in this area. Lang (2015) also attests to the necessity of future research of a qualitative nature in order to better understand the attitudes of lay people towards individuals with substance abuse problems, as qualitative research could assess attitudes and understandings of SUDs. Furthermore, the use of open-ended questions is recommended as this would enable lay people to generate a coherent, nuanced view of substance abuse (Lang, 2015). The literature conveys that people generally have different perceptions of what constitutes or lead to mental illness. Generally, lay people often perceive substance abuse in terms of the moral models, while professionals attributes substance abuse problems to the medical model.

# CHAPTER 3: METHODOLOGY

## 3.1. Introduction

Research methodology and design refers to the plan, map, methods, techniques and procedures that are used in data gathering (Bryman, 2012). Social constructionism allows for participants to be seen as “experts” of their own lives, the researcher together with participants are co-constructors or creators of meaning (Charmaz, 2008). The purpose of this chapter is to map the methods employed to carry out the study, from the formulation of the research questions and sampling strategy, data gathering, and the analysis. The researcher begins this chapter by discussing the theoretical framework guiding this research.

## 3.2. Theoretical Framework: Social Constructionism

Social constructionism is the lens through which this research is carried out and understood. Social constructionism offers a way to define, understand, and study social problems that is distinct from other frameworks as implied in its basic assumption that social problems are socially constructed (Schneider, 1985). The social constructionism theory of multiplicity proposes that there are many ways of viewing and describing reality, based on values and the social context (Gergen, 2009). Furthermore, according to this theoretical paradigm, meaning and understanding is formed through interaction with others (Creswell, 2013). In this research, the use of social constructionism illustrates that social problems cannot be divorced from their cultural and political contexts. Brucker (2009) suggests that social constructions of social problems such as substance abuse are often reflective of societal views. Due to this, these views are either positive or negative. Burr (1995) proposed four key assumptions underlying social constructionism, described below.

### 3.2.1. A critical stance towards taken-for-granted knowledge

Social constructionism encourages that we take a critical stance in understanding ourselves and the world. Burr (1995), in this tenet, encourages us to be critical and challenge the idea that knowledge is based on objective and unbiased observation of the world. Furthermore, Burr (1995) cautions against readily accepting taken-for-granted knowledge as it appears to be or as constructed by dominant groups and alienate minority groups, in this case, lay people. This taken-for-granted knowledge of dominant groups continues to reinforce injustice and discrimination of marginalised groups' knowledge or subjective experiences. For example, dominant views (those espoused by professionals as reflected in the DSM) in the context of substance abuse ascribe to the medical/biological models, ignoring social, cultural or political factors.

### 3.2.2. Historical and cultural specificity

According to Burr (1995), the way in which we understand the world, that is "truth" or "reality", is historically and culturally specific. Based on this tenet, our understanding of the world and phenomena is shaped by the current and previous social, political, cultural and economic arrangements. For instance, in a diverse country like South Africa with a variety of cultures and political views, the understanding of social abuse problems will be influenced by the context. Furthermore, the changes in the classification criteria of SUDs from the DSM 4 to the DSM5 is reflective of this. Further suggested by this tenet is that truth or knowledge is not only culturally and historically specific, but is also a product of history and culture.

### 3.2.3. Knowledge is sustained by social processes

Our knowledge of the world or truth is created, constructed and maintained through communication, social interaction and social processes (Burr, 1995; Reed, 2007). Social

constructionism maintains that through the process of social interaction, people speak to one another, co-creating social reality or knowledge (Burr, 2003; Gergen, 2010). This then suggests that language is a tool through which knowledge is sustained through social processes (Andrew, 2012; Burr, 2003). According to Burr (2003), people actively produce and manipulate discourse, and are also a product of the same discourse. Within social constructionism, discourses are constantly changing social constructs (Burr, 2003). In view of this research, this can be taken to mean that lay people are co-constructors of knowledge, which in this case is the understanding of substance abuse.

#### 3.2.4. Knowledge and social action go together

Social constructionism purports that knowledge and social action are interconnected. This suggests that knowledge results when there is collective action and social participation (Burr, 1995; Gergen, 2009). This view implies that there is a reciprocal relationship that exists between knowing and social action. This is illustrated very well by Burr (2004) who states that individuals with alcohol abuse problems were blamed for their "drunkenness" and deserving of imprisonment as punishment for such behaviour. However, as time has evolved the individual with substance abuse problem is no longer blamed for their addiction and, therefore, the appropriate response or social action is treatment (Burr, 2003). This aforementioned example not only illustrates the reciprocity of knowledge and social action, but also maintains the social constructionist idea that knowledge or truth is not static but is continuously evolving with time.

In essence, social constructionism rejects realist and essentialist views regarding social reality. Furthermore, the notion of truth as a singular notion/idea is challenged and emphasis is on viewing knowledge as provisional and negotiable (Macfarlane & Tuffin, 2010). Further

postulated by constructionism is the belief that knowledge results from an ongoing process of social interaction (Shotter, 1993). Constructionism also places a strong emphasis on the forms of relationships out of which realities are constituted and changed (Gergen & Gergen, 1996). Specific to the current study, this paradigm provides insight into how the understanding of substance abuse is shaped by society. Various authors acknowledge the impact of social constructions on the individual's drug use and the importance of language, as well as social tradition in influencing personal responses to substances (Gergen & Gergen, 1996; Szasz, 1985).

Gergen and Gergen (1996) state that, within social constructionism, drug and alcohol use is less about individual choice, but rather, it is embedded within relationships. This suggests that people use certain drugs as a function of personal or social meaningin order to convey acceptance or rejection of various social identities (Szasz, 1985). Furthermore,  to promote an experience of autonomy (Szasz , 1985). Therefore, in order to understand substance abuse, it is necessary to focus on analysing the social constructions related to the substance itself with less emphasis on personal meaning of substance use (Burrel, 1999). In relation to the South African context, various authors have pointed out that social constructions related to various illegal drugs and drug users have been used to promote racial intolerance and socioeconomic agendas (Epstein, 1996; Willutzki & Wiesner, 1996).

The disease or medical model of understanding substance abuse is widely criticised within social constructionism. For instance, Epstein (1996) argues that the disease oriented way of speaking about substance use has negative consenquences, such as isolating drug use from the social context. "Further, the drug or alcohol user is seen as a helpless victim of his her own body, subjected to genetic flaws and chemical imbalances, or victim of a 'killer

compound,' such as crack cocaine" (Gergen & Gergen, 1996, p. 78). Additionally, within social constructionism critical reflexivity is encouraged, especially directed toward the tendency of experts to reify the disease model of addiction (Gergen & Gergen, 1996).

### 3.3. Qualitative Research Approach

A qualitative approach which aims to explore and understand the meaning that individuals or groups ascribe to social or human problems was appropriate for this study (Creswell, 2013). The researcher seeks to explore the understanding of substance abuse among lay people. Explorative research is usually prompted when there is a dearth of information about the topic and the population being studied (Creswell, 2013). This approach is chosen as it enabled lay people to reflect and share their understanding of what constitutes substance abuse, as shaped by their social contexts. This research was conducted using an exploratory qualitative research approach, which was ideal for allowing participants to share their understanding of the topic and how it is constructed in their context (Bryman, 2012). Furthermore, a qualitative approach facilitated an in-depth study of participants' understanding of what substance abuse means to them (Brink, 1993).

