

THE CIRCULARITY OF TRAUMA-ADDICTION-TRAUMA

by

Soraya Smith

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DOCTOR EM CRONJÉ
PROFESSOR JM NIEUWOUDT

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Student number: 3096-642-6

I declare that

THE CIRCULARITY OF TRAUMA-ADDICTION-TRAUMA

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

MRS S SMITH

DATE

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This research is a tribute to my son Sebastian Harold Smith and his Nana, my mother, Thelma Kulsum Miller—out of our vision, forever in our hearts.

KEY TERMS

Trauma; childhood trauma; childhood sexual abuse; physical abuse; neglect; emotional/psychological abuse; environments; development phases; adulthood addiction; types of addiction; mental health issues; relationships; support structures; coping mechanisms

SUMMARY

The rationale for the study was to investigate the symbiotic connection of trauma and addiction. The focus is on childhood trauma and the turn to addictive practices to quell the memories and experiences endured as children. Chapter One discusses the methodology regarding the approach of the study and includes an introductory literature review of the phenomena. Additional literature is included in the ensuing chapters. A personal account of the motivation behind the research is chronicled in Chapter Two. In this chapter, I share with the readers my personal experiences around trauma and addiction in my family of origin. The notion of the blending of trauma and addiction is the focus of Chapter Three. It includes the approach to treatment of trauma and addiction as well as addiction counsellor training in the South African context. The storied lives of the participants and their experiences of trauma and addiction are encapsulated in Chapter Four. Finally, Chapter Five rounds off the study with the analyses of the narratives of the unique individuals who contributed to this research undertaking.

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Chapter 1

DIAMONDS ARE FOREVER

1.1 INTRODUCTION

I took a leap of faith and ventured into the realm of trauma and addiction. My exploration is about the personal experiences tendered from the hearts and souls of unique human beings. They are my inspiration and my *raison d'être* for this expedition. I narrate their stories from their understanding and the meaning of their experiences and worlds. This is done from what I believe to be a holistic sense of understanding and awareness. In doing so, I find myself inextricably connected to the expedition, not only as a co-participant and researcher but also as a fellow human being. Thus I include my own subjective experiences, thoughts and feelings. These I reflect on and blend my persona with the people who are the driving force towards this adventure. In addition, I take the liberty of stacking up my subjectivity against the personal experiences, thoughts and feelings of the inimitable people I have had the privilege of having shared precious moments with.

I am indeed honoured to have been part of their world, albeit only for a short while. The time was short but their memories and stories as well as my own, are etched in my mind. These precious moments, for me at any rate, are epitomised in the song “Diamonds are Forever” written by songwriters Barry and Black (n.d.) and sung by Dame Shirley Bassey.

1.1.1 Digging for diamonds

The diamond metaphor is to express the rareness and strengths of traumatised and addicted people. This dissertation is about their ability

and self-determination to have come, against all odds, from the way beyond and to rise like shining diamonds in the sky. Diamonds in their natural state are found deep in the bowels of volcanic rocks in the form of kimberlite (Klimetz, n.d). Most people appear to be under the impression that this was how the city Kimberly in the Northern Cape of South Africa got its name. Kimberly, as it turns out, was actually named after Lord Kimberly, the British Colonial Secretary in circa 1873. Apparently, this was because he had difficulty pronouncing the Dutch name, "Vooruitzigt". Lord Kimberly also disapproved of the name "New Rush" (referring to the diamond rush at the time) claiming that it was too vulgar. For his convenience, the town was named after him (Lunderstedt, 1998). As deposits of the volcanic rock were first recognised in Kimberly, kimberlite was named after the town—not the other way round as most people tend to assume.

People who are or have been traumatised would like to burrow deep down and hide but do not always succeed. Metaphorically speaking, they retreat to deep volcanic lines to re-unite with their kimberlite beginnings. Unresolved trauma has an uncanny knack of raising its ugly head (Dayton, 2000). Similarly, addicted people are adept at hiding, at least while they are actively using. Eventually they crawl out of the woodwork looking for more drugs and/or alcohol or attempts to get clean. Worse-case scenario, they end up in a body bag or a coffin. However, all is not doomed as at some point they could realise that enough is enough. They have reached their personal crossroads.

What I am particularly interested in, not to mention exceedingly curious, is to talk to traumatised people to find out if they used drugs or alcohol to cope with their experiences. I am also interested in talking to addicted

people to learn if trauma plays any role in their addiction. This dalliance of trauma and addiction seems to be widely acknowledged and researched in the United States of America (Carruth, 2006; Dayton, 2000; Miller & Guidry, 2001; Shapiro, 2001).

Rather disappointingly, it would appear that there is scant research of this nature within the South African context. Notwithstanding there are a number of articles on the Internet that refer to the circularity of trauma and addiction trauma in this country. For instance, in a piece written by Rogerson (2015) trauma, including other psychosocial problems, has contributed to an increase in drug addiction in South Africa. Moreover, he adds that the strong link between trauma and addiction elevates drug addiction. Thus the use of drugs to numb out the ordeal of a traumatic experience is a means of self-medication for temporary relief.

Of the dialogues I had with traumatised and/or addicted people, all were addicted to substances (alcohol and/or drugs); one was addicted and claimed not to be traumatised; another brushed aside his trauma as irrelevant; and the rest were traumatised and addicted. The personal stories of the research participants are in Chapter 4.

1.1.2 Every diamond is unique

When people are considering purchasing a diamond, jewellers and gemmologists talk about the 4Cs of these precious stones. Through the medium of the 4Cs, people in the trade can communicate in the language of precious stones. The 4Cs of a diamond represents its cut, carat, colour and clarity (De Beers, n.d.). The diamond metaphor extends to the unique and idiosyncratic personalities or facets of each and every traumatised

and addicted individual. Each individual is represented by their precious and inimitable characteristics with and without their flaws.

1.1.3 Better a diamond with a flaw than no diamond at all

Human beings are not perfect but we often berate ourselves for not being better or ideal people. We chastise ourselves for not being superefficient at work, for not being a model spouse or parent or for not being able to deliver a well-structured dissertation. Perhaps the only way to believe in ourselves is to realise that we do make mistakes.

From time to time traumatised individuals blame themselves for what has happened. It is imperative for them to be reassured that what has happened is not usually due to their own doing. What is even more important is for them to know that there is something they can learn from their experiences. Sometimes we regret what we have done and try to repent in some way. This realisation is characterised in an alcoholic I worked with who tried his level best to resist drinking. His relationship with his partner was compromised due to his drinking and he is desperate to prove to her that he can stay sober. He knows he has erred and is now trying not to repeat his mistakes. He has learnt a hard lesson and he does not want to travel that road again (Vajda, 2009).

1.1.4 A diamond in the rough

At times we find ourselves jumping to conclusions that some people just do not fit in with the norms and rules of society. By virtue of serendipity and also by digging deep enough, we may get the opportunity to meet a person who is indeed a diamond in the rough. This is perhaps when we realise that some people are capable of unbelievable potential despite their less salubrious circumstances. More importantly, not only do they

have this potential, they have the innate ability to act on it. I have been fortunate enough to have met some people who live and breathe this potential. Sometime ago I met a recovering addict who was a chronic substance abuse user for many years. After several attempts to get clean, he eventually recovered and became and continues to be a beacon of light for addicts on their arduous road to recovery.

1.2 WHOLENESS AND UNITY

It would appear that traumatised people tend to be treated with less disdain or contempt than addicts. Drugs may well be “a universal scourge” (Ramphela, 2012, preface) and lest we forget, users are human beings and, in some measure, are entitled to be treated as such. Although I fully expect many people to differ with my view, I believe that addicts have their rights despite their somewhat dubious antics to support their drinking and/or drugging. I accept that there are extenuating circumstances particularly when violent behaviour and/or murder are involved.

We may not be always aware of the prevailing circumstances leading up to the use of and becoming addicted to drugs and/or alcohol (for example, childhood sexual abuse, Dayton, 2000). Similarly, we may not know what forces are behind or leading up to someone ending up as a victim of trauma or as an addicted individual or a combination of the two. These illusive “forces” are what drives my curiosity and interest in and about trauma and addiction. I intend to satisfy my spirit of inquiry in the following manner.

1.2.1 Methodology

The phenomena of trauma and addiction are extensively covered in umpteen books, journal articles, the media and the like. What I am truly

looking for is an inside perspective of what truly goes on in the lives of people who have been affected by trauma, by addiction and particularly a combination of the phenomena.

Human beings are more than just a collection of our parts and we function as a whole, with every part of our being. I believe that it is one-sided and naive to assume that our behaviour can be reduced to particular actions or circumstances. In pursuit of doing justice to the individuals who are the backbone of this study, I decided that it would be prudent to incorporate more than one qualitative design.

Quoting Aristotle (n.d.): “The whole is greater than the sum of its parts” echoes my belief that a single mode of enquiry is inadequate to capture the multi-faceted nuances of our human existence. I have thus engaged in ethnography, auto-ethnography, narratives and reflexivity. I believe that these complementary qualitative research inroads come close to a respectful, humane and holistic approach to the experiences of the individuals in this study.

1.2.1.1 Ethnography

Ethnography is one of the central features of the soon-to-be portrait. The beginnings of the portrait on the easel are lacklustre and devoid of the gentle and defining strokes of auto-ethnography and reflexivity. This seemingly modest attention to detail with its complementary affiliation with ethnography, in my view, brings the portrait to life through depth, contour and shape. The final touches of the painting are accentuated by the discerning features of shades of narratives, bringing voice and personal meaning to the portrait. As one stands back to appreciate the finer details of the portrait, one comes to appreciate the nuances of a gentle

blend of qualitative exploration emulating and bringing the realities of people to pulsating life.

Ethnography is well known as a way of studying the cultures of the many people in the world. Genzuk (1999, p. 2) cites Marvin Harris and Orna Johnson in that the customs, beliefs and behaviour of particular cultures are captured in ethnography. As such, they can be conceptually depicted on the canvass of life that beckons to portray “a portrait of a people.” The objective of my inspiration is to metaphorically “paint” a portrait of traumatised and addicted individuals.

Fetterman (in Genzuk, 1999) alludes to more or less the same view as Harris and Johnson who posit that ethnography describes the culture of groups. Ethnography, a branch of anthropology and used in a number of disciplines including psychology, analyses the similarities and differences as well the norms and rituals of cultures.

1.2.1.2 *Written informed consent*

As individuals and researchers, we do not have carte blanche to enter uninvited into the lives of individuals. We do not have the right to just barge in and bombard them with questions and queries about their personal lives. We need to be polite, respectful and tread tentatively when entering the private enclaves of their lives. We need to have their consent or invitation to enter their personal space.

As ethics would have it and for the individuals I interviewed, written informed consent, in keeping with the requirements of the Health Professions Act (1974) was obtained from the Ethics Committee of the Unisa Department of Psychology to conduct and record the interviews.

From the outset, I briefly outlined my research, my role as well as the roles and contribution of the research participants. I also informed the participants of a number of important things such as firstly, the confidential nature of the interview; secondly, their privacy and confidentiality in the writing-up of my research and; finally the role of Unisa as the supervising university. Every effort was made to ensure that no personal identifiers of the participants were used in the write-up.

In addition, I offered each participant a copy of the transcripts of their interviews. All interviewees who participated were given two written informed consent forms to read and sign. I signed and dated both copies and returned a duly completed copy to each participant. The second copy I filed in my research records.

The interviews were conducted in various places such as at the home of one of the participants; four at the Centre where they were rehabilitated; and two at my practice. I generally asked the participants to let me know what time would be most suitable for them. The most important criterion was to ensure that at all times we had privacy and a safe space to ensure confidentiality. They were at liberty to respond freely to open-ended questions.

1.2.1.3 *Semi-structured interview schedule*

In ethnography, participant observation and interviews are typically used to collect the data. This is in anticipation of capturing a holistic and deeper understanding of particular cultures. The cultures I am referring to here are those of traumatised people on the one hand and addicted individuals on the other. For the most part, the research participants

spoke freely and there was little need for probing or to refer to the interview schedule.

1.2.1.4 *Auto-ethnography*

As mentioned previously, ethnography is an approach that looks at the many facets of the norms and rituals of cultures. Ellis, Adams and Bochner (2011, no page number) add that “the researcher uses tenets of autobiography and ethnography to do and write auto-ethnography.”

In merging ethnography and autobiography to result in an auto-ethnographic account means that one engages in self-reflection to think about personal experiences. An autobiographical story is followed by linking cultural meanings and understandings of the traumatised individuals and addicted individuals in this study. The intention is to deliver a more meaningful and evocative research experience (Ellis et al., 2011). In my research I attempt to do this through the narratives and dialogues between the participants and myself. Moreover, I emphasise that the most important facet of these narratives is about the individuals who inspired this research. I openly admit that I have a vested interest (personal or otherwise) in how the interviewees came to be where they are or have been. In Chapter 2, some of my personal experiences are shared. In addition, this chapter attempts to explain how I became involved in trauma and addiction as domains of psychological interest.