### 3.4. Research Aims

The aim of this study was to explore lay people's understanding of what constitutes substance abuse. The study wished to determine how substance use and abuse is spoken about, understood and constructed amongst non-professionals. Furthermore, this study also sought to examine and evaluate whether lay people's understanding of substance abuse corresponds with, or contradicts, professional understanding, particularly as specified in the DSM-5.

### 3.5. Participants and Sampling Strategy

A combination of purposive and snowball sampling were utilised to recruit suitable participants for the study. This form of nonprobability sampling was adequate for a qualitative research design as it enabled the researcher to accomplish the objectives of the research (Marshall, 1996; Patton, 1990). Patton (1990) define purposive sampling as the selection of information-rich sources that are available at the time of the research, who are willing to participate in the research and are typical of the population being studied. Snowball sampling is defined as the process of accumulating a sufficient sample through contacts and referrals (Marshall, 1996).

The sampling frame were people who are not currently involved in the treatment or care of substance abuse. The participants were recruited by approaching acquaintances and community members and requesting them to participate in the research. Some of the participants were recruited in Pietermaritzburg in Kwazulu natal and others in Grahamstown, in the Eastern Cape. People who have a background in nursing, psychology, social work or any other healthcare training were excluded from the study. The reasons for this exclusion is that the researcher was ideally seeking individuals with no formal knowledge or training in substance abuse and were, therefore, regarded as a layperson (possessing no "expert" knowledge on the topic). This then suggests that anybody over the age of 18, of any gender, race and language with no training in public health or any health related field was considered for participation in the study. The sample size consisted of 50 participants. This sample size allowed for 12 focus group discussions, consisting of between four and eight participants per group. A sample of this size is acceptable for a qualitative study as the aim was to work with a sample that is information rich and so can be studied in depth (Durrheim & Painter cited in Terre Blanche et al., 2006)

The participants in the groups were diverse in terms of age, race and gender. This diversity was aimed to maximise the exploration of different perspectives within the group (Kitzinger, 1995). A total number of 20 participants were university students and this group aged between 19 and 25. The other 30 participants consisted of factory workers, hall wardens, unemployed individuals and church members, age range 21 to 45.

### 3.6. Gathering of Information

Focus group discussions were used to generate discussion and collect information on the topic. "Focus groups are defined as a group of individuals that are selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is subject of the research" (Powell & Single, 1996, p. 499). Furthermore, the use of focus groups as a qualitative method enabled the researcher to understand the issue of substance use in a "naturalistic" setting and also generate detailed, rich and "thick" data (Powell & Single, 1996). Focus groups are extremely useful in exploring people's knowledge and experiences (Kitzinger, 1995), as well as assessing understandings of health behaviours and other social problems (Basch, 1987; Khan & Manderson, 1992). This method allowed for the researcher to obtain the information required on subjective understandings of substance abuse. Another major advantage of focus groups as a qualitative method is that they provided the researcher with an opportunity to observe participants engaging in interactions that are focused on attitudes and experiences which are of interest to the researcher (Morgan & Spanish, 1984). Thomas, MacMillan, McColl, Hale, and Bond (1995) postulate that the process of social interaction of the group also generates deeper and richer information than would be obtained from one-on-one interviews. In addition to this, focus groups are able to provide a relatively large amount of information in a relatively short period of time (Rabiee, 2004).

The focus group discussions were guided by the use of a semi-structured interview schedule, in order to focus and guide the discussion (Powell & Single, 1996). The interview schedule assisted the researcher to ensure that the topics that were intended for discussion were covered (Dawson, 2007). Furthermore, a schedule assisted the researcher to focus his/her mind on the research topic and it also enabled him/her to think of the areas to be covered in the group discussions (Dawson, 2007).

### 3.7. Research Procedure

After ethical clearance was granted, potential participants who were members of existing formal groups (e.g., university students, hall wardens, church members, etc.) and informal groups (e.g., community members, acquaintances, etc.) were approached. Potential participants were then asked if they were willing to participate in the study. Thereafter, participants were asked for referral of people that they know who may be interested in participating in the research and these individuals were approached by the researcher. Dates and times to conduct the focus groups were negotiated with the participants. To accommodate the research participants, the focus groups were conducted at a location close to where the participants live. At the beginning of each focus group the principal researcher and co-researchers introduced themselves to the participants and assured participants of confidentiality and anonymity. The research topic and aim of the study was again explained to the participants. Thereafter, the participants were welcomed and thanked for their willingness to participate in the study. Participants then provided written consent for audio recording and transcription of the focus group discussion (see Appendix 5). The researcher and made notes during the focus groups to refer to during transcription. The co-researchers also took notes during the focus groups as this would assist them during transcription. The focus groups discussions were audio recorded and transcribed at a later time by the researcher

and co-researchers. However, there were some disappointments where some participants failed to arrive for scheduled sessions and this called for rescheduling of some of the sessions on several occasions.

### 3.8. Analysis

The information gathered from the focus groups was analysed using thematic analysis. Braun and Clarke (2006) define thematic analysis as a foundational qualitative research method used to identify, analyse and report patterns or themes within collected data. Thematic analysis is a widely used qualitative research method (Attride-Stirling, 2001).

The following six phases of thematic analysis were followed in analysing the data (Braun & Clarke, 2006). In the first phase of analysis, the researcher familiarised herself with the data. The researcher immersed herself in the information by repeatedly reading the information in an active way searching for meanings and patterns within the information (Braun & Clark, 2006). Furthermore, the researcher began making notes for coding during this phase. During the second phase, the researcher generated initial codes. In this phase, the researcher began by reading and familiarising herself with the information and then generated a list of ideas about what was in the information. The researcher then documented what she found interesting. Furthermore, the information was organised into meaningful groups (Tuckett, 2005). This process involved systematically working through the entire information set and identifying interesting aspects in the data items that may form the basis of repeated themes across the information set. The third phase involved searching for themes. During this phase, the researcher re-focussed the analysis at a broader level of themes (Braun & Clark, 2006). The researcher then analysed the codes that were generated in the previous phase and during this phase she then considered how the different codes combine to form an overarching theme

(Braun & Clark, 2006). At the end of this phase the researcher had a collection of themes and sub-themes. The fourth phase, reviewing themes, involved reviewing and refinement of the themes from the previous phase. In the fifth phase, the researcher began to name and define themes. This phase entailed identifying the essence of what each theme is about and determining what aspect of the information each theme captured. For each individual theme the researcher then wrote a detailed analysis, this analysis included how each theme relates to other themes. In the analysis the researcher also conveyed how each theme relates to the research questions and she included the sub-themes (Braun & Clark, 2006). By the end of this phase the themes were clearly defined.

The sixth phase is producing the report, during which the researcher did the final analysis and the write-up of the report. According to Braun and Clark (2006), the write-up needs to provide sufficient evidence for the identified themes within the information. The researcher conveyed this by including enough extracts that demonstrate the prevalence of the theme. The researcher also chose those extracts that capture the point that the researcher is demonstrating.