1.2.1.5 *Narratives*

The dialogic (Moen, 2006) between the participants and myself were either recorded or written and I narrate their understanding and meaning of their worlds. According to Gudmundsdottir (in Moen, 2006, p. 2) “narrative research is the study of how human beings experience the

world, and narrative researchers collect these stories and write narratives of experience.”

In keeping with the academic nature of research, the personal narratives as well as my own observations are peppered with supportive or challenging citations to give them a sense of credibility. I add my own personal views in my own self-conversations as I am part and parcel of the reflexivity process. A window into part of my *raison d'être* for my exploration is the subject of Chapter 2 “Me and My Shadow” (as mentioned above). Initially I was reluctant to include my personal story as part of the research. Having capitulated I believe that this is what Smith (2006) means by the “personal touch” to qualitative research. I was also inspired by Dr Marc Lewis’ (2012) book “Memoirs of an addicted brain” in which he writes quite candidly and openly about his personal experiences surrounding his addiction and the traumas he experienced. The manner in which he shares his experiences is a shining example of reflexivity in the flesh symbolised in print.

1.2.1.6 Reflexivity: Up front and personal

Whereas ethnography is a researcher’s perspective of a people, reflexivity takes into consideration the personal thoughts and reflections of the researcher—an inside description so to speak. Smith (2006) puts forward that my insider view contributes to the writing-up of the research through my self-analysis and subjectivity. Reflexivity is thus the extent to which my personal views and involvement contributes to this exploration. It provides a forum for a subjective awareness of my effect on the process and outcomes of my research and how I translate this. It is about what I feel and think about what I want to research and my involvement in what transpired. More than that, it also says something about the essence

of who I am and my point of reference or departure that orientates my behaviour and life.

Hughes (n.d.) from Warwick University in the United Kingdom emphasises two sides of the self that influence choice and reasons for doing certain research. The one she calls the “biographical” side of life (i.e., the facts). These so-called “facts” includes values, motives, politics, employment and personal status. Age, gender, sexuality, ethnicity and ability refers to “social divisions”.

In the chapters that follow and where the opportunity arises, plus the all-important narratives, I intersperse my biographical facts and social divisions. I also recorded and now share some of my inside views of the field notes and reflexivity logs I kept (Smith, 2006).

1.2.1.7 *Field notes and reflexivity logs*

One of my reasons for making field notes was to observe the non-verbal communication of the participants (NVC—grimaces, gestures, eye contact, body language, nuances in speech and use of particular words, intonation etc.). I recorded these as field notes and from time to time in my reflexivity log together with any other interesting observations (such as crying or on the verge of crying). This exercise provided an opportunity to make observations such as anxiety, withdrawal, reservations, hesitation and the like.

I maintained field notes and reflexivity logs for two reasons: one, as a memory jogger to help with the writing-up of my research and; secondly, to add my personal anecdotes and analyses. Chapter 5 rounds off the study with an interpretation and analysis of the data collected from the participants and the themes that emerged. In the reflexivity log I recorded

and analysed my personal feelings and involvement in the interview process (Smith, 2006). The usefulness of these features comes up in the dialogue between myself and the participants.

1.2.1.8 *Rich data, credibility and trustworthiness*

A man is only as good as his word. For this journey, I opted for interviews using semi-structured enquiries to qualitatively collect the data. The medium of collecting the data was through semi-structured interviews. At some point during the planning stages, the thought of using unstructured interviews come to mind. Denzin and Lincoln (2000, p. 652) observed that unstructured interviews “provide a greater depth of data than the other types”. I settled for a semi-structured approach to interview the participants. As you will read in the next paragraph, the choice of unstructured interviews could have worked equally quite well.

The semi-structured interview included a number of open-ended questions. This was the intended plan but did not play out as planned. When there was the need or opportunity to pose a question, I did so when there was the opportunity. For the most part, I left the participants to speak freely particularly when they were in the midst of recalling their experiences. They appeared to be content doing this and I did not interrupt. I acquiesce that this turn of events is more indicative of unstructured interviews. I say this as the interviewees had a free rein to say what they wanted to say and when they wanted to. In summation, I can say that the interviews basically oscillated between semi- and unstructured interviews (Denzin & Lincoln, 2000).

According to Denzin and Lincoln (2000, p. 10), a person’s point of view is appealing to both quantitative and qualitative research. On the other

hand, they are quite clear that from a qualitative perspective, one can get closer to the individual's viewpoint through "detailed interviewing and observation." These authors also believe that in order for researchers to get closer to our respondents' meanings, we need to go beyond superficial meanings or pre-ordained assumptions (Denzin & Lincoln, 2000). I wholeheartedly subscribe to their viewpoint particularly when one is working with both traumatised and addicted individuals. Furthermore, I believe that an approach such as this dovetails quite nicely with the rich data collected in qualitative research which most qualitative researchers believe offers credibility and trustworthiness. Interviewees are given the floor to speak from their hearts and experiences. They do not simply respond to questions that are geared more towards answering the researchers' curiosity rather than tapping into the research participants' experiences.

Here I subscribe to Carl Rogers' (Rogers, 1969; Grobler, Schenck & Mbedzi, 2013) emphasis on the all-important facilitator skill of listening to and understanding people from their personal frames of reference. It is vital to listen carefully to and understand traumatised as well as addicted people without being judgemental. The contextually and culturally rich data participants produce is the contribution made by qualitative research (Mack et al., 2005). Naturally, revelations such as these are highly personal and confidential. I was, and still am, fully aware and cognisant of ethical considerations such as written informed consent and confidentiality. I tried my level best to honour and maintain an honest and genuine respect for individuality and cultural differences sans judgement.

Moreover, I treated all participants and other people I met during and after my research with dignity and appreciation of their self-worth (Constitution of the Republic of South Africa, 1996). I also adhered to

the ethical considerations of the Health Professional Act (1974). When I was given permission to enter their lives and experiences, I stepped tentatively into their worlds and into their cultures. Our journey started on Route Canvass, where most roads at this juncture, yields to the highways and byways of Cultures.

1.3 A CANVASS FOR CULTURES

1.3.1 Introduction

It is no secret that people hail from a multitude of diverse cultures. We all have a pretty good idea of what culture we belong to and what behaviour is expected of us in any given situation. The culture of traumatised people, like any other culture, is typically infused by characteristic behaviours, thoughts and feelings. Likewise the behaviour, thoughts and feelings of addicted individuals is inclined towards a distinctive profile.

The difference between these two cultures and the more commonly accepted cultures is that the former are not your usual, common garden kind of culture. Often times there are assumptions made about some populations, particularly addicts. On average, addicts are labelled as deviated individuals who are not in line with socially acceptable norms and rules. Similarly, a traumatised person turned addict could also be deemed to be out-of-line with the rules and regulations of society. But what we tend to see is the active addict and largely ignore the individual's personal or underlying circumstances which could be his or her traumatic experience.

On another level though, we are more inclined to treat non-addicted, traumatised people with kindness and empathy. After all, the majority of

traumatic experiences are out of their control (for instance, an earthquake or the tragic loss of a loved one) and they cannot be held responsible for what happened. The trauma could depend on the nature and context of the trauma. For instance, what happens to a sex worker who is raped by a client? Is this a traumatic incident or is it part of the job description? According to SWEAT (The Sex Worker Education and Advocacy Taskforce), Sisonke Sex Worker Movement and the Women's Legal Centre, violence against sex workers is rampant in South Africa (Sonker Gender Justice, 2014).

In some instances, like the one cited above, the boundary between addiction and trauma is somewhat blurry. I find myself having to take a step back and look at the whole picture of trauma and addiction and not just their elementary parts. To do this, I have selected the perception of holism to achieve the bigger picture.

1.3.2 Holism

Gestalt therapy politely borrows from Aristotle's concept of holism in that the whole is more than a sum of its parts (Corey, 2009). Holism also reminds me of Carl Rogers' wholeness and unity not only of individuals but also of communities, families and groups (Grobler, Schenck & Mbedzi, 2013). In my view these human categories gives rise to cultures since cultures constitute or are made up of communities, families, groups and individuals. I quote from Corey's interpretation of Gestalt therapy (2009, p. 201): "All of nature is seen as a unified and coherent whole and the whole is different from the sum of its parts". I am aware that the Gestalt school of thought is based on the individual. Together, individuals have the tenacity to grow, develop and cultivate their cultures.

1.3.3 Cultivating cultures

Naturally, different cultures will define culture by virtue of their own practices and beliefs. After all and over time, their culture and its behaviours have been nurtured and cultivated over many, if not hundreds of years. Not only do cultures perceive themselves in characteristic ways, conscientious or rather, “unconscientious” observers tend to label or see other cultures as behaving in particular or sometimes peculiar ways. Ever heard someone say? “Oh, they behave like that because it’s in their culture” or “women are bad drivers.” Dictionary.com (2005) offers numerous definitions of the concept of culture and three rather disparate descriptions of culture are discussed below.

- The Roshan Cultural Heritage Institute (n.d.), a Persian non-profit organisation based in Hawaii USA, describes culture as a cohesive blend of language, arts and sciences, thought, spirituality, social activities and interaction.
- Dictionary.com (n.d.) volunteers quite a comprehensive definition of culture that includes a nation (for instance, South Africa); a person or society who has done extremely well in some manner (for instance, Nelson Mandela); merit in the arts (Leonardo da Vinci comes to mind); manners and the like (respect your elders); a development of the mind and education (epitomised by Albert Einstein); and the behaviours and beliefs of particular social, ethnic or age group, the youth culture and the drug culture (e.g., traumatised and/or addicted individuals).
- Culture has also been used in somewhat different contexts. For instance, in a casual sense such as “a culture of coffee” (Coffee Culture Café and Eatery, n.d.).

- Another example of its use is as “a culture of violence” affectionately used to describe South Africa’s high levels of crime (Hamber, 1999; Stewart, 1997-2009).

1.3.4 Cultures agree to disagree

Granted traumatised people and addicts alike are somewhat atypical customs. But then so were the opposing cultures of the Tutsis and Hutus of the genocide in Rwanda in 1994. Another frightening genocide, the Holocaust of World War II depicts a case in point. What is it that drove the different cultures in Rwanda and the Nazi troops to commit such atrocities? It is well documented that the Jewish communities/culture living in most of the European countries were the object of Hitler’s Third Reich. In South Africa, the Hendrik Verwoerd regime and the apartheid era epitomises the stark differences between the then-nation’s cultures. The current debacle between Russia and the Ukraine brings home to roost that cultures will be cultures, even in the 21st century. Cultural differences may emerge whether they are over politics, religious practices, what currency to use or simply what bread to buy. Let’s just say that cultures agree to disagree. And then they try to live in peace and harmony.

Returning to the story and coming off the soap box, my exploration is about two cultures. On the one hand and as the reader is aware, it is about traumatised people. On the other hand, it is about addicted individuals and whatever comes in between. It is this symbiotic interface that inspired me to attempt to describe their customs and habits. They are the engineers, the designers and implementers of ultimately their own destinies, notwithstanding their personal circumstances.

The canvass is presently bare and my inspiration to fill it is imbued by the cultures of traumatised and addicted individuals. How does a “painter” depict a delicate concept such as culture? The answer for me is simple: from his or her own personal perspective with a generous measure of help from others. I am not an outsider observer looking at the portrait. Rather, I am featured in the portrait as part of its whole. Together we are a portrait of a people.

1.4 A PORTRAIT OF A PEOPLE

I have walked that long road to freedom

I have tried not to falter

I have made missteps along the way

But I have discovered the secret that after climbing a great hill, one only finds that there are many more hills to climb

I have taken a moment here to rest, to steal a view of the glorious vista that surrounds me, to look back on the distance I have come

But I can only rest for a moment for with freedom comes responsibilities and I dare not linger for my long walk is not ended

Nelson Rolihlahla Mandela

1.4.1 Introduction

For me, the saying by Mandela captures how people manage to weather the storm of trauma albeit in the face of adversity. It also succinctly represents the arduous and bumpy road to recovery from addiction despite the fallen bridges. What I really like about this saying is the reality check. The storm may have been weathered but another one is looming in the next cloud. The bumpy road may have been fixed and travelled but another one may be lurking around the corner. If you stumble, you pick yourself up and do your best to surge forward towards the horizon. My interpretation of the saying is not intended to sound pessimistic. I feel that the message Mandela is trying to get across is that once the job is done, we must not be tempted to sit back on our laurels. We

have to constantly strive to not only maintain what we have achieved but to also better and maintain it.

To reiterate, the omnipotent spirit of my exploration is symbolised by the multi-dimensionality of people. Presently, the canvass is painstakingly going through some kind of metamorphosis towards “A Portrait of a People”. I prefer to think of the portrait as a “work of art” not because I see myself as an “artiste extraordinaire”. People are indisputably works of art, individually sculptured and portrayed in the living and loving of their unique lives. This portrait is a merely an attempt to capture the very essence of some traumatised and addicted people. It is also about bringing to the fore the indispensable roles of the support systems of their loved ones, their personal sense of spirituality and the helping fraternity.

The idea of the portrait at this stage is but a sketch—blandly incomplete and devoid of significant and striking detail. Once the diamonds have been found and the canvass has been methodically and culturally prepared, the intricate, finer details of the portrait are ready to take form and shape and to earn its 4Cs diamond stripes.

The road to recovery for both traumatised and addicted people is no walk in the park. Their journey is unquestionably threatened not to mention compromised in the absence of genuine support and care. Without a shadow of doubt, the pivotal and most significant support system stems from family and close friends. Equally important support systems are the helping professions (doctors/psychiatrists, nurses, psychologists, counsellors, lay counsellors, pastoral counsellors and the like). In times of need and abject desperation, a stalwart support system

that many people turn to is spirituality. Sometime ago and in passing, I met a recovering cocaine addict who strongly believed that spirituality was the salvation from his addiction. He shared that his piety was not purely of the religious kind. Rather, he shared, it was from within his own, deep sense of himself that served as his guiding light.

Most people are keenly aware that people in physical or psychological trouble need some form of help. If a leg is broken we go to the doctor who will fix the body. If the damage is “in the head” another doctor will fix the psyche. I acquiesce that not all people will seek or want help or treatment. As I alluded to earlier on, there are many times when there will be a good dose of reluctance and resistance. Sometimes spouses will even threaten divorce and separation from their children to convince their partners to go to rehab for instance—to get help, to get clean. This is what nearly happened to a young couple who were on the verge of immigrating to Australia. One of them was stubborn and in denial. Eventually she realised that she had to get treatment if she wanted to keep her family together. In the long run, her recovery was good enough to begin a new life with her young family “down under”.

Now that I have introduced the key stakeholders in my expedition, let’s move on to the omnipotent, individual cultures of trauma and addiction. The psychological meaning of these two cultures is followed by the support systems of family, close friends and spirituality. I round this off with the support provided by the helping fraternity, both lay and professional.

1.4.2 The culture of trauma

Have you heard someone saying that he or she is traumatised? Sometimes it is said in an almost humorous way, such as: “I didn’t have my coffee this morning. I am traumatised”. An entirely different take emerges when the situation is more serious: “I was raped by a gang of men. I am traumatised”.

During the early days of my internship, I counselled a woman who described her ordeal of how she was brutally raped by a gang of men. She was only able to remember bits and pieces which is a memory problem typical of a traumatic experience. To complicate matters further, her drink was also laced with an unknown and undisclosed substance. She was left at the scene of the crime where she was eventually, and thankfully, rescued and taken to hospital for treatment. The woman in question survived the ordeal to tell her story in public and behind closed doors.

Horrific as it is for those who are directly affected, the psychological anguish after a trauma can similarly affect witnesses or innocent bystanders. In the rape case above, the bystanders were far from innocent. Quite the opposite as they were her attackers. In stark contrast, the people who witnessed the bombing of the Twin Towers building (now known as “Ground Zero”) in New York City were witnesses of a completely different calibre. They watched in horror as people jumped from incredibly sky-scraping heights in an attempt to escape the towering inferno. Few survived but many perished. One can only imagine the overwhelming trauma the onlookers experienced.

1.4.2.1 What does it mean to be traumatised?

I would now like to revisit the two trauma scenarios I mentioned earlier. My response to the first one, the coffee scenario, is straightforward and in my view, really needs no explanation. The second scenario is a different kettle of fish altogether. The fundamental nature of a traumatic experience (witnessed or experienced) is that something catastrophic and awful has happened to the person. The upshot is that the person is invariably in a state of shock and disarray and in all likelihood, extremely frightened, fragile and disoriented.

Although exceedingly paramount, it is not only the fear and anxiety of traumatic exposure that can lead to psychological distress. There are a host of other symptoms that can lead to significant discomfort and disorientation for victims/survivors of trauma. Like most of the examples I have seen, I too have chosen the well-known PTSD (posttraumatic stress disorder) to illustrate traumatic reactions, as described in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013).

These symptoms could be intrusion (distressing memories and dreams, flashbacks or “daymares”, nightmares, reminders of the trauma); avoidance (pushing out and refusal to think about or have anything to do with the trauma itself); changes in cognitions or thoughts and mood [e.g., difficulty remembering important parts of the incident, self-blame, talks about the world as an evil place, is fearful, angry, harbours feelings of guilt and/or shame, etc.]; and experiences of increased arousal and reaction to external stimuli (i.e., shocks easily, “jump-out-of-my-skin” reaction when a sudden noise is heard, on constant super alert, etc.) (APA, 2013).

In the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (APA, 2013), the people involved in and the prevailing situation of a traumatic event or episode are couched in a more psychiatric and formal way. This American manual is used by psychiatrists and psychologists the world over including South Africa. It is mainly used for diagnostic purposes (for example, by psychiatrists and clinical psychologists) or sometimes for the identification of symptoms (for instance by registered trauma counsellors). The latter being the case, trauma survivors can be referred to more qualified practitioners for specialised treatment. The regulations defining the scope of the profession of psychology is legislated in the Health Professions Act (1974).

1.4.2.2 Resistance, reluctance and acceptance

In my experience with survivors of trauma (and no doubt the experiences of many other helpers), from time to time I often hear how incidents are minimised. Survivors seem to use excuses such as being in the wrong place at the wrong time; that it was their own fault; and/or that they should have been more careful. Their thoughts or cognitions sometimes become irrational or distorted. Some try and put on a brave face claiming they can handle the situation. Gradually and as time goes by, the tell-tale signs begin to surface.

Fortunately, most people come to realise that they "are not quite themselves". At this time, they may begin to entertain the thought that they need help. Another significant realisation is that they come to concede that they are upsetting and hurting the very people who care for them most—their families and close friends. Often they (family and

close friends) try to convince him or her, to get help or to at least think about getting help.

At this time, traumatised people may decide to take control of their lives with a little help from family and friends. Initially, they may have been stubbornly reluctant to get any assistance; they may also have been vehemently resistant; and eventually they may give in. This is their personal turning point and ultimately their own decision. This characteristic reluctance and resistance towards change may, in the long run, translate into acceptance towards healing. If there are support systems in place, most will turn in this direction to carry them forward and beyond.

1.4.3 The culture of addiction

Addiction and its cultural origins are well documented not to mention entrenched. My interest lies specifically in the cultural behaviours of addiction to alcohol and psychoactive drugs. The historical background of these mind-altering substances appears to coincide with cultural practices that date back thousands of years. I have selected particular substances (i.e., alcohol, cannabis, cocaine, heroin and prescription/over-the-counter [OTC] drugs) and have done this simply on the basis of their supposed notoriety.

- **Alcohol**

Alcohol consumption and its intoxicating properties have a long history and according to Keller (1979) dates back some 50 000 years ago. In South Africa, the “dop” system was introduced during the colonial settlement era in the Cape Colony and continued for the next 300 years and into the now defunct apartheid years. In Afrikaans (one of the 11 official languages of the country), the word “dop” is the “South African

informal meaning of a tot or a small drink, usually alcoholic” (The Free Dictionary, n.d.). The “dop” system operates on the premise of payment for work with alcohol in lieu of wages. Despite the prohibition of the system shortly after democracy in 1994, the arrangement continues to persist (albeit only on a few farms). Nonetheless and according to London (1999), the “dop” system can be seen as a contributory social problem that potentially fuels alcohol use and abuse. However, alcohol alone is not to blame for social problems in this country or any other country. Major problems that South Africans face on a daily basis are poverty, unemployment, lack of adequate education, inadequate access to available resources like medical care, public transport and the like. Case in point are the street children in South Africa and their economic and family situations. They may leave their parents’ home for serious reasons such as poverty and parental alcoholism in search of a better life for themselves (Idemudia, Kgekong, & Kolobe, 2013).

- **Psychoactive drugs**

From a cultural perspective, “psychotropic substances have been used by humans for thousands of years” for spiritual rituals as well as therapeutic purposes (see Hamarneh, 1972; Stein, Ellis, Meintjes & Thomas, 2012, p. 1). Psychotropic drugs are sometimes called psychoactive drugs and are known to affect behaviour and perception. Most people tend to think that these drugs refer only to illegal drugs but caffeine and nicotine also fall into this category (APA, 2013). The five main classes are opiates and opioids (e.g., heroin and methadone); stimulants (e.g., cocaine, nicotine); depressants (e.g., tranquilisers, antipsychotics, alcohol); hallucinogens (e.g., lysergic acid diethylamide [LSD]); and marijuana and hashish (dagga) (The Free Dictionary, n.d.). Below is a brief historical

account and description of cannabis, cocaine, heroin, and prescription/over-the-counter (OTC) drugs.

- **Cannabis**

The difference between cannabis marijuana/marihuana, hashish and dagga has always been a mystery to me. The nomenclature includes cannabinoids (found in the cannabis sativa plant) under the umbrella term of cannabis (Jiang et al., 2005). The word cannabis apparently comes from the Greek word kannabis, the Arabic word, kannabi or the Persian word kannab (Makgakga, 2004). The difference in the use of the word appears to depend on in which country the plant grows. For instance, in South Africa cannabis is known as dagga, zol, grass and a number of other names (Makgakga, 2004). Furthermore it would appear that cannabis and marijuana are one and the same and that both are derived from the annual herb cannabis sativa. Hemp (a very strong fibre used to make ropes) also comes from the same plant. The derivatives of the cannabis plant (for instance, marijuana, [Mexican Spanish word for cannabis], dagga, hashish) can be smoked or ingested (Makgakga, 2004).

The cannabis plant comes in three varieties. Sativa or hemp and is grown for fibre and seed oil and is low in stimulating cannabinoids. Another strain is indica which is used as a medicine and is a moodaltering drug and high in cannabinoids; The third kind, spontanea, has very little of the tetrahydrocannabinol (THC) found mostly in the cannabis indica strain (Makgakga, 2004). THC is the ingredient responsible for the psychological effects (e.g., thinking, memory, pleasure, etc.) of cannabis. This chemical releases dopamine in the brain that results in feelings of euphoria (Boles Ponto, 2006).

It is common knowledge and believed that currently cannabis is an illicit drug. Nevertheless, thousands of years ago it was used for medical and industrial reasons. Today, the substance is legal for medical reasons in countries like America. In South Africa, the possibility of medical marijuana/cannabis becoming legal is looming for the possible treatment of chronic illnesses such as cancer. According to the Inkatha Freedom Party (IFP) MP Mario Oriani-Ambrosini, who was diagnosed with stage four cancer, if marijuana is not legalised for medical reasons, it would be a “crime against humanity” (SAnews.gov.za. 2014). Sadly, the MP passed away some time after making this statement (Coetzee, 2014).

- **Cocaine**

According to Narconon (2014), the basic ingredient in this powerful psychoactive drug is the South American grown coca plant. Sometime between the 1500 and 1800s, the leaves of the plant were innocently used by the native labourers working on the plantations. Its use during this time was harmless as the euphoric quantities were so low that the risk of addiction was minimal. It also helped the workers to curb their appetites and to work longer in the high altitudes where the plants grew. It was the Spanish who first came to South America in the 1500s and exploited and monopolised this situation. They were not after the coca plant itself but rather the gold and silver deposits in places like Bolivia, Peru and Colombia. The labourers, who have been chewing the coca leaves for thousands of years, were used to extract these minerals to line the pockets of the Spanish economy.

In 1860, a German scientist by the name of Albert Niemann identified the stimulating ingredient in the coca plant. He named the white, crystal

powder which he extracted from the coca leaves “cocaine”. This stimulant, psychoactive drug, which can be snorted or injected, is one of the most highly addictive drugs (Hendricks & Wilson, 2013). Famous people who have used Niemann’s cocaine include the world famous psychologist Sigmund Freud; John Pemberton who in 1886 included cocaine as the main ingredient in the soft drink Coca Cola (he was forced to remove cocaine from Coca Cola in 1903); and Thomas Edison, the inventor of the light bulb. According to Curtis (in Hendricks & Wilson, 2013) crack became popular in the 1970s and is “the most addictive drug on earth”. Crack cocaine is currently more popular than powder cocaine (Narconon, n.d.).

- **Heroin**

Heroin falls under the opioid group of drugs (APA, 2013) and is classified as a depressant. Furthermore, it a psychoactive drug that is synthesized from morphine. It usually comes in a white or brown powder or black tar form. Morphine is a natural substance that comes from the seed pod of the Asian opium poppy plant. This highly addictive, dangerous and versatile drug can be injected, inhaled, sniffed or smoked (Narconon, 2014). According to Scott (1998), “heroin took its name from the adjective heroisch (heroic) sometimes used by nineteenth-century German doctors for a powerful medicine”. According to Lewis (2011), heroin is the most powerful drug.