### 3.9. Ethical Considerations

Ethical clearance to carry out the study was granted by Rhodes University's Research Projects and Ethics Review Committee (see Appendix 3). In this study, all participants were recruited on a voluntary basis and the participants were informed about the purpose and nature of the study. Due to the potentially sensitive nature of the personal experiences shared by the participants, they were assured of confidentiality and anonymity. The researcher used pseudonyms in the transcripts and the final report of the study to ensure anonymity and confidentiality. All of the collected information from the participants, including audio

recordings of the focus group discussions and transcripts, were stored in a password protected computer to safeguard the participants' anonymity.

Furthermore, the participants were informed of the potential harm or benefits of participating in the research. Written informed consent to participate in the study (see Appendix 4), as well as for recording and transcription (see Appendix 5) was provided by the participants. Participants were also made aware that they were free to withdraw from the study at any stage without any consequences. The risks of participating in the study were considered minimal, however sharing personal experiences related to substance abuse could evoke emotional distress. Therefore participants within Grahamstown were made aware that the Rhodes University's Counselling centre was available for participants who may be in need of psychological support. However, the participants situated in Pietermaritzburg were made aware of the available psychological services within the local hospitals, namely Northdale and Edendale hospitals.

### 3.10. Reliability and Validity

Trustworthiness is one of the essential qualities that qualitative research should possess and it encompasses credibility, transferability, dependability and confirmability (Guba, 1981). According to Shenton (2004), credibility refers to the internal consistency that is achieved through observation, prolonged engagement with participants and peer review. In order to ensure credibility, the researcher, examined previous research in the field in order to frame research findings (Shenton, 2004).

Transferability, on the other hand, entails that qualitative research should be understood in context (Shenton, 2004). According to Krefting (1991), transferability becomes the

responsibility of the party who wishes to transfer the findings to a different setting, rather than the original researcher. The researcher has provided sufficient information regarding the research methodology, the data collection methods, the location of the research and the participants to allow for research comparison and to address applicability (Krefting, 1991). In terms of confirmability, the researcher must ensure as far as possible that the study findings are reflective of the participants' experiences and perspectives rather than those of the researcher (Shenton, 2004). The researcher made notes during the focus groups and the audio recordings were a way to ensure confirmability. Also, the above ensured that the participants' experiences were transcribed as they had intended.

Reflexivity is another important principle to be considered when establishing the validity of psychological research. Lazard and McAvoy (2017) stipulate that it is esssential that researchers engage with reflexive processes because reflexivity is central to doing qualitative work. Reflexivity is defined as the assessment of the influence of the researcher's background, personal history, perceptions, and interests on the research process (Ruby, 1980). This principle requires the researcher to be aware that his or her experiences and understanding of the world may affect the research process (Morrow, 2005).

During this study the researcher was involved in a process of critical self-reflection in order to be aware of how being a psychology masters student as well as her previous experience working with individuals with substance abuse problems may impact the research process. Furthermore the researcher's aforementioned experience and knowledge could possibly place her in a position of being regarded as an "expert" and this would affect the analysis and findings of the study. As much as possible the researcher was able to note any biases or assumptions arising from past experiences and her knowledge of that came to the fore during

the research process (Morrow, 2005). However, working within the social constructionism frame the researcher's positioning as a co-constructor of meaning is embraced and the information analysed is to a certain extent influenced by the researcher (Morrow, 2005). Furthermore, this theoretical frame maintains that it is the responsibility of the researcher to constantly reflect on the research process and how it is being affected by the researcher (Marks, 1993).

Also, it was important for the researcher, who is also a therapist in training, to constantly remind herself of her role as a researcher in the study and not a therapist, specifically during the focus group discussions. Havercamp (2005) acknowledges the challenge faced by psychologists or counsellors conducting interviews for research as well as the difficulty that these professionals face in managing the boundary between research and therapy. The aforementioned principles are regarded as a priority to the researcher in order to ensure the reliability and validity of the study.

### 3.11. Conclusion

This chapter detailed the research methodology undertaken to carry out this research. The research participants were recruited based on specified inclusionary criteria and the information used for the analysis was collected by conducting focus groups. The researcher was able to uphold research ethical considerations throughout the whole research process. The collected information was analysed using Braun and Clark (2006) thematic analysis. The researcher began this chapter by discussing the theoretical framework that underpins this study. Following this, the researcher then explored the methodology of the research. The researcher provided the rationale for the chosen research approach as well as the research aims.

# CHAPTER 4: FINDINGS AND ANALYSIS

## 4.1. Introduction

The purpose of this research was to explore lay people's understanding of substance abuse and how this confirms or contradicts professionals' understanding as reflected in the DSM 5. This study was prompted by the scant literature on lay people's understanding of substance abuse and the desire to understand how lay people define and understand substance abuse. The few studies that have been conducted in this area noted that lay persons tend to endorse moral models while professionals tend to lean towards the medical models of understanding SUDs (Furnham & Lowick, 1984; Truan, 1993; Walters & Gilbert, 2000; Weine et al., 2016). In this section the researcher will present the findings and discussion with reference to the research questions. The aim of this research is to explore how lay people understand substance abuse and to evaluate if this understanding aligns with or contradicts that of professionals.

Similar views regarding substance abuse were expressed by participants and these views are largely influenced by participants' social contexts. The following six themes emerged from the information gathered: severity of substance abuse; substance use, abuse and dependency; functionality; loss of control; gateway substance use and experimenting and mental health literacy.

## 4.2. Theme 1: Severity of substance abuse

One of the major themes that were identified is severity of substance use. According to Zafarghandi et al (2018), substance abusers can either be classified into two types, as either with high or with less severity. This implies that though two individuals may have a

substance abuse problem, the severity/seriousness of the problem may differ. Furthermore, as seen in the literature review chapter differences exist between individuals who are addicted to the same substance (Windle & Scheidt, 2004). Research demonstrates that, the severity of a substance abuse problem is defined in terms of the impact or the negative effects that substance use has on the domains of functioning, which include family, work, physical health and mental health (Conners-Burrow, et al., 2013; Gmel & Rehm , 2003; Zafarghandi et al., 2018). Similarly, the common view among participants was that the severity of substance abuse is indicated by the negative effects that it has on the individual's interpersonal relationships, physical and mental health. Participants further construct severity of substance abuse as indicated by the quantity of a substance used, the frequency of substance use and presence of withdrawal symptoms.

***Extract 1:***

***Lwazi**: Ja, my uncle I think has a drinking problem…no… [laughs]... I know he has a drinking problem. He is epileptic and he is on treatment. The whole family has tried to intervene but he won't listen. He will drink the whole day until he passes out, wake up and drink again. He won't come home for days and he won't eat or bath the whole weekend, he just drinks until his money runs out. He will come home and have seizures for days. His wife couldn't take it anymore, so she left. [FG11, Pg 3]*

***Extract 2:***

***Josh:** okay it depends if you use marijuana frequently or alcohol frequently just to get a slight buzz I don't feel like that's abuse, I have been stoned to the point where I can't walk or talk like I've been stuck on a couch just sitting there, that's abuse, I've been drunk to the point where I can't get up and I've thrown up on myself that's abuse, if*

*you consistently get drunk to the point where you throw up or have a solid hangover the next morning, that's abuse. [FG8, Pg13]*

The above extracts convey that severity of substance use can differ from one person to the next as indicated in the literature. In the above extracts particularly, severity is defined in terms of the negative effects that excessive substance use has on physical health. Participants also convey that the severity of substance use can lead to instances where individuals place themselves in danger. **Lwazi**'s extract in particular conveys excessive substance use that has negative implications for most domains of functioning namely: health, family, interpersonal relationships (Conners-Burrow, et al., 2013; Gmel & Rehm , 2003; Zafarghandi et al., 2018) and this indicates high severity of substance abuse (Zafarghandi et al., 2018). This extract also demonstrates an attempt at an intervention by the family significant others of the substance abusing individual and this also implies the high severity of the substance abuse problem for this particular individual. Overall, participants' construction of severity of substance abuse also touches on functionality or lack thereof (one of the broad themes) as an indication of the severity of substance abuse.