The pain-killer morphine, developed from opium, was developed circa 1810 by a German pharmacist (Narconon, 2014). The advent of this drug was seen as a significant break-through given its physical, pain-relieving properties. The wonder-drug morphine was named after the Greek god

of dreams, Morpheus. It was given this name due to the induced euphoric dream-state of the user. Morphine, like its offspring heroin, is highly addictive. Coincidentally, some 60 years later, heroin was also invented in Germany and was marketed as being safer than morphine.

Dating back to the 19th century, the sale and use of opium presented a social problem for a number of countries. In Aracan, an old 18th century state in southwest Burma, the use of opium was punishable by death (Moule, 1877). According to Strang, Griffiths and Gossop (1997), heroin smoking started in Shanghai in the 1920s and made its way across to the United States approximately a decade later.

- **Prescription/over-the-counter (OTC) drugs**

As far as prescription medication is concerned, a South African study undertaken by Myers, Siegfried and Parry (2003) focused on benzodiazepines and over-the-counter (OTC)/prescription analgesics (painkillers). These two are touted as the most misused medications with the former being the most widespread globally. Valium, a well-known central nervous system depressant, is one of the most abused prescribed medications (Sue, Sue & Sue, 2006). According to Narconon (n.d. no page number), prescription drugs are as much to blame for addiction as any other street drug.

1.4.3.1 What does it mean to be addicted?

The word or the act of addiction is invariably associated with alcohol and/or drugs. Labels or categories such as “alcoholic” and “drug addict” are all too familiar to most people. But do we really know what they mean? Like trauma, addiction is also used in contexts such as “I am addicted to TV” or “I am addicted to shopping”. Drugs and alcohol in

most countries seem to have a negative reputation particularly when consumed in excessively large, almost pathological quantities.

Alexander and Schweighofer (1988) explain that the word “addiction” was originally used to refer to “given over” or to be devoted to something like religion, for instance. During the 19th century temperance and anti-opium movements, the word was adopted to describe the compulsion to drugs and other vices. The word, as formulated then, seems to have stood the test of time as today, the definition remains largely intact and seemingly appropriate (albeit contested from time to time).

West (2006, p. 10) defines addiction as a “syndrome in which a reward seeking behaviour has become out of control” and it is “this loss of control [that] can lead to considerable harm”. Similarly, Thesaurus.com (n.d.) defines addiction as an activity that is habit-forming and harmful. This definition includes the two familiar synonyms of addiction—craving or dependence.

In my interviews with addicts, I enquired if they considered addiction as a disease. The American Society of Addiction Medicine (ASAM) (2011) defines addiction as follows: (Note: The original United States English spelling and the punctuation is retained in the definition below.)

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviours. Addiction is characterised by an inability to consistently abstain, impairment in behavioural control, craving, diminished recognition of

significant problems with one's behaviours and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

The DSM-5 (APA, 2013, p. 485) opted not to use the word "addiction" when referring to the abuse of alcohol and psychoactive substances. They have deviated (e.g., APA, 2008, 4th edition) from its use based on two accounts. Firstly, they say that the current definition of addiction is vague and secondly, that it has negative connotations. The term they now prefer to use is "substance use disorder" as they feel it is a more "neutral term". As most practitioners tend to use the DSM for diagnostic or identification purposes, I will use their definition from here on.

Finally, I leave you with Dayton's (2000, p. xv) take on what it means to be addicted. She believes that addiction is about self-medicating through the use of drugs, alcohol, food, sex, gambling or any other extreme behaviour to quell the emotional pain evoked by traumatic experiences. It seems quite transparent from the explanations above that addiction boils down to particular behaviour. I have to exonerate myself here as my exploration does not include process or behaviour addiction such as gambling or eating disorders. For my study, I have chosen to focus only on addiction to alcohol and/or psychoactive drugs (i.e., substance use).

1.4.3.2 Resistance, reluctance and acceptance

It is fairly common for many people to deny or ignore that they have a problem with alcohol and/or drugs. Sometimes they will use any excuse

to validate drinking and drugging. Surviving a traumatic experience is one reason that may sometimes be used to drink or take drugs. Hanging out with friends and having fun is another. Some may say that they can handle their drugging and/or drinking believing that it is under control. Two of the most common and popular substances are marijuana and alcohol especially for youngsters. One of my reasons for homing on these two substances is the relative ease with which they can be obtained. Another reason is that alcohol is legal (age-dependent) and that cannabis could very well become legal in South Africa.

- **Alcohol**

Take a stroll down any street in built-up, residential or industrial areas of South Africa and see how many bottle stores you can find. Never mind the bottle stores, what about supermarkets that have alcohol on their shelves? What about tucked away shebeens and pubs or bars in hotels? If you have no interest in alcohol then it is relatively easy to overlook or hardly notice these places. If you do imbibe, you will probably know exactly where to find a bar or bottle store. If you go to another city or country, chances are you will try and find out where you can buy some alcohol. It's relatively easy to find alcohol stockists in South Africa and many other countries. It is small wonder that the lure of alcohol can become difficult to resist.

In spite of the convenient accessibility to alcoholic beverages in this country, purveyors of establishments are legally bound to comply with the regulations of the Liquor Act 59 (2003). Despite rules and regulations that have been promulgated to control alcohol consumption, abuse of the substance has continued to be a nagging problem for South Africa. A

30-phase quantitative study carried out between July 1996 and June 2011 (Dada et al., 2011, p. 3) in which, amongst other substances, the levels of alcohol consumption across the nine provinces were documented. Their findings revealed that “alcohol is still the most common primary substance of abuse among patients seen at specialist treatment centres across all sites (with the exception of the WC and NR)”. WC represents the Western Cape and NR the Northern Region.

According to the Mayo Clinic (n.d.), if you drink, do it in moderation or be frugal in your alcohol consumption. SAB Miller (formerly South African Breweries (n.d.) believes that there is no single definition of “moderate drinking” as different countries have diverse meanings of “moderation”. On their site, Talkingalcohol.com, they suggest that the best thing to do is to check with your doctor about what drinking level is best for you.

- **Cannabis**

The current, legitimate reason for using cannabis is that it can be used for the treatment of medical conditions. The psychoactive drug is alleged to relieve those who are afflicted by a number of diseases or conditions for example—AIDS (HIV) & AIDS wasting, cancer/nausea, Crohn’s disease or gastrointestinal disorders, epilepsy or seizures, migraines, the terminally ill and so forth (ProCon, 2016).

As mentioned previously, cannabis could become legal In South Africa for medical reasons (SAnews.gov.za., 2014). My personal concern is that some people may abuse the medicinal uses of dagga (a South African local name for marijuana (The Freedictionary, n.d.). I fear that this may then signal further resistance and reluctance to give up using the drug. While the legalisation of cannabis in South Africa for medical purposes

may appear attractive on the surface, in reality, I believe that there could be some inherent problems. Personally I foresee that (a) the legal availability of the drug may lead to increased usage and with it further abuse; and/or (b) the potential to relapse for those who have given up as a consequence of its legal status. It will be interesting to see how the legalisation of medical marijuana in the United States of America pans out. There are now 23 legal medical marijuana states (ProCon.org., 2014).

As a matter of interest and in this country, there is a drug cocktail known as “whoonga” (also known as nyaope or wunga). This highly addictive drug has taken the country by storm since its inception in 2010. Originally it was thought that the cocktail was made up of dagga/marijuana, heroin, ARVs and rat poisoning (Grelotti et al., 2014). However, the inclusion of ARVs in whoonga has been refuted as new research suggests that there is no such ingredient in the concoction. (IRIN Africa, 2014).

I am reminded of a conversation I had with a young man who was addicted to whoonga. After quite some time he realised that his drugging was destroying his relationship with his son and girlfriend so he decided that he had to give up the drug. As he had no money to go for treatment, he decided to get clean on his own. He described his withdrawal and incredible pain during his self-induced detoxification. He writhed with pain that was so intense it contorted his body and lifted him off the bed.

Another whoonga addict described his unbearable back and stomach pain as he lay writhing on the floor of a police holding cell suffering from

withdrawal symptoms. The only way to get rid of the excruciating pain is to smoke the drug again which apparently provides temporary relief. Whoonga has been dubbed as the “cruellest drug of the South African slums” (Jolson, 2010).

1.4.4 Support structures

The support structures of both traumatised and addicted individuals share a number of common features. For this reason I have grouped the support structures under one heading but with two separate components for the sake of clarity. The first support structure is the family and close friends of traumatised and also addicted individuals (Section 1.4.4.1). This crucial support structure is followed by the individuals’ own sense of spirituality (Section 1.4.4.2). Another support system is the helping fraternity (e.g., psychiatrists, medical doctors, psychologists, nurses, etc.) who assist traumatised and addicted individuals during and after their experiences (Section 1.4.4.3).

1.4.4.1 Family and close friends

Added to the cultures of traumatised and addicted people are families and close friends. They can be traumatised on hearing that a family member has been in a serious car accident or has overdosed on heroin. Similarly they can become traumatised if they have witnessed something harrowing (APA, 2013). As mentioned previously, family and close friends are typically the backbone of a support structure especially in times of need. They tend to get a double dose of the traumatic event. On the one hand they provide support while on the other, they themselves are traumatised by what has happened to their family member or friend.

1.4.4.2 Spirituality

I previously mentioned the significant role of spirituality in life. Recall the drug addict who believed that salvation from his addiction was strongly influenced by his own spirituality? Once addicts and/or alcoholics accept and acknowledge that they have a problem, they need immense willpower to resist drinking or drugging. At this time, the support from family and close friends becomes paramount. Without this support, the prognosis for recovery is pretty slim. As is the case with traumatic experiences, family and close friends often provide the much needed support that their loved ones need in order to get clean. Like trauma, spirituality tends to play a pivotal role in the acceptance of and recovery from addiction.

The 12-step programme of Alcoholics Anonymous (AA) (Appendix A) emphasises the importance of spirituality. According to the AA (2001, p. 567), when individuals make changes in their lives, they “find that they have tapped an unsuspected inner resource which they presently identify with their own conceptions of a Power greater than themselves.” The same AA 12-step programme has been adapted for use by Narcotics Anonymous (NA) (Appendix B) (WSO, 2008).

I hasten to add that families and close friends do not always support the addict or alcoholic. They may be enthusiastic to begin yet if the affected person continues to drink or do drugs, they soon become disillusioned and loose interest in their wellbeing. Some addicts and/or alcoholics become semi-permanent residents in private treatment facilities for as long their parents or families continue to pay upwards of currently R30 000 per month.

People tend to choose their own religious beliefs or faiths or personal spirituality to help them deal with their trauma or addiction ordeals. At some time during these experiences, personal and/or spirituality may come to the fore. In my experience as a trauma counsellor, religious spirituality becomes paramount almost at the beginning of the traumatic incident. I have heard people either saying that God has forsaken them or that God will get them through the trauma. I remember the ordeal of a young woman who was abducted and almost thrown from the tenth floor of a high-rise building. She kept praying that God would save her and He did. Following approximately two years of court detail, her abductor eventually got a 15-year sentence for attempted murder without parole.

Family, close friends and spirituality do not work in isolation from each other. Rather they are a complementary whole that naturally synergise during times of crises. Added to this complementary relationship are the helping fraternity who augment the efforts of family, close friends and the light of spirituality.

1.4.4.3 *The helping fraternity*

In my view, the helping fraternity is made up of many people. For those who have been in a traumatic incident such as a serious motor vehicle accident, murder, rape, an earthquake, a near-fatal overdose on heroin and the like, the paramedics, fire fighters and police officers are usually the first responders (APA, 2013). Once the survivors have been brought to a safe place such as a hospital, they are attended to by medical personnel and later, if necessary, by psychological professionals.

The helping professions provide invaluable support structures for survivors of trauma and addiction. Their support can be called upon in many

spheres of the medical profession (doctors, psychiatrists, nurses) in the psychological fraternity (psychologists, registered counsellors, lay counsellors, pastoral counsellors, social workers and many others). Support does not only come from the professionals. There are umpteen non-professional organisations where you can find lay counsellors who can render trauma and addiction counselling to people in need. These include trauma or victim support centres at police stations, non-profit or non-government organisations (NPOs or NGOs) and many places of worship.

Having worked in a number of community-based, non-government organisations, I have personally seen the relentless efforts of many lay, often unpaid counsellors helping both traumatised and addicted people. Some of them come from their own traumatised environments, some from addicted homes and also from concurrent traumatised and addicted environments. I recall a lay counsellor who was sold into prostitution by her own biological mother when she was only 11 years old when it first happened. In the same trauma centre, I also worked closely with lay counsellors who helped people with the trauma of their addiction. The area we worked in was renowned, or at least actively rumoured to be controlled by drug dealers. In spite of these diverse and sometimes dangerous situations, the counsellors continued relentlessly to counsel people in their communities.

Personally and I believe that others might agree, it is important to recognise that helpers themselves may need counselling and debriefing from time to time. Individuals who work with survivors who have been traumatised may experience what Pearlman and Ian (1995) refer to as vicarious traumatisation. This is as a result of a traumatic incident (for example, child sexual abuse, rape and the like), or an addiction episode.

What this amounts to is that the trauma of some clients may be so overwhelming that they themselves (professional and lay counsellors) become traumatised themselves (Pearlman & Ian, 1995).

1.5 CONCLUSION

The purpose of Chapter 1 is aimed towards orientating the readers to the manner in which individuals can and are exposed to the phenomena of trauma and addiction. As such, it sets the stage and creates the forum of the ensuing chapters. In particular, this chapter emphasises the belief that traumatised or addicted people are, like all people, unique human beings. As such, I believe that a qualitative approach is the appropriate methodology for this study given its focus on the sensitive nature of human behaviour in this context.

Chapter 2 (the following chapter) chronicles my personal exposure to addiction and trauma within the family context. The next chapter provides an overview of the realm of addiction within the South African context (Chapter 3). Moreover, it is about the person who encouraged me to work with individuals who are or were dealing with addiction and trauma. Circle of Friends is the focus of Chapter 4 that aims to speak to the reader about the accounts of the extraordinary individuals who consented to take part in the study. Their narratives are analysed in Chapter 5 and highlights the common threads of their experiences surrounding the circularity of trauma and addiction.

Chapter 2

ME AND MY SHADOW

2.1 INTRODUCTION

As this chapter is about my personal interest in the phenomena of trauma and addiction, the title of “Me and My Shadow” seems fitting. I had to think hard and fast about the deep-seated forces that drove me to do this research. And once again, I decided to take another leap of faith. This time though, the leap is way harder than digging for diamonds given its more private nature. Right from the beginning, I knew full well that I had to dig deep into my past. I was candidly aware that this would involve delving into my family of origin growing up in South Africa. For this excavation and in the sections that follow, I present my subjective memories with particular reference to those of my formative years. Hence, the first section of life in South Africa in the early 1960s is documented in more detail in comparison with the ensuing sections. I have used Jung’s (1968) shadow archetype to illustrate the experiences and memories that are hidden in what he refers to as the collective unconscious. I have tried to illustrate that what is hidden in our shadows can be recognised and over time, be integrated with our personalities in a healthier form.

This chapter documents my attempts to bring hidden weaknesses and projections to the surface and into my conscious mind. To orientate the reader, I use Jung’s concept of inferiorities interchangeably with complexes and from time to time with weaknesses or subordinations. The intended purpose is to unveil and confront my inferiorities to lessen the hold they

have over my personality. In so doing, I am also edging my way onto the canvass of my metaphorical portrait of a people (see Chapter 1) while attempting to confront my shadow. Prior to addressing these issues, a basic introduction of Jung's archetypes and the collective unconscious (Jung, 1968) is necessary. The introduction of Jung's archetypes, particularly the shadow, forms the basis of this chapter. It commences with a quote from Jung and the shadow archetype.

2.2 THE ARCHETYPES

Everyone carries a shadow and the less it is embodied in the individual's conscious life, the blacker and denser it is.

C.G. Jung (1968)

2.2.1 Introduction

In one of his many works, Jung wrote about his archetypes and the collective unconscious. Jung's theory posits that the human psyche functions on three levels of consciousness—the conscious, the personal unconscious and the collective unconscious. The third level is the home of the shadow. I have drawn quite extensively on the work of Meyer, Moore and Viljoen (2008) in terms of the elucidation of Jung's archetypes. With the assistance of the book written by Jung (1968) entitled Archetypes and the Collective Unconscious, an outline of these levels is provided below.

2.2.1.1 *The conscious*

The ego forms the baseline of the conscious and is essential for ego development commencing from infancy. Ego conscious develops from the unconscious. Jung points out that when a child is born, he or she does not have an ego conscious and is born with a clean slate (tabula rasa). The infant responds to and functions primarily according to external stimuli

or sensory perception (Meyer et al., 2008). For instance, if the nappy/diaper of an infant needs to be changed, he or she will respond by crying or other visible signs of discomfort.

2.2.1.2 The personal unconscious

The personal unconscious stores experiences and interactions and their interpretations. These contents are accessible to consciousness with communication between the personal unconscious and the ego. Our individual complexes are stored in our personal unconscious. According to Jung (cited in Meyer et al., 2008, p. 103) a complex is “an instinct which has undergone too much psychisation that can take its revenge in the form of an autonomous complex”. Our complexes (or inferiorities) are usually laden with emotional intensity.

2.2.1.3 The collective unconscious

The collective unconscious is also known as the transpersonal unconscious. It is transpersonal in the sense that it represents a psychological inheritance from previous generations and ancestors. Jung writes (1968, p. 43): “This collective unconscious does not develop individually but is inherited” and Jung points out that this happens on a universal level rather than individually. Moreover, this level of the human psyche according to Jung, operates independently and has no communication with the conscious or the personal unconscious (Jung, 1968; Meyer et al., 2008). The collective unconscious is where our instincts and archetypes are stored. (Jung’s concept of instincts has been defined above). His most important archetypes are the persona, the anima, the animus and the shadow. My focus is primarily on the shadow.

2.3 THE SHADOW

Meyer et al. (2008, p. 103) explain and I quote: “The shadow is probably the strongest but also the most dangerous archetype” The reputation of the shadow is ostensibly attributable to stored impulsive urges and emotions that society would typically judge as improper. Unconsciously, they are repressed and relegated to the deep dungeons of the shadow, where they ferment and sometimes grow into disproportionate sizes.

Manifestations of the shadow in action can be positive or negative. On the positive side, it is the source of our vitality, spontaneity and creativity. This occurs when our ego and shadow are in sync. Conversely, the negative consequences of our repressed impulsive urges and emotions and our inability to appropriately deal with them, tends to invoke feelings of inadequacy. Unconsciously, we have lost communication with who we are—the very essence of our humanness. We become engaged in an irreconcilable *mêlée* (Meyer, et al., 2008). Just about everything in the unconscious is hidden in a shadow, rendering it negative, dark and gloomy. The shadow appears to be the breeding ground for the majority of our inferiorities.

2.3.1 Inferiorities

A vast amount of these irksome subordinations are often as a consequence of things that may have happened in our childhood—at a time when we are most vulnerable. Inferiorities tend to be emotional in nature and emotions, according to Jung (1968), are reflections of experiences and memories of individuals. Emotions are the consequences of our reactions and not simply an activity manifested or observed in our behaviour.

Bothersome emotions are invariably filed in our shadows. To become conscious of our shadow involves considerable effort as coming to terms with our dark side is no mean feat. Jung (1968) insists that we have to be brave and take the plunge to learn more about ourselves. He emphasises that this difficult journey into the dark is essential for self-knowledge (Jung, 1968). It is perhaps a place where we can come head-to-head with our projections. If you thought that our inferiorities were difficult to deal with, our projections, by all accounts, appear to be far more challenging.

2.3.2 Projections

According to Jung (1968, p. 20), hostile situations can be avoided “as long as we can project everything negative into the environment”. It is not that simple to integrate our shadows with our ego conscious personality. There are certain parts that are more resistant to cajole into the conscious realm of who we are. The troublemakers in our efforts towards self-knowledge seem to be our projections that put up a dogged fight when tampered with. Truth be known, some projections are exceptionally stubborn and may never be moved at all.

What precisely are these pesky projections? According to Reber, Allen and Reber (2008, p. 622) projection is the “process by which one ascribes one’s own traits, emotions, dispositions, etc. to another.” As I am approaching the process of projections from Jung’s perspective, a psychoanalytical definition is appropriate and fitting. As such Reber et al. (2008) explain that denial is involved and that projection serves as a defense mechanism “to protect oneself from anxiety and that some underlying conflict has been repressed”.

Projection works in mysterious ways. For instance, a mother who is obsessed with her own weight is constantly telling her daughter that she is overweight. I recall my sister, who is an addicted exercise freak, constantly nagged her daughter to lose weight. My niece was not particularly overweight but my sister was when she was a teenager. On a personal level, my father said I had a weak personality. Was he projecting his own weaknesses onto me or am I really weak? Room for speculation.

What this boils down to is that we have a tendency to project both our positive and negative feelings, images and thoughts onto others. It is just as well that it is not all negative. From a personal point of view, I know I am short and in the past I used to get upset when this was pointed out. Nowadays I am less sensitive to such comments but am aware when the height of others is negatively commented on—I tend to defend them. Perhaps my own inferiority continues to be a projection and refuses to budge. Where does this come from and when did this inferiority become a projection? I am not entirely sure but at least I am aware of it—it is semi-conscious rather than hidden and I can live with this. If you are short—you are short. *Fait accompli*.

Failure or denial to recognise our stubborn, deep-seated projections runs the risk of allowing the internal mechanisms the opportunity to run amok. Projections have an uncanny knack to manipulate a situation simply by virtue of its own power. If it (the projection) wants something/someone to be something/someone and it works, then it is successful in achieving its desired goal.

The problem with projections is that they are illusory connections to reality. Think about the good old days of movie projectors. Back then and today, real, live actors play out scenes which are then filmed. These images are replayed as images (illusions) via a mechanism (digital or otherwise). I am of the opinion that this example serves to demonstrate the process of turning reality (real live, breathing people) into illusions (images on celluloid). The images are just that—they are not real but an illusion of reality. Think narcissistic personality disorder (NPD).

2.3.3 Narcissistic personality disorder (NPD)

Narcissists are past masters at projection and they usually engage in this tactic to manipulate others or to pamper their own grandiosities. This unconscious behaviour by a narcissist denies their own behaviour, leaving them free to accuse others of exactly the same tactic.

To find out a bit more about how this personality disorder got its name, I checked online and found some information on the Encyclopaedia Britannica website. There are a number of editors for this site and, for brevity, I have cited and referenced them as Encyclopaedia Britannica Editors (2014). According to these editors and Greek mythology, Narcissus was renowned for his unique handsomeness. His mother was told by Tiresias (the blind seer), that her son would live a long life if he never recognised himself. According to myth, Narcissus was scorned by his love for a nymph and his reaction to the rejection angered the gods. On looking at his reflection in the waters of a spring, he fell in love with his own reflection and either pined away or killed himself.

Essentially a person who is narcissistic is obsessively full of their own importance. Everyone must recognise and acknowledge their sense of

prominence. Strong, pervasive characteristics are a sense of entitlement and grandiose perceptions of their own beliefs and behaviour. In simple terms—they are self-centered, obsessively in constant need of attention and always wanting to be in the limelight. Narcissists put themselves on a pedestal whereas those who are not, are less inclined to blow their own trumpets.

The Diagnostic and Statistical Manual of Mental Disorders 5th edition (APA, 2013) presents a formal diagnosis of NPD covering five or more of nine symptoms. In addition to the ones mentioned above, these include a preoccupation with fantasies of unlimited success, power, brilliance, beauty or ideal love; a belief in being special and unique and prefers to be in the company of important people or institutions; manipulates others for their own needs; lacks empathy; envious of others and believes others are envious of them; and displays arrogant, snooty behaviours or attitudes.

Certain narcissistic behaviour and attitudes can often be mistaken for confidence or strong self-esteem. Do not be fooled as such overt behaviour is a smoke screen that serves to camouflage a damaged and somewhat fragile self-esteem. The foundation of this delicate self-worth is typically shrouded in secret shame and humiliation. Narcissists cover up these inferiorities through their projections to make themselves look in control—to make themselves appear better than they perceive themselves to be (APA, 2013).

2.3.4 Shadow dusting

Welcome to the first insight into my shadow. I have used the example of NPD simply to demonstrate the power of our projections. Although I

am aware that I have my own projections, I believe that a diagnosis or identification of NPD would be inappropriate. I acknowledge that I have poor self-esteem but I have not tried to camouflage it. I think the way in which I currently regard myself has strengthened due to maturity. What follows below is the journey my confidence and self-worth has travelled from where it was to where it is today.

2.4 FAMILY FOUNDATIONS

Since I was a little girl, I always believed that the way in which we grow up in our families is somehow connected to the way in which we turn out as adults. I have a childhood memory of hearing myself whispering: "I wonder what other people are really like in their own families". Today, the foundation of my belief is confirmed by the nomenclature of the functioning of families (e.g., Becvar & Becvar, 2009; Boscolo, Checchin, Hoffman & Penn, 1987; Minuchin, 1974).

As time went by, I realised that as hard as we try to put things in the past and move on, some memories are doggedly resistant. Of course, not all memories are bad. Most of us have many memories of the good variety and we tend to remember these with fondness and happiness. When I reflect on my childhood, I remember some good memories and some I would prefer to forget. The latter are the ones that have been cast-off to the shadows of my collective unconscious (Jung, 1968).