### 4.3. Theme 2: Substance use, abuse and dependency

Substance use, abuse and dependency was one of the main themes that emerged. Participants used these three concepts as indicators of the severity of a substance abuse problem. Furthermore, participants spoke about the differences between these terms and did not make reference to SUD. Participants construct use, abuse and dependence as steps or a progression. As seen in literature, this progression also refers to gateway substance use, where an individual progresses from not using substances to use of licit substances and later progress to

use of illicit substances (Kandel, 2002). Substance use is usually seen as the first step, followed by substance abuse, and ultimately leading to dependence. Abuse is often perceived to be milder than dependence, however some of the DSM 4 substance abuse criteria indicates clinical severe problems that can be quite debilitating for the individual (Hasin, 2015). Participants further suggested that abuse of most substances is often due to dependency and vice versa, while others believed that abuse can occur without dependency. Substance dependency is defined as the physiological and psychological state in which a user has developed a dependence on drugs such as alcohol, tobacco, opiates or amphetamines (Breshears, Yeh, & Young, 2009 ; Qi, Tretter, & Voit, 2014). Furthermore, some participants acknowledged that at times people are dependent on certain substances in order to function. According to participants, for instance psychiatric patients require drugs in order to be functional members of society. In this case the dependency is not perceived negatively, but instead is seen as necessary in order to survive.

#### 4.3.1. Use

Substance use refers to the use of any substance without there being dependence or any form of abuse. Substance use is said to occur along a continuum and that not everyone who uses a substance becomes addicted (Breshears, Yeh, & Young, 2009). As seen in literature, others have found that substance use is defined or classified according to the effects of specific substances and consequences of using them (Windsor & Dunlap, 2010). Furthermore, use has been described as functional, as long it does not affect the user’s ability to meet their personal obligations such as raising children, running a household, keeping a job, abstaining from substance use when necessary (Windsor & Dunlap, 2010). Similarly, in the current study a common view among participants was that substance use has no negative effects on an individual’s ability to function and on interpersonal relationships. Participants construct

substance use as “normal” or the “ideal” as there is often no or minimal negative effects, however there were differences in this view specifically regarding the use of illicit substances. Some of the participants view the use of some illicit substances as “abuse” and they attribute this to the negative effects that are often associated with these types of substances. The common view among the participants is that “use” is often the first step towards substance abuse. This is view is consistent with the Gateway Hypothesis, which purports that substance use typically follows progressions or phases from non-use to use of licit substances that then typically leads to use of illicit substances (Kandel, 2002).

***Extract 3:***

**_Paul:_** *“…Yes daily functioning, so long as it doesn’t hinder that it, can be seen as recreational”. [FG 7, Pg3]*

***Extract 4:***

**_Paul:_** *I feel as long as you are doing it to let off steam or just destress and it doesn’t become like a need, like you need it to get through the day. When it becomes a need that’s when it passes from recreational to like an addiction. [FG 7, Pg3]*

The above extracts illustrates the way that participants define substance use. Here, participants construct substance use as that, which has no negative impact on the individual. Furthermore the above extracts imply that substance use is judged by the ability to maintain functionality. The participants’ construction of use is based on people’s ability to maintain functionality and interpersonal relationships without any negative effects resulting from substance use. This view seems to align with that of substance abuse literature.

#### 4.3.2. Abuse

Abuse is defined as the pattern of use that results in either, failure to fulfil role obligations, place oneself and others in danger and interpersonal problems (Breshears, Yeh, & Young, 2009). Literature shows that lay people emphasise diminished control in their definitions of substance abuse, while professionals' definition of abuse focuses on physical dependence (Walters & Gilbert, 2000). The participants in this study on the other hand view substance abuse as the use of a substance in large quantities and /or on a regular basis, which results in the inability to exercise control on their behaviours. A common view among participants was that substance abuse has an extremely negative impact on interpersonal relationships as well as negative health consequences. This view is consistent with literature, where heavy substance use specifically alcohol has been recognised to have adverse effects on work performance, interpersonal relationships, and overall poor quality of life (Gmel et al., 2000; Gmel and Rehm, 2003; Sloboda et al., 2012). Participants have also indicated that the type of substance used determines the kind of effect on the individual. Participants particularly alluded to illicit substances as having debilitating effects for the user and significant others than licit substances.

***Extract 5:***

***J:*** *"It must be whether it becomes,... abuse must be when it starts becoming bad for you in some way". [FG 1, Pg 3]*

***Extract 6:***

***Zane:*** *Ja, ja, ja, that's what I was going to say, also, in the moment where your, your uh state of inebriation has very negative consequences. [FG1, pg3]*

***Extract 7:***

***Shadrack:*** *"……….. So like substance abuse with alcohol would be going to work drunk, um you know being drunk consistently basically and not being able to function any longer to your detriment and to other people around you. So like for me that would be substance abuse; the abuse of any substance where you're unable to function and it effects people around you. (FG2, Pg1)*

In the above extracts participants generally define and construct substance abuse based on the effects that it has on individuals' functionality and interpersonal relationships. This view aligns with that of the literature as already discussed, particularly the negative impact on one's functionality or ability fulfil role obligations. Furthermore, participants suggest that excessive use a substance is also an indication of substance abuse. Participants also generally view substance abuse as problematic, however milder than substance dependence.

**4.3.3. Substance dependence**

As seen in literature substance dependence is described as the physiological and psychological state, where an individual develops a dependency on drugs such as alcohol, tobacco, opiates or amphetamines (Qi, Tretter, & Voit, 2014). Dependence is divided into physical (changes in the body such as tolerance and withdrawal) and psychological (perceived need for the substance to feel good, function or to avoid feeling bad) dependence (Breshears, Yeh, & Young, 2009). As seen in literature the diagnosis of substance dependence was used in the DSM 4 to diagnose a person who did not meet the criteria for a diagnosis of substance abuse (APA, 2000). Participants on the other hand view substance dependence as the abuse of substances and to them abuse entails frequent use of and/or use of a substance in large quantities. Hasin (2015) acknowledges that there is often an assumption that dependence is more severe than abuse. This was also a common view among the participants, who construct dependence as a stage

where one should ideally been considering seeking treatment. The common view among participants is that individuals depend on substances in order to be able to meet life obligations and to be functional members of society. Furthermore, participants construct substance dependence as a progression from abuse and these terms are viewed as steps that follow to one another. This implies that substance abuse leads to substance dependence. Participants further suggested that dependence cannot occur without abuse, however abuse can occur without dependence. Similarly, in the DSM 4 a diagnosis of substance abuse was only given if an individual did not meet the criteria for a diagnosis of substance dependence (APA, 2000). However, for a person to be given a diagnosis of substance dependence they would have to meet some of the substance abuse criteria (Hasin, 2015). The extracts below illustrates participants' construction of dependence.

***Extract 8:***

***Ayanda:*** *They would probably sort of make everything revolve around that substance and if they didn't get to have it, it would affect everything else so they would plan everything around being able to have that. [FG3, Pg4]*

***Extract 9*:**

> **Doug***: I mean someone who's dependent would be…if they were like, taking it every day, um, and struggled to get by without it. But an abuser would be like, you know, going H.A.M. [binge situation], not every day… [FG6, Pg4].*

***Extract 10:***

> ***H:*** *And that's kind of part of dependency where you start to, like, rely on your substance to function properly. [FG 6, Pg3]*

The above extracts highlight how participants construct substance dependence as a need to use a substance in order to function. This implies without the use of substances then the addicted person will not be able to cope with the demands of life. This further necessitates the use of substances which then reinforces the using behaviour. Further suggested by the extracts is that an individual would do anything in order to obtain the substance and that an individual actively engages in actions to be able to obtain the substance. The participants in the above extracts also suggest that the substance becomes central or a priority to the user. This indicates that other areas of the individual's life will be adversely affected. Similarly, as seen in literature (Gmel et al., 2000; Gmel & Rehm, 2003; Sloboda, Glantz, & Tarter, 2012), problematic substance use and dependency has been known to have increased the risk for problems in interpersonal relationships, employment, contribute in academic failure and overall poor quality of life.

### 4.4. Theme 3: Functionality

Individuals' ability to function is one of the main themes that emerged from the discussions. Participants have used the concept of functionality to refer people's ability to keep up with daily obligations such as employment, meaningful engagement in interpersonal relationships, academic requirements, etc. Thus, participants felt that functionality or lack thereof should be one of the ways to define substance abuse. Similarly, as seen in literature (Gmel et al., 2000; Gmel & Rehm, 2003; Sloboda, Glantz, & Tarter, 2012) functionality plays a significant role in defining substance abuse/SUDs, where the common theme is that substance abuse problems have a negative impact on the various domains of functioning. Askew (2016) also suggests that the ability to control drug use enables individuals to maintain functionality in

their lives. Others have also suggested that compulsive and dysfunctional substance use is constructed as unacceptable, and encourage that control and functionality should be central in substance users' narratives (Decorte, 2001; Lau et al., 2015; Monaghan, 2002; Riley et al., 2010).

Furthermore, participants mentioned that the ability to participate in day to day tasks can also be a way of distinguishing between substance use, abuse and dependency, as already discussed in an earlier theme. Participants believe that the term abuse is when an individual follows a particular pattern of use in order to be able to function, for instance using a particular substance on a daily basis in order to function. This implies that without the use of the particular substance, the individual is unlikely to be able to function, that is adequately participate in day to day activities.

Similarly, there was a shared understanding among participants regarding the negative impact that substance abuse has on the various domains of functioning. Participants particularly emphasised the negative impact that substance abuse has on interpersonal relationships and occupational functioning, and how this contributes to their definitions and understanding of substance abuse. To further illustrate this point, Gmel and Rehm (2003) have pointed out that heavy alcohol use in particular has been associated with poor work performance. Gmel (2000) also found that occupational and interpersonal problems were highly likely for those individuals with problematic substance use. Furthermore, participants shared that people's employment is usually the first to be negatively impacted when people begin abusing substances. Also, this is evidenced by either not being able to carry out their duties or by staying away from work due to intoxication.

Participants have also referred to functional use of certain substances, participants refer to this as ideal kind of use. However, others have used this concept to describe controlled and

moderated substance use, where there is no negative impact for the user, which is "functional use" (Askew, 2016).

***Extract 11:***

> **Shadrack:** *Um, yeah again not being able to function properly I suppose, um and then being a liability to yourself and others, being a danger. [FG 2, pg1]*

***Extract 12:***

> **John:** *I think maybe it's like when someone uses a substance to the point that it starts affecting like their personal life and their work…whatever, like important aspect I guess. Um ja…I guess people are like then dependent to an extent. [FG 5, Pg 1]*

***Extract 13:***

> **Zama:** *Ja, also my brother became "useless, he would spend the whole weekend sleeping and even miss work on Mondays…and we'd know that, ok he had been taking that stuff. He wouldn't bath or eat the whole weekend. He got fired from work and he's girlfriend also left him. I mean…who wouldn't? [FG 11, Pg 2]*

The above extracts convey the adverse effects of problematic substance use on the people's overall functionality. The common view held by participants as conveyed by these extracts is that substance abuse often leads to interpersonal and occupational problems. Furthermore, the above extracts indicate that participants construct functionality as the ability to maintain gainful employment as well as maintaining healthy interpersonal relationships. This implies that these concepts are the core indicators of ones' functionality. Furthermore, this view

indicates that an individuals with substance abuse problems are likely to experience problems at work that may then lead to loss of employment, which results in loss of income. With regards to interpersonal difficulties the above extracts imply that a substance abusing individual may experience difficulties relating to significant others due to either the effects of substances use or the substance abuse behaviour itself. This view is well documented in literature as discussed earlier.

### 4.5. Theme 4: Loss of control

Loss of control was another major theme of how participants constructed substance abuse. Participants believe that the abuse of certain substances can cause individuals to lose control of their lives or behaviours. As seen in literature, other studies have also found that diminished control is emphasised by both lay people and "experts" when defining substance abuse (Walters & Gilbert, 2000). Others, have also suggested that in SUDs there is a disruption of goal directed behaviour as well as an impairment in goal directed control (Vandaele & Janak, 2018). Similarly, in this study loss of control was a prominent feature in participants' definition substance abuse. Participants constructed loss of control as having minimal or no control at all over one's behaviour due to substance abuse problems. Literature, suggests that it is more appropriate to conceptualise drug use on a spectrum that runs from control to dysfunction, and that this would ensure a better understanding of the impact of drug use (Askew, 2016). This suggests that when substance use becomes problematic individuals progress from having some level of control in their lives to having none. Room (2003) has acknowledged that the concept of loss of control is quite significant in framing addiction.

***Extract 14:***

***Zanele:*** *For me some people, when they are using drugs they just eh like lose control, like you know life just spirals out of control. For instance somebody drinking so much that they do things that they would not normally do when sober. [FG11, Pg4]*

***Extract 15:***

***Mandisa:*** *I know this guy, he drinks and I think he also takes cocaine. Every month end when he gets paid, once he starts drinking, it's like all hell breaks loose. He'll drink all weekend and take cocaine. He doesn't even go home for the whole weekend. And, he is married… just imagine. [FG 11, Pg6]*

The above extracts highlight the loss of control that is often associated with substance abuse. The participants in the above extracts construct loss of control in two ways: firstly, as the inability to control drug consumption, which then leads to maladaptive behaviour. Secondly, as relating to behaviour, where an individual conducts themselves in a dysfunctional manner, similar to the individual described by **Mandisa,** due to excessive substance use. This view positions the drug user as a passive recipient, rather than an active agent in the continued substance use and abuse (Askew, 2016). This further constructs the individual as a victim of the abused substance or substances.