My journey into my shadow is aided and abetted by Jungian philosophy. Before setting off on this precarious journey into my shadow, I have to find a map or some directions to reach my destination. This map is provided by my family of origin and my accompanying memories, experiences and feelings during my formative years. From a personal

point of view, this is the map of the territory of my reality. It is a map that is fraught with directions en route to my shadow. Thankfully, I am assured by Becvar and Becvar (2009) that the map is not necessarily the territory.

I leave this territory with a quote from the renowned actor Anthony Hopkins: “I think the healthy way to live is to make friends with the beast inside oneself, and that means not the beast, but the shadow. The dark side of one's nature. Have fun with it and you know, is to accept everything about ourselves” (Brainy Quotes, n.d.). (Note: The original words, grammar, punctuation and sentence structure of the quote have not been changed in any way).

2.4.1 Small beginnings

Reflecting on how and where I grew up, I often think of how confused my childhood was. One of my most vivid and lasting recollections of confusion is about religion. This confusion came into fruition when I started school and has stayed with me ever since. My mother was a young Catholic farm girl. My father, who was nine years older than my mother, came from a Muslim background and lived in the city. My parents married when I was about seven months old and my mother had by this time converted to Islam. She was 16 at the time and was, in the proverbial, as meek as a lamb being led to the slaughter.

2.4.2 Daisy

My mother and her older sister came from an impoverished background and getting married at a young age seemed like a good idea at the time. My maternal grandmother had remarried and her new husband, who

was Muslim, seemed to encourage the coupling. This step-father, by all accounts, was quite a cruel man.

I remember my mother telling me that she had a little pet lamb called "Daisy". One day when she came home from school, her step-father told her that he had slaughtered Daisy for the evening meal. My mum went hungry that night and did not eat lamb for many, many years after the incident. My aunt (my mum's older sister) told me that she had to protect both herself and my mother from their step-father's sexual advances. It seems as if my grandmother was oblivious to this and perhaps such actions in the 1940s were largely ignored or conveniently overlooked.

Nowadays, despite sexual offences being rife in this and other countries, there is far more awareness of such illicit sexual practices. According to the South African Criminal Law Sexual Offences and Related Matters, Amendment Act, 2007), the current, legal age of consent to sex in South Africa is 16 and above. Translated this means that according to current legislature and in hindsight, both my mother's step-father and my father could have been found guilty of a criminal offence (had they been caught).

I have done the math to prove this to myself. I was born a month after my mother's 16th birthday. This means that I was conceived when she was 15 which today, is under the age of consent to sex. My aunt would have been 17 at the time. As far as current legislation is concerned, this would have put her one year over the age of consent to sex. Safe sex.

2.5 SOUTH AFRICA–PART I

By the time we had our first home, I had a sister who was born five days before my first birthday. Five years later, my first brother was born and then six years later the youngest brother was added to the family. By the time the youngest child was born, I had been at the Catholic Convent for a few years. I am not sure if the domestic violence started before or after the last child was born. I seem to remember it being there all the time, like being “part of the family” so to speak.

- **Religious confusion**

My sister and I went to a Catholic convent because it was what my mother wanted. She believed that we would get a better education if we went to a White school rather than to an Indian or Coloured one. At this school, I was bullied, teased and discriminated against and, at the same time, learning to become a good Catholic girl. I have absolutely no recollection of my sister ever coming to my rescue. In the afternoons, we had to go to Muslim school known as madrasah (American Heritage Dictionary of the English Language, n.d). It was a long day and we were only about eight or nine years old at the time.

Sometimes we had no money to get back from the Convent. If I asked my father for bus fare in the mornings, he would tell me to look in his trouser coin pocket. In the 60s, men’s trousers had one of these tiny pockets where they could keep coins. As he was still in bed when it was time for us to leave, it was dark so I was not able to see how many coins I had taken out. Often it was not enough so we had to walk home and then to the Islamic school. On a good day, the money was enough to get us to the nearest bus stop. From here, we still had to walk about three kilometres home. Then we had to change from

convent to madrasah clothes and head on to our religious afternoon classes. We always got there late and more often than not, we were caned because of our lateness. The day was not yet done as after our lessons and the long walk home, we had to cook, clean and sort out the boys. Both our parents worked. Homework was another issue.

Eventually my sister and I decided that we would bunk afternoon school. We did this for quite some time until my father found out. We were physically punished, something we had gotten used to except this time it was particularly severe.

My confusion with religion was not only in the realms of education (i.e., convent versus madrasah). When it came to family functions, most of the time we had to go to my father's parents' home. From what I can remember, my paternal grandfather seemed to be a gentle man but my grandmother was less affectionate. Here, we would mingle with our aunts, uncles and cousins and be ridiculed and teased for going to a white, convent school. Granted not all of them treated us in the same way which was a blessing in disguise.

The domestic violence continued with my mother, my sister and I being the primary targets. I remember a time when we got home from taking the boys to the swimming pool we got a hiding for being late. The older of my two brothers ran away to escape the dreaded belt. In my view, he is still a coward. He could afford to be as he was touted as the golden boy by our parents. All's fair in love and war.

- **Gambling and the mood barometer**

My father liked to gamble on horses believing that it would bring him the untold riches he so eagerly desired. Of course, and as most people

tend to recognise, gambling does not always pay off. We would wait in trepidation for his return home on Saturday evenings and gauge his mood by the look on his face. If the barometer indicated that he had won, he would treat us by taking us to the drive-in or to the movies. Those were good times with good memories, despite being entrenched in a patriarchal and sexist environment.

When we lived in South Africa, I can remember my father gambling just about every Saturday. He meticulously studied the race card before each meeting and kept a keen eye on the odds of the betting. On reflection, I believe, and to be fair, he does not quite fit the bill for an identification of gambling disorder according to the DSM-5 (APA, 2013). On the other hand however, I do believe he was obsessed with the game. If he lost at the races, he would vent his anger and frustration on the female members of the family. Disruption of family life is one of the symptoms of gambling disorder and which he, my father, was most certainly guilty of. Ironically, the elder of my two brothers is a gambler, mostly of the casino variety. It would appear that the apple doesn't fall far from the tree.

- **Saving grace in the bottle**

Our only saving grace was my maternal grandmother who lived across the road from us. Not to say that my mother didn't try to protect us. She tried to but she usually got caught in the cross-fire. My grandmother's third husband, who became our caring and doting grandfather, also protected us.

My grandparents rented this little house from the furniture factory. Often we used to play in the discarded sawdust and pretend that it was snow

(not ever having seen snow). During the school holidays and weekends, my sister and I used to sit in the old cars that my grandfather used to fix. My grandmother taught us to knit baby booties and we would sit in the cars and play with the kittens that were born in the yard. These are cherished memories. I can still smell the oil from the cars and the breath of the kittens. It makes me smile.

My grandmother was an alcoholic and on Saturdays she would put on her best show. Saturdays were also father's horse racing days so that meant we had to fend for ourselves. Ma, as we affectionately called her, was out of commission. Dad was free to cut his losses on us—the female of the species.

2.5.1 *Shadow dusting*

We find that by opening the door to the shadow realm a little, and letting out various elements a few at a time, relating to them, finding use for them, negotiating, we can reduce being surprised by shadow sneak attacks and unexpected explosions.

Clarissa Pinkola Estés (1992)

Coming to terms with our shadows on a conscious level requires considerable moral effort. This exercise is very difficult because we have to dig deep to recognise the dark aspects of our personality. These aspects are present and are very real. Despite how difficult it is to carry out this task, it does wonders for improving our self-knowledge (Jung, 1968).

- **Religion**

My childhood experiences of religion were hidden in the shadow of my collective unconscious for quite some time. The sentient upshot of these experiences is that I am uncomfortable with matters relating to religion, particularly Islam and Catholicism. How did I relate to these divine interventions and allow them access into my conscious mind? I found a

use for them through my marriage to my husband who is a Roman Catholic. I decided that when we had children they would be Catholics. As planned and agreed, both our boys were christened as Catholics. I am not a follower of religion although I have a healthy respect for all religions. I also tried to connect with Muslim-hood at some stage in my adulthood life but I was uncomfortable with the religion. I have addressed my inferiorities with religion and am content with my alternatives.

- **Domestic violence**

Nowadays I work with and try to empower survivors of domestic violence. This is how I try and exorcise the negativity in my unconscious mind which for me has been and continues to be remarkably cathartic. I had ignored my childhood experiences of domestic violence for a long time and left them smouldering in my collective unconscious. Perhaps I hoped that they would just go away, disappear. But I found an avenue to vent and to release these pent up emotions through my work with survivors of domestic violence. A 50-50 deal.

I have become familiar with the South African Domestic Violence Act (1998, p. 2) with its ten types of abusive behaviour. They are listed as physical abuse; sexual abuse; emotional, verbal and psychological abuse; economic abuse; intimidation; harassment; stalking; damage to property; entry into the complainant's residence without consent, where the parties do not share the same residence; or any other controlling or abusive behaviour towards a complainant. When I think back on what happened in our family, I can remember at least five types of domestic violence. I can tick the boxes for physical abuse; emotional, verbal and psychological abuse; intimidation; economic abuse and controlling and abusive behaviour.

It is surprising and depressing to realise just how little women and children know about their rights. Not only that, some spouses unquestionably accept their abusive relationships as part and parcel of the marriage or partnership “deal”. My mother seemed to be helpless about her abuse and often tried to cover up her black eyes and bruises. If someone asked her about her bruises, she would say she walked into a door. As far as I can recall, she never went to see anyone for help with her abuse. In this country, and according to the Domestic Violence Act (1998), anyone can apply for a Protection Order if they have become victims of domestic violence.

As children, we (my sister and I) also covered up our welts from the belt. I still get a little anxious when I hear the sound of a whipping belt. How can such a little thing create such intense fear? I think I grew to accept the physical abuse as part of family life and had no idea one could get help for this kind of abuse.

What I am abundantly aware of is that we were a private, enmeshed family with rigid boundaries. Disengagement from others, including the outside world, certainly in the earlier years, was the order of the day (Becvar & Becvar, 2009; Minuchin, 1974). No-one had any business knowing, let alone interfere, with what happened behind closed doors.

My gran and aunt often tried to intervene but they were told to mind their own business. We simply were not allowed to talk about what happened in the family. Episodes of emotional and physical abuse was a closely monitored and guarded family secret (Boscolo et al., 1987).

Yet in the eyes most people, we were just an ordinary family.

After one particular beating, I have a memory of sitting in a corner on the floor, behind a chair, cowering. We were holding the balloons my father had given us as a peace offering. Funny, sometimes it seemed my father felt some remorse after he had beaten us and would try to make amends. Did we let him? Of course we did. He was our father and we loved him. Unconditional love.

2.6 ZAMBIA

The whys and wherefores of the family move to Zambia are not quite clear to me. The most I can remember is that we were at my paternal grandparents' house. From here, and what seemed like the middle of the night, we were bundled into a small, blue Opel Kadet and sped off into the shadows. My parents were seated up front with father at the wheel. The four siblings, aged somewhere between thirteen and two, were huddled on the back seat together with my mother's treasured set of cutlery. Destination unknown. No questions asked.

2.6.1 TV for the first time

We seemed to be travelling for hours and days on end not knowing where we were going to. At some point we stopped at a motel at one of the borders between South Africa and Zambia (Chirundu). Here, we sat for about a week waiting for visas to enter the country. Eventually this happened and we went to stay with family friends in Luanshya. This is a small town on the Copperbelt and near to the city of Ndola in the north of Zambia. We experienced television for the first time!

After some time my father found a job and we moved to Kitwe, another city on the Copperbelt. My sister and I went to school in the city which was not far from where my father worked. The boys stayed with my

mother in a village outside Kitwe where the older one went to school. Nothing particularly extraordinary happened and we maintained the lives of what I reflect on as being a fairly normal family. The abuse seemed to dwindle at this time with a few skirmishes here and there. Things were looking good.

One of the first things my father did was find out about the horse races. In Zambia in those days, the whole family could go to meets. During the season, we went to the race course on Sundays and had a comforting family outing. I am not a gambler but once in a while I will bet on the July Handicap.

In Zambia, I maintained my grade point average and stood third in my year. At this stage, I began to think of what I would like to study. My confidence grew in the context of this multi-national, government school where I made friends from all walks of life. On rare occasions, I was allowed to spend the night with friends. Then my father got another job which offered to pay for schooling abroad with one air fare home per year. Scotland was the chosen designation based on the premise that his maternal grandmother was from this country. Not only that, it was a non-sectarian school. This meant that we could continue to be Muslims from a distance. No pork for us.

In September 1971, my sister and I, escorted by my mother and younger brother, were checked into the boarding house in Edinburgh, Scotland. When we came home on holiday for the first time, the domestic violence was back in action. To make matters worse, my mother had started drinking.