### 4.6. Theme 5: Gateway Substance Use and Experimenting

The type of substance used or abused is significant in attempting to understand substance abuse problems. As seen in literature, substance use is said to follow a particular pattern, which often begins with the use of licit substances and then progress to the use of illicit substances (Choo, Roh ,& Robinson, 2008; Kandel, 2002; Kirby & Barry, 2012). This progression is known as the gateway hypothesis or gateway theory (Choo, Roh, & Robinson, 2008; Kandel, 2002; Kirby & Barry, 2012). Participants in the study have spoken of a

progression in substance use and how this progression leads to substance abuse. Generally, participants' view is that many individuals usually begin using certain substances occasionally, however, with time there is an increase in the quantity of the substance used which then results in substance abuse. Participants, view this progression or increase in substance use as a way to enable the substance user to achieve the desired effect or level of intoxication. This also refers to tolerance as there is a need to increase the quantity of a substance in order to achieve the desired effect from the substance (APA, 2013). Participants acknowledge that this progression is not limited to quantity of substance, but also includes a progression in terms of the type of substance used. Literature shows that substance users are likely to progress from the use of mild substances to the use of more potent substances as suggested by the Gateway theory (Kandel, 2002). As seen in literature, the Gateway theory further suggests that the use of licit substances increases the likelihood of illicit drug use at a later stage (Kirby & Barry, 2012). Furthermore, individuals often begin experimenting with the more socially acceptable substances such as alcohol or tobacco and proceed to cannabis and other illegal substances (Howell, 2010). Similarly, the common view among participants was that alcohol and cigarettes are perceived as less dangerous and therefore are more socially acceptable unlike some illicit substances. However, there were mixed views among participants regarding cannabis, some participants perceive cannabis to be harmless and even less dangerous than alcohol, while others felt that this substance can be quite problematic. Some participants felt that because cannabis is sometimes used for medicinal purposes and this conveys that it is not as dangerous as other substances.

***Extract 16:***

***G:*** *Alcohol is more acceptable than doing heroin or… well some of those people find smoking pot more acceptable than drinking so it's a bit of a, there's twist to that one. (FG1, Pg4)*

***Extract 17:***

***S:*** *So like any use of it is abuse automatically just like cocaine and uh, like super addictive drugs, like one use and your pretty much hooked. Whereas like marijuana, or um, LSD, or 'shrooms', they are generally, they are generally not supremely addictive and most people don't become dependent on them. I mean there are some cases, but it's not, um like with other things. [FG2, Pg2]*

***Extract 18:***

***A:*** *You have like the 'entry level' things...Beer is a lot less worse than heroine for instance. [FG5, Pg2]*

***Extract 19:***

***I:*** *I think it's also socially constructed so cigarettes and alcohol are more, you know, people accept them more than, you know, they'd accept heroin or coke, so there's also that factor. [FG 6, Pg3].*

The participants in the above extracts highlight some of the gateway substances that are commonly used. The participants' views are consistent with those found in literature regarding which substances are regarded as gateway substances (Choo et al., 2008). Furthermore, participants are also of the view that substance use progresses from licit substances to illicit substances, this is also consistent with the literature. Participants also position certain substances (alcohol and cigarettes) as "not that bad" or less dangerous and they believe that individuals typically begin experimenting with these types of substances. As also seen in

literature, (Howell, 2010), the perception of these substances is because they are more socially acceptable. Also, implied by the extracts is that there is often a reluctance to accept certain substances or there is a negative perception towards some illicit substances (such as, heroin, cocaine, etc.) due to their addictive nature. Furthermore, it appears that the social context in which a substance is used contributes to how it is perceived. Participants felt that the media also has an impact in how certain drugs are perceived.

### 4.7. Theme 6: Mental health literacy

As seen in literature this concept refers to people's knowledge and beliefs about the diagnosis and treatment of mental illness (Furnham, Lee, & Kolzeev, 2015; Jorm, 2000). This concept, as discussed in the literature review chapter, is multidimensional. It incorporates, the ability to recognise symptoms of specific disorders; knowledge and beliefs about risk factors and causes; knowledge and beliefs about self-help interventions; knowledge and beliefs about professional interventions; attitudes that facilitate help seeking when necessary; and knowledge of how to seek information regarding mental health (Jorm et al., 1997). Participants in this study did to a certain extent display some of these components or knowledge specifically regarding substance abuse. Participants were able to recognise symptoms as well as some of the risk factors of substance abuse. Participants were also aware of the professional interventions available, however participants believe that professional interventions are not always indicated in addressing substance abuse problems as participants are of the view that the responsibility to address substance abuse lies with the individual. Furthermore, some of the participants' views, specifically regarding the causes of substance abuse were in contrast to those of professionals. Some of the participants were also reluctant to view substance abuse as an illness, more

specifically a psychiatric condition. Rather, it appears that participants construct substance abuse as a habit that can be controlled if an individual is willing to do so.

Similarly, (Klingemann, 2011), found that lay people often view substance abuse problems as a sign of social dysfunction and emphasise willpower and exerting pressure on the individual in order to facilitate recovery. This concurs with, (Angermeyer & Dietrich, 2006; Link, Phelan, & Bresnahan, 1999; Jorm, 2000; Jorm et al., 1997), as seen in the literature review chapter regarding lay people's tendency to align with non-medical models of mental health conditions or social phenomena, in contrast to professionals who often endorse the medical model. Similarly, other studies have also demonstrated that lay people often endorse supernatural explanations for psychiatric conditions and also believe that mental illness is a result misuse of psychoactive substances (Adewuya & Makanjuola, 2008). And another study conducted in Malaysia showed that lay people often attribute mental health conditions to social-environmental causes rather than biological causes (Swami, Furnham, Kannan, & Sinniah, 2008).

It appears as if participants in the study believe that substance abuse problems are to certain extent self-inflicted. This view has at times led to negative perceptions towards substance abusing individuals than those with other types of mental illness, this belief is a result of the view that substance abusing individuals are violent an dangerous (Angermeyer & Dietrich, 2006; Barry, McGinty, Pescosolido, & Goldman, 2014). It is also implied that individuals can to a certain extent control substance abusing behaviour.

Furthermore, participants do not seem to perceive substance abuse as a disorder requiring a formal diagnosis. Participants are of the view that one can recover from substance abuse and recovery is dependent on an individual's willpower. However, this view does not align with

that of professionals of substance abuse as a chronic condition that requires treatment (Klingemann, 2011).

***Extract 19:***

> ***Ntokozo:*** *I think a person can stop using when they are serious about stopping, I mean if you can see that maybe dinking or whatever drug you are using is becoming a problem, then you can stop if you really want to. [FG 11, Pg5]*

***Extract 20:***

> ***Donavan:*** *Yeah, I think it depends on willpower, you need to be really strong mentally in order to be able to stop. Also, I found that you should not socialise with the people you used take the substance with. [FG11, Pg5]*

The above extracts illustrate that most of the participants' view regarding substance abuse. The extracts demonstrate that participants construct substance abuse as a temporary condition, where a person is able discontinue use if they are willing to do so. Furthermore, participants in these extracts position willpower and social influence as important factors that influence recovery in substance abuse. Participants' view of substance abuse implies that participants do not perceive substance abuse as a medical condition but as a habit that can be discontinued by limiting contact with substance abusing peers. During the focus groups participants also cited poor socioeconomic circumstances as a factor in the etiology of substance abuse problems. This further implies a belief in social environment factors as the cause of substance abuse, this is view aligns with (Jorm, 2000), who postulated that lay theories often cite psychosocial factors in the etiology of mental illness.