When I think back on the move from South Africa to Zambia, I think there were some subtle changes in the dynamics of the functioning of my family. My father had lightened up somewhat even though he still had his regular bouts of anger and moodiness. Perhaps his turn-around in behaviour was due to his more stable work situation and being able to provide for his family. This did not occur to me at the time. I am reflecting on what could have been the reason for this perplexing, yet welcoming change in attitude. For as long as I can remember, we always had to gauge his mood to predict his behaviour. He had a cataclysmic effect on the temperament of the entire family—dogs and cats included. Maybe he had some mood disorder—who knows? May his soul rest in peace.

- **Boyfriend patrol**

At this time, my sister and I were teenagers and wanted to do “teenage” things. As I was more of a rebel, it was more a case of me than her. We could actually have gone through this period together as we were only 11 months and five days apart. She was your typical goody-two shoes individual and perhaps I was just more mature and adventurous than she was.

According to Erik Erikson (cited in Corey, 2009), at the age of 15, I was smack-bang in the midst of the adolescence psychosocial stage, trying to negotiate a deal between identity versus role confusion.

Democracy was not an option in our home—dictatorship ruled supreme. Arguments were bound to happen and indeed they did, particularly between my mother and myself. Boyfriends were out of the question and my mother was the custodian of this rule, a rule she monitored with

vigilance and ferocious determination. I think in her mind, there was no way we would be lured into the same predicament she found herself in when she was just a teenager. On reflection, I can understand where she was coming from. Back in the day, when she was a young, naive 15-year old from the farm, she was smitten by my father and his cavalier attitude. She was drawn in hook, line and sinker. Emphasis on the sinker.

2.6.2 Shadow dusting

During my mother's boyfriend patrol period, I switched allegiance from my mother to my father. I tried to back the right horse to garnish some support but I lost big time. It was at this time that my father told me that I was weak and that I was not as strong as my sister. These words have stuck with me all my life. What also stuck was the fact that my brothers were never physically punished in the same way that the sisters were.

Low self-esteem has been my stock-in-trade for a long time. I am sensitive to this characteristic not only in my own personality, but also in others. Over the years and through maturation, I have managed to dust the cobwebs off my shadow and become more self-confident, more self-assuring. Sometimes people near and dear to me read it as being arrogant. Perhaps I over-compensate and tend to overdo this new found sense of confidence. Maybe one day I will get my personality, my psychological type, assessed.

- **Psychological types**

In the event that I decide to go for testing, I would choose the MyersBriggs Type Inventory (MBTI) personality test. I am interested,

actually more curious, to see how my personality impacts on my behaviour. The reason for choosing the MBTI is that this objective personality test is based on Jung's psychological types. The scales of the MBTI are Introversion-Extroversion (E-I), Thinking-Feeling (T-F), Sensing-Intuition (S-I) and Judgement-Perception (J-P) (Foxcroft & Roodt, 2009).

For fun and also out of curiosity, I tried the HumanMetrics online Jung Typology Test (n.d.). The results indicated that I have a moderate preference of introversion over extraversion (56%); a slight preference of intuition over sensing (12%); a distinct preference of feeling over thinking (62%); and a slight preference of judging over perceiving (11%). According to Jung's theory, one of the four psychological functions is dominant. My dominant function-type is feelings and my attitude-type is introversion.

I also tried the online Jung Personality Test (123 Test, n.d.). Interestingly, the results of the previous test were very similar, bordering on identical. Where the previous test gave percentages on the dimensions, this test provided descriptions as well. My Jung personality type is Introvert-iNtuitiveFeeler-Judger (similar to the one above). Introverts tend to be reflective, reserved and private. It is true that I do not need people around me all the time. Intuitively, I am more attracted to information that is imaginative rather than boring and mundane. I am most certainly more focused on the feelings of other people and I have always been this way. My lifestyle is planned and orderly, organised and controlled which often irritates my family. Everything has to be in the right place and cupboards have to be neat and tidy.

The results of these online personality tests are reassuring and have done wonders for my self-confidence. However, I do feel that I need the real McCoy to really test where my levels of confidence are. Most people

understand confidence as a state of being assured about one's own sense of self. It is also a belief in our own trustworthiness or honesty (Reber et al., 2009). Staying with Jung's theory, the self is one of a number of archetypes. He also referred to the self as the supraordinate personality (Jung, 1968). I have taken the liberty of quoting Jung's own words (as cited by Luton, n.d.) about what he meant by the supraordinate personality.

The "supraordinate personality" is the total man, i.e., man as he really is, not as he appears to himself ... I usually describe the supraordinate personality as the "self," thus making a sharp distinction between the ego, which, as is well known, extends only as far as the conscious mind, and the whole of the personality, which includes the unconscious as well as the conscious component. The ego is thus related to the self as part to whole. To that extent the self is supraordinate.

2.7 FULL CIRCLE

The full circle I refer to here is my move away from the now defunct, era of apartheid South Africa in the late 60s and my return to the country in 1993. The next year, 1994, was the first time I voted in my own country. In fact, it was the first time I have ever voted in my entire life. I had a strong feeling of patriotism and belonging. Prior to returning to my country of origin, I had been to Zambia (as chronicled above). From this country I then went to boarding school in Scotland. After school, I went to college and worked before coming home to my new family home in Botswana. Finally, I returned to South Africa with my own nuclear family and this is where I am today.

2.7.1 Scotland

As mentioned previously, my mother and I came to many blows with the boyfriend issue. Being shipped off to Scotland was, in a way, an escape to freedom where I could exercise choice. But it was freedom with a long lead. I remember on our first trip home from boarding school, we wanted to go to a disco. In Scotland, we often went out dancing and socialising with our friends. Being back at home was a different story altogether. Our wings were clipped. This was a favourite saying of my father when he had to institute order.

My sister and I were 16 and 17 respectively and in Zambia, my mother went out with us. She was our chaperone which, after Scotland, felt incredibly infantile. Not only was it infantile, it was also embarrassing and demeaning as we had to leave at about 11pm—just when the real party had started. The Iron Lady had no patch on my mother coupled with when the oppressed becomes the oppressor.

- **Nostalgia**

I have fond and less fond memories of Scotland. On the not so fond side of the spectrum, the weather was abysmal. It was dull, cloudy and exceedingly cold in the winter and in defrost mode in the summer. The kind of weather I experienced first-hand as depressing and for me at the time, made me intensely homesick. The standard of schoolwork was much higher and I struggled to keep up. Soon my ambition to pursue a meaningful career competed with the bleak Scottish weather.

During the time between being at school, going to college and working in Scotland, I remember one single day when the maximum temperature was 29°C. Just about everyone was out sunbathing and some turning

bright red in the process. The summer temperature in Zambia, particularly in October (what locals refer to as the “suicide month”), was exceptionally hot and way above 29°C.

On the bright side of my Scotland days, I made some really good friends, friends I am still in contact with to this day. At the school I went to, our class has a reunion every five years and we meet in Edinburgh to catch up on our lives. Scotland is where I first experienced cannabis and it was nothing to write home about. I also tried alcohol for the first time.

- **Homeward bound**

I learnt to be independent while living in Scotland and I outgrew some of my South African mannerisms. The girls at school used to tease me about my accent but by the time I left the country, I had a full-blown Aberdonian accent. The folk from Aberdeen, a city in the Scottish Highlands, have a very distinct accent which most people have difficulty understanding.

I truly wanted to get home to Africa. I missed the sunshine and I missed my family. My sister was already home and being on my own in Scotland with no family was lonely and depressing. Just like the weather. So I decided to leave Scotland and go home.

2.7.1.1 Shadow dusting

I dropped my South Africanism when I was in Scotland so that I would not be ridiculed for having a strange accent. An Aberdonian accent is just as strange and people laughed at me when I got home. I really did not give much thought to it at the time but on reflection, I think it

was a matter of being accepted. Nowadays, accept me and my accent even if I come from Mars.

2.7.2 Botswana

Home was now Botswana and where my family of origin had immigrated to. But things had not changed much despite looking forward to some changes. Although we were all older and supposedly wiser, I returned home and came and head-to-head with a status quo. I was 21½ years old and I had to ask for permission to go out with my friends. I had to share a car with my brother and his turn was over the weekends. As I was working, I used the car during the week and I had to pay my share towards the upkeep—he made no contribution. Fortunately this arrangement was short-lived as I eventually bought and paid for my own car. My sister got married and went to live with her husband in the north of the country. My brothers were in a constant war with physical fights being the norm. My mother was drinking and my father was having an affair with someone at work. Home-sweet-home.

It was in Botswana that I tried cannabis once again. It was not an experience I want to repeat ever again as what happened was most unpleasant. I went berserk but thankfully, a friend helped me out. To this day, if I smell burning cannabis, I panic. And so ended my career as a weed recruit. My colleague, who is the subject of Chapter 3, told me that there was probably some other psychoactive drug in the joint.

- **The more things change the more things stay the same**

Returning to the family state-of-affair reminds me of the French proverb by Jean-Baptiste Alphonse: “Plus ça change, plus c'est la même chose.” Translated from French to English means: “The more things change, the

more things stay the same” (Lawless, n.d.). Watzlawick, Weakland and Fisch (1974) open chapter one of their book entitled *Changes: Problem Formation and Problem Resolution* with this maxim. The authors propose that our perceptions and thoughts are not wholly responsible for the changes we make in our lives. Rather, they simply operate to maintain current positions through comparison and contrast. On returning home, it seemed my family had not changed at all—there were just variations of the same status quo.

Given the context in which family problems are formed, Watzlawick et al. (1974) believe that some of these problems can be resolved. Becvar and Becvar (2009) shed some light on their view. If problems are to be solved, the dynamics surrounding where the problems started or emerged needs to be understood. Not only is it important to look at the origins of the problem, consideration of how the problem is maintained and resolved are equally, if not more important. If these factors are taken into consideration, the solution to a problem becomes possible. We tend to experience life problems when we complicate normal life difficulties (e.g., sibling rivalry). When such interactional problems arise, the very nature of its solution tends to give rise to further problems.

Recall the car issue between my brother and myself? To counteract this problem, my father bought a car for us to share. This attempt on his part to solve the problem actually caused more problems. This solution did not fix the problem and the situation persisted and spilled over into other areas of our lives. For instance, we would not speak to each other for days on end. According to Watzlawick (in Becvar & Becvar, 2009), one cannot not communicate. The non-communication between my brother and myself relayed to everyone in the family, including ourselves

that we, my brother and I, were at war. My father, in literally and physically turning his back on the situation, indicated that he was not interested and not getting involved. Never mind the fact that he was the one who tried to solve the problem in the first place. His abdication to ignore the problem succeeded in adding more fuel to the fire.

Problems in families are formed and maintained when ineffective solutions made in the past are repeated. This only serves to worsen the original, unsolved problem and contributes to what Watzlawick et al. (1974) refer to as the positive feedback loop. This situation may occur when attempts to solve a problem actually increases the problem behavior. Simply put: the more of A leads to B and the more of B leads back to more of A. For example, the unfair sharing of a car between my brother and I really angered me. As a consequence, I became quite emotional about the situation. If anyone asked me what was happening, it made me even more annoyed and emotional. To resolve this problem, a change or an elimination of the unsuccessful solution needed to happen. To do this, either something different had to be done or the cycle of the positive feedback loop had to be broken.

As I mentioned before, I made the change when I bought my own car and thus eliminated the “arrangement” and consequently the problem. It’s just as well we all went our separate ways. Splitting of the Titans.

- **Parting ways**

Eventually we all went our separate ways with my sister and myself going to live in different countries with our respective spouses. My father’s extra-marital relationship led to the parting of ways of my parents shortly after their 25th wedding anniversary. He remarried and had two children

from this marriage. My older brother got married and went to live in the north of Botswana. My younger brother remained single and got married some years later. He claims we are a dysfunctional family.

My husband and I came to visit my mother one Christmas only to find her in a terrible state—physically (she was very thin), financially, emotionally and psychologically. I think it was at about this time that she was taking over-the-counter pain killers, supposedly for her arthritis. Her drinking had escalated and she had some serious financial problems. We managed to clear most of her debts including getting the mortgage payments up-to-date. She continued to live in the family home until 2012 when she was diagnosed with Alzheimer’s disease and vascular dementia. She passed away in March 2012 and she was my rock.

2.7.2.1 Moving on

Following a spell in the United States of America, where our first son was born, my nuclear family returned to live in Botswana. My siblings were married, some with children, some without. Both brothers and their children still live in Botswana. In fact, my brothers and my mother had all become Batswana (citizens of Botswana). My sister is married with one child and lives in the United Arab Emirates with her second husband. Our youngest son was born during our last spell in Botswana. My mother was working for a friend and getting on with her life and she was financially stable. We had all moved on in our own inimitable ways. My mother stayed in Botswana until she became ill and that’s when she came to live with my family in South Africa. After her death, we eventually sold the family home in Botswana—a process that was as acrimonious as any nasty divorce settlement—if not worse. Plus ça

change, plus c'est la même chose—the more things change the more they stay the same.