Overall, participants do to certain extent possess some mental health literacy, they are able to recognise symptoms of mental illness as well as the risk factors associated with the illness.

### 4.8. Conclusion

In conclusion, lay people's understanding of substance abuse is subjective and also strongly influenced by the social context. From the information analysed it is apparent that the common discourse among lay people is that substance abuse follows a progression from use, abuse to dependency. Furthermore, participants view substance abuse as progressing from the use of licit to the use of illicit substance, as reflected by the gateway theory (Degenhardt, et al., 2009 ; Kandel, 2002; Kirby & Barry, 2012). Participants' definitions of substance abuse centred on functionality, poor interpersonal relationships, loss of control and the progression of use. Based on this, participants' views of substance abuse do align with those of professionals to a certain extent. However, some differences between participants' views and those of professionals were also noted specifically, with regards mental health literacy. Notably, beliefs or views regarding the etiology and curability of substance abuse problems.

# CHAPTER 5: CONCLUSIONS

## 5.1. Introduction

This study aims to explore the understanding of substance abuse by lay individuals and whether this confirms or contradicts that of professionals, as reflected by the DSM5. The DSM or professional view of SUDs may be useful for diagnostic purposes, however it is but one way of classifying individuals. Furthermore, there are many differences between individuals who may be addicted to the same type of substance (Windle & Scheidt, 2004).

Thus, the understanding of substance abuse is subjective for each participant and it is constructed through social interactions and social processes. The findings of this research reveal how lay people construct their understanding of substance abuse. These findings further demonstrate how societal views influence the understanding of substance abuse. In the following section the researcher discusses the summary of findings, the limitations of the study and makes recommendations for future research.

## 5.2. Summary of Research Findings

The findings of this study indicate that lay peoples' understanding of substance abuse centres on the impact that substance use and abuse have on peoples' lives. According to participants, an individual's ability to function with or without the use of a substance determines whether one has a substance abuse problem or not. Further suggested by the findings of this study is that lay people often associate poor interpersonal relationships, functionality or lack thereof and loss of or diminished control with substance abuse problems. This view is consistent with that of professionals and the DSM5 (APA, 2013).

The study also revealed that participants construct substance abuse problems as a progression from use, abuse and dependence. Furthermore, participants have also suggested that this progression is also an indication of the severity of substance abuse problem. The research also revealed that substance use often begin by experimenting with licit and more socially acceptable substances such as alcohol and /tobacco. This view is similar to that of professionals as reflected by the Gateway theory, regarding the progression of substance use from licit to illicit substance use ((Degenhardt, et al., 2009 ; Howell, 2010; Kandel, 2002; Kirby & Barry, 2012) .

The study has further revealed that lay people's construction of substance abuse problems is often influenced by mental health literacy. Furthermore, the researcher found that lay people attribute substance abuse problems to social and environmental factors. This view is similar to that found in previous research, (Angermeyer & Dietrich, 2006; Link, Phelan, & Bresnahan, 1999; Jorm, 2000; Jorm et al., 1997), regarding lay people's tendency to align with non-medical models of mental health conditions, in contrast to professionals who often endorse the medical model.

The findings of this research indicate that there are similarities in the views of lay people and those of professionals regarding substance abuse problems. Though participants' understanding of substance abuse is consistent with that of professionals, this study found that participants demonstrated a preference for the DSM 4 classification of SUDs over that of the current DSM5. Participants are of the view that the DSM5 is broad in its classification of SUDs in contrast to the DSM 4, which they regard as concise and specific. This view concurs with earlier research (Martin, Steinley, Verge, & Sher, 2011; Urbina, 2012) in which concerns about the low threshold of the DSM5 diagnostic criteria were raised and the

possibility of these criteria diagnosing “millions more” people with SUDs when a diagnosis is not warranted. Furthermore, the DSM 5 does not convey the extent of problems experienced by persons with substance abuse problems (Zafarghandi et al., 2018).

### 5.3. Limitations

The purpose of this study was to explore lay people’s understanding of substance abuse and whether this understanding confirms or contradicts that of professionals as reflected by the DSM. This research has yielded interesting findings, however, they are not without limitations. The researcher outlines these limitations briefly below:

This study is qualitative in nature and consists of a sample size of 50 participants. Although, a sample of this size is sufficient for qualitative exploratory research and participants provided rich descriptions of their subjective realities, it must, however, be stated that the results of this study cannot be generalised to all populations fitting the participants’ characteristics.

This research has yielded rich and detailed information about participants’ subjective experiences relating to substance use and abuse. The participants in this study consisted of a diverse group of individuals in terms of gender, race, etc.: It would have been interesting to obtain views of each gender separately and contrast and compare these views to examine if there would be differences on how each gender understands substance abuse.

Although, the participants in this study were diverse in terms of age, race, gender and educational qualifications, the majority of the participants are from urban areas. It may be interesting for future studies to focus on rural participants to determine if they would have differing views or understanding of substance abuse. Additionally, most of the participants

have formal education (some high school and some currently university students); this is likely to have a bearing in their constructions of substance abuse.

### 5.4. Recommendations

In light of the findings as well as the limitations of the study the researcher presents the following recommendations:

Future studies in this field could explore the factors that influence understanding and definition of SUDs.

In view of the sample mostly consisting of individuals with formal education, future research could compare views of those with a higher level of education with those without to determine if level of education has any bearing on how SUDs are understood.

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**APPENDICES**

**Appendix 1: Interview Schedule**

**Introduction:**

Introduction of researchers and welcoming of participants. Consent discussed again with participants. Participants were again assured of anonymity and participants were given an opportunity to share any concerns that may arise at any stage of the research.

**Questions**:

1) When we speak about substance abuse, what comes to mind? How do you define substance abuse?

2) What would you say informs this definition?

3) Do you know anyone who you would say uses substances excessively? Explain.

4) How does this person behave when they are intoxicated?

5) What are other signs of substance abuse?

6) Are there any behaviours that you associate with substance abuse?

7) Is there a difference between substance use and abuse? What are they?

8) Are there substances that you regard as worse than others? What are these?

9) Is there anyone who would like to share their personal experience with substance use or abuse? This may include personal experience or a family member.

## Appendix 2: Confidentiality Agreement for Transcription Services

**CONFIDENTIALITY AGREEMENT: Transcription Services**

I, ________________________ (name of transcriber), agree to maintain full confidentiality in regards to any and all audio recordings and documentation received from Asanda Ranase related to his/her (circle appropriate) research study on Exploring lay people's understanding of substance of substance abuse.

Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents;

2. To not make copies of any audiotapes or computerized files of the transcribed interview texts, unless specifically requested to do so by Asanda Ranase.

3. To store all study-related audio recordings and materials in a safe, secure location as long as they are in my possession;

4. To return all audio recordings and study-related documents to Asanda Ranase in a complete and timely manner.

5. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audio recordings and/or files to which I will have access.

Transcriber's name
(printed):____________________________________________________________

Transcriber's signature: _______________________________________________

Date: _______________________________________________________________

**Appendix 3: RPERC Approval Letter**

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# RESEARCH PUBLICATION AGREEMENT

A signed copy of this agreement must be submitted with all research proposals submitted to the Research Projects & Ethics Review Committee (RPERC). This document must also be signed by: (i) students undertaking Honours level projects and (ii) students and others acting as research assistants for staff members.

| **Name of student** | **Asanda Ranase** |
|---|---|
| **Name of supervisor/project leader** | **Elron Fouten** |
| **Provisional title of thesis/report** | **Exploring lay people's understanding of substance abuse** |

A major task of a University is to provide the infrastructure necessary for the conduct of research and for the dissemination of findings through publication in academic journals or edited books. Those who enrol for a postgraduate degree (which includes any form of research) or act as research assistants become participants in this task. With regard to the former, this means that the University has the responsibility and right to take whatever steps may be appropriate to turn student's research work into one or more publications. In light of this, postgraduate students and those acting as research assistants in the Department of Psychology must sign the following agreement as a condition for undertaking supervised research or acting as research assistants.

1. I, Asanda Ranase, undertake to plan and execute the research project referred to above under the supervision of the supervisor Elron Fouten and to remain in regular consultation with the supervisor / project leader on all aspects of the research.

2. With regard to supervised research, I understand that I have the right to publish the research, that I must reach agreement with the supervisor regarding the nature of the publication and the publication medium (e.g., specific journal or book chapter), and that I should take active steps towards publishing it within six months of being informed by the University that the degree has been awarded.

With regard to supervised research, I understand that my supervisor has the right to prepare and submit the research for publication if either: i) I indicate that I do not wish to work on the publication of the research myself, or, ii) I do not provide adequate evidence of having taken significant steps towards submitting the material for publication within six months of being informed by the University that the degree has been awarded.

3. With regard to supervised research, I understand that when the research is submitted for publication my own affiliation and that of my supervisor should be given as 'Rhodes University'.

4. I understand that the following guidelines should be followed in assigning authorship when the work is submitted for publication. These include, that:

a) The student should normally appear as first author and the supervisor as second author.

b) In some cases other students or researchers may be included as additional authors (where they have made a contribution to the scientific value of the research).

c) Where the supervisor's preparation of the work for publication involves him/her in considerable additional work (e.g., updating the literature review, additional data analyses, responding to instructions for revision from journal reviewers, or where the student has had no involvement in the writing up of the article for publication), s/he has the right to appear as first author.

d) Where a student or other participates as a research assistant in a staff member's research project, such as in gathering and/or analysing the data, but this does not result in a thesis, the student's contribution should be acknowledged. If the involvement was only helping to collect the data, the acknowledgement would normally be given in the text.

e) Should the student or other acting as a research assistant contribute substantially to the academic merit of the publication, then the student or other may be listed as a co-author. This is to be negotiated with the project leader.

f) Should there be uncertainty about the status of the student, research assistant, supervisor, or project leader with regard to authorship/co-authorship any one of these parties may approach the department's Research Projects & Ethics Review Committee (RPERC) for a decision.

| **Signature:** | **Date:** |
| --- | --- |
| | |

**Appendix 4: Participant Consent Form**

## AGREEMENT BETWEEN STUDENT RESEARCHER AND RESEARCH PARTICIPANT

I, ________________________________________, agree to participate in the research project of Asanda Ranase on Exploring lay people's understanding of substance abuse.

**I understand that:**

1. The researcher is a student conducting the research as part of the requirements for a Master's degree in Clinical Psychology at Rhodes University. The researcher may be contacted on 0724274688 or by email: asandaranase@hotmail.com. The research project has been approved by the relevant ethics committee, and is under the supervision of Mr E. Fouten in the Psychology department at Rhodes University. He can be contacted on (046)603 8003 or by email: e.fouten@ru.ac.za

2. The researcher is interested how lay people understand substance abuse.

3. My participation will involve a focus group discussion lasting approximately one and a half hours.

4. I may be asked to answer questions of a personal nature, but I can choose not to answer any questions about aspects of my life which I am not willing to disclose.

5. I am invited to voice to the researcher, any concerns I have about my participation in the study, or consequences I may experience as a result of my participation, and to have these addressed to my satisfaction. In the unlikely event that I experience any distress as a result of my participation the psychology clinic may be contacted for further support on (046) 6038502.

6. I am free to withdraw from the study at any time. However, I will commit myself to full participation unless some unusual circumstances occur or I have concerns about my participation that I did not originally anticipate.

7. The report on the project may contain information about my personal experiences, attitudes and behaviours, but that the report will be designed in such a way that it will not be possible to be identified by the general reader.

8. The focus group will be audio-recorded; I grant permission for this with the understanding that only the researcher and one or more nominated third party transcribers, will have access to these recordings and that the recordings will be stored in a secure place.

**Signed on: ______________________**

**Participant**: **_____________________** **Researcher: ______________________**

**Appendix 5: Consent Form for Audio Recording**

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**USE OF AUDIO RECORDING FOR RESEARCH PURPOSES: PERMISSION AND RELEASE FORM**

| Name of participant | |
|---|---|
| Participant's contact details: | Email address: |
| | Phone number: |
| Names of researchers: | Miss Asanda Ranase |
| | |
| Level of research: | Masters |
| Brief title of project: | Exploring lay people's understanding of substance abuse |
| Name of supervisor: | Mr. Elron Fouten |

**DECLARATION** (Please initial/tick blocks next to the relevant statements)

1. The nature of the research and the nature of my participation have been explained to me in writing.
2. I agree to participate in a focus group discussion, and to allow audio recordings to be made of this discussion.
3. The audio recordings may be transcribed:

| Without conditions | |
|---|---|
| Only by the researcher | |
| By one or more nominated third parties | |

4. I give permission for the audio recordings to be retained after the study and for them to be utilised for the purposes of this research under the following condition:

☐ My name does not appear on any reports related to the research.

Signature of participant: ________________________ Date: ________________

Witnessed by researcher: ________________________ Date: ________________
_

**Appendix 6**

**CONFIDENTIALITY AGREEMENT: Transcription Services**

I, ________________________ (name of transcriber), agree to maintain full confidentiality in regards to any and all audio recordings and documentation received from Asanda Ranase related to his/her (circle appropriate) research study on Exploring lay people's understanding of substance of substance abuse.

Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents;

2. To not make copies of any audiotapes or computerized files of the transcribed interview texts, unless specifically requested to do so by Asanda Ranase.

3. To store all study-related audio recordings and materials in a safe, secure location as long as they are in my possession;

4. To return all audio recordings and study-related documents to Asanda Ranase in a complete and timely manner.

5. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audio recordings and/or files to which I will have access.

Transcriber's name
(printed):____________________________________________________________

Transcriber's signature: ________________________________________________

Date: _________________________________________________________________

**Appendix 6:**

**Parker's (1992) Transcription Conventions (Adapted)**

| Symbol | Meaning |
|---|---|
| Round brackets ( ) | Indicates doubts arising about the accuracy of material |
| Ellipses ... | To show when material is omitted from the transcript |
| Square brackets [] | To clarify something to help the reader |
| Forward slashes / / | Indicates noises, words of assents and others |
| Equals sign = | Indicates the absence of a gap between one speaker and another at the end of one utterance and the beginning of the next utterance |
| Round brackets with number inserted, e.g. (2) | Indicates pauses in speech with the number of seconds in round brackets |
| Round brackets with full stop (.) | Indicates pauses in speech that last less than a second |
| Colon :: | Indicates an extended sound in the speech |
| Underlining | Indicates emphasis in speech |