2.7.2.2 *Shadow dusting*

There is a considerable amount of resentment sitting in my shadow and most of it seems to be around my childhood and my parent's predictable divorce. I have reconciled my bitterness by coming to terms that their divorce was the best option. Besides, lots of people get divorced. My acceptance of their divorce is in spite of my father wanting to have a life with another woman. This is also quite a common occurrence so no big deal here either. I felt for my mother because whatever she tried to make the marriage work, nothing seemed to work. I think she loved him to her dying day.

It took a long time for me to accept that my father had a new family. I often wondered if he treated his new wife and children in the same way that he treated us. When I tried to reconcile with him I could see that he doted on his young wife and children. We kept in touch for a short while and when it dwindled, I made no effort to make contact.

When he became ill, I did visit him once out of respect. I was not present at his funeral. I think what I need to do is to learn how to forgive or forget. Maybe some stuff in our shadows cannot or will not be dusted no matter how hard we try. Mr Min's trusted furniture polish fails to do the trick.

Shadow dusting is problematic with regard to my brothers, particularly the older one. Needless to say we do not get on and have been estranged since the passing of my mother. I feel strongly that both brothers were the "favoured children" although both my parents, particularly my father,

was fond of saying that he had no favourites. I disagreed then and I continue to disagree now. Rejection and a sense of unfairness still lurk in my shadow and intensified with the closing of my mother's Estate. The darkness lightens up day-by-day with the rising of the morning sun. I know there is light at the end of the tunnel.

2.7.3 SOUTH AFRICA—PART II

My husband and I, together with our two sons, moved to Johannesburg in 1993. The boys went to the same school as their father did. It was an admirable family tradition as their cousins both went to the same school. Today, the son of one of these cousins is also at St Benedict's. Our older son broke the mould, so to speak and changed to another school. He was happier at this new school as most of his friends were there. When he went to college and what followed changed our lives changed irrevocably.

2.7.3.1 Tragedy

On the 17th of February 2001 at 6am, tragedy struck when our older son was killed in a car accident. Our younger son was in the car with him when the accident happened. He survived with severe facial injuries and the inexorable loss of his older brother. So what was formerly a family of four is now a triad. As we learnt, and continue to learn, life continues as a family of four—we learn to live with the gap. One often hears about "closure" after the loss of a loved one. How is it possible to close the door on a loved who has passed away? The notion of closure for my family when we lost our son so tragically is simply out of the question. We have grieved his untimely death but the door to our hearts is always open.

2.7.3.2 *Shadow dusting*

The loss of a child is one of the most traumatic experiences of life. The temptation to relegate such an experience deep into the bowels of my shadow is a lousy cop out. To be honest, I did indulge sometimes simply because the pain of the loss was too intense. Granted tranquilisers helped to numb the pain (Daniulaityte & Carlson, 2011). Alcohol brought the anguish to the fore in a disguised way. Children should not die before their parents—it's simply not fair. This irreconcilable fact of life sits in my shadow and, from time to time, it surfaces to remind us that life is indeed extraordinarily fragile. But life as we know it, goes on.

2.8 THE MEETING

Life took us to the eastern coast of South Africa where we have been living for the last 13 years or so. This is where I met the person who has managed to literally turn my career upside-down in a good way. We met one day to chat about the link between trauma and addiction. Prior to this, I had only been working with trauma and had not really given much thought to addiction. The next chapter, Chapter 3, is about the meeting of trauma and addiction.

2.9 CONCLUSION

Traumatic experiences may knock on many doors seeking entry into peoples' lives. Each of us opens this door with our personal and unique choice of keys. There is a myriad of things that people do and say when they are traumatised. Some may turn to drink and drugs to help them get through the pain or numb the agony. Others may not and seek alternative ways of getting through the ordeal. From time to time, we may wonder what awful things we did or said to deserve such melancholy. Once the dust is seemingly entrenched in our shadows, we

carry on as best we can. At some point, we realise that the time has come to do some shadow dusting and to lighten our load. Some shadows can be cleared with relative ease—others are more obstinate. Nonetheless, these shadows, dusted or not, have made their way onto the canvass in readiness for the portrait of a people.

LAW AND ORDER

3.1 INTRODUCTION

The metaphorical portrait of a people is taking shape and form with the introduction of the person who inspired me to do this research. Up until our paths crossed, I was more interested in the psychological turmoil of traumatic experiences and had not given much attention to addiction. A few years down the line, my awareness of the gravity of compulsion was irrevocably changed. This chapter was constructed in collaboration with Andersen and myself in a series of personal communications (June 21, 2014; September 28, 2014 & October 6, 2014).

3.1.1 Humble beginnings

My first encounter with an addiction-related case was someone I met some years ago. Bearing in mind that at the time, I had scant experience working with addiction and my focus was primarily on the ordeal she had endured. Truth be known, I was a rookie intern at the time. The woman I worked with was abducted by her so-called boyfriend and was held captive while he smoked drugs and was also drinking. Not only did she have no idea what he was smoking, I was also absolutely clueless. I recall her mentioning that the substance was white and that there was a cloud coming from what seemed to be a pipe or a bottle.

Some years later, I managed to join the dots and realised that her boyfriend could have been smoking either crack cocaine or 'TIK' (crystal methamphetamine). At the time, I had some knowledge of cocaine but my knowledge of methamphetamine was scant to say the least. I

subsequently learnt that 'TIK' is a popular drug used primarily, but not solely, in the Western Cape of South Africa (Bateman, 2006). Moreover, the use of high doses of both cocaine (in powder and crystal form) as well as TIK can lead to aggressive or violent behaviour (APA, 2013).

3.2 A SOBERING ENCOUNTER

3.2.1 Introduction

My experience (or lack thereof) presents some idea of the extent of my naivety when it came to the severity of addiction to drugs and alcohol. This was the case until I met an addictions counsellor. We met for the first time in 2009 and our relationship has flourished over the last five years or so.

During this initial meeting, she shared that she had become aware of the connection between trauma and addiction through working in the field of addiction. She based this awareness on her working experience in various rehabilitation centres over a period of 16 years. In her opinion, she advocates that the rapport between addiction and trauma is a complicated area requiring high levels of expertise to address and treat effectively (S. Andersen, personal communication, June 21, 2014). When she talks about the phenomenon, it is quite clear and understandable that her interests are clearly invested in addiction. For instance, she refers to "addiction and trauma" whereas I have a preference for "trauma and addiction" which equally demarcates my emphasis. Unlike Rudyard Kipling's saying "never the twain shall meet" addiction and trauma have indeed met and continue to do so in whichever order they may be referred to.

At this first meeting, Andersen informed me about the addiction rehabilitation centre she was currently working in and the model of treatment it was operating from (i.e., the Minnesota Model). She also informed me about the kinds of patients being treated at centres such as this one. Another interesting aspect of this meeting was about the relationships with relevant professionals in private practice. Andersen further informed me that it was important to communicate with these professionals particularly for the continuance of care (S. Andersen, personal communication, June 21, 2014). This first communique, for me, laid the groundwork for a sense of order in which the treatment of addiction can be addressed. To put our first meeting into perspective, I have provided a brief description of the Minnesota Model.

3.2.2 The Minnesota Model in brief

After the model was first developed, it found its way to what is today known as the Hazelden Betty Ford Foundation in America. The model changed the way in which addicts and alcoholics were treated. Instead of being treated as social misfits and moral failures, their addiction was approached in a more humane and civilised manner (Hazelden, n.d.).

The Minnesota Model of addiction treatment, also known as the abstinence model, was developed in the 1950s in the United States of America. The uniqueness of the model was based on the balancing of professional and trained non-professional staff based on the philosophy and principles of Alcoholics Anonymous (AA). The treatment of addiction focuses on particular areas such as a treatment plan that is individually styled (includes addiction education); the active involvement and participation of families and significant others who are also educated about addiction; a

stay of 28 days as an in-patient; and the participation of all patients in AA both while in treatment and after they leave the rehabilitation facility (Anderson, McGovern & Dupont, 1999). There are, of course, several other articles written about the Minnesota Model and one in particular is by Patricia Owen.

Owen (n.d.) writes about the Minnesota Model Counselling Approach in an article written under the auspices of the American based National Institute of Drug Addiction. A vast majority of the treatment is done in group contexts as well as individual sessions one to three times a week. It is not within the scope of this chapter to go into detail of the model. Its place here is merely to bring it to the attention of the reader. Similarly, the same qualification applies to the rehabilitation centres in this country and as outlined below.

3.2.3 Introduction to rehabilitation centres in South Africa

The Department of Social Development (DSD) is the lead government department responsible for addiction treatment in this country. The Department of Health (DoH) is accountable for medical detoxification and mental health services. The mandate of the National Department of Social Development's (DSD) is to ensure that people who need addiction treatment have access to and treatment by recognised service providers (Temmingh & Myers, 2012). In her personal communication Andersen (June, 2014) shares with the reader that one of her areas of expertise is the writing up of standards, policies and procedures for substance abuse treatment centres. She is also involved with getting these centres registered with the Department of Social Development.

According to Temmingh and Myers (2012), most of the treatment centres in South Africa are located in the provinces of Gauteng and the Western Cape. Myers, Louw and Fakier (cited in Temmingh & Myers, 2012), add that the vast majority of these facilities are in the private sector and tend to be rather expensive. Medical aid will only pay for a certain period and requires the motivation of the medical profession. This means that those who are in dire need of treatment may not always be able to afford the treatment. Meyers, Louw and Fakier as well as Myers and Parry (in Temmingh & Myers, 2012) state that non-government organizations where treatment could be provided on a pro bono basis, are not always able to keep up with the demand.

3.2.4 Enter law and order

This chapter is entitled “Law and Order” as it clarifies the manner in which trauma treatment is approached within the realm of addiction from the perspective of Andersen (personal communication, June 21, 2014). Reflecting on her communication, I came to realise that (a) the crossing of our paths brought about some sense of order to my understanding of substance abuse use and addiction; (b) that our discussions provided me with some direction regarding the manner in which people who use drugs and alcohol are perceived and treated; and (c) that there is indeed a synergy between trauma and addiction.

3.2.4.1 Identification of substance abuse and trauma disorders

According to Andersen (personal communication, June 21, 2014) when people are in rehabilitation, they are there for treatment of their addiction first. She makes it quite clear that in the event of any underlying trauma, this has to be addressed as well and possibly again at a later stage

of treatment. Andersen (personal communications, June 21 & September 28, 2014) further adds that trauma counsellors focus on the client abusing substances as a consequence of their trauma (for instance, past childhood traumas or adolescent trauma). This may lead to missing a substance use disorder (hereinafter referred to as a SUD or SUDs) giving rise to the inherent complexities when dealing with trauma and addiction.

She further explains that addiction counsellors focus specifically on the use/abuse of substances first by addressing the mental disease. The identification (by an addictions counsellor) or diagnosis (made by a psychiatrist or physician) working with addiction would thus be the SUD (Andersen, personal communication, June, 21, 2014; September 28, 2014). The diagnosis would be in accordance with the DSM-5 (APA, 2013). By implication, a trauma- and stressor-related disorder would be done in much the same manner.

Andersen (personal communication, September 28, 2014) further expounds that the complexity of addressing SUD in conjunction with trauma is that often patients who have SUD are not identified. This generally tends to occur within a private practice context and often where the client has a need for medication that can be prescribed for the treatment of trauma. The trauma is only attempted to be addressed and not the true extent of the SUD.

3.2.4.2 *Two sides of the same coin*

It is important that the SUD is addressed first in order for the patient to explore and address the trauma effectively. This is regardless of whether the identification is a trauma- or stress-related disorder or a SUD. Patients with comorbid traumatic experiences who are admitted into

treatment centres for addiction are seldom treated for their trauma by trained and experienced trauma specialists (S. Anderson, personal communication, June 21, 2014).

The vast majority of those in rehabilitation centres have trauma issues that need to be addressed whether these are from prior to their substance use or during. Consequently, the very clear link between addiction and trauma as well as unresolved trauma, will result in the client returning to substance use. By the same token, the unresolved substance use will result in the trauma not being addressed (S. Andersen, personal communication, September 28, 2014).

Anderson (personal communication, September 28, 2014) cautions however, that there are rare cases where the trauma is so severe (as a norm she mentioned in comorbid clients) that the client cannot remember most of it. In these instances, it is best to work with the client and not persist in addressing the trauma if the client is functioning well. It is prudent to follow this line of action as failure to do so might result in a complete psychiatric breakdown. Most addiction clients tend to be evasive and are reluctant to reveal their feelings. Counsellors need to assess at all times what is in the best interests of the client and be skilled in dealing with trauma. Usually it is done in a very controlled and specific manner due to the dangers of relapse during this time. Addiction counsellors are coming from the perspective of addressing both the addiction and the trauma in effectively managing the client in a treatment setting (Andersen, personal communication, September 28, 2014).

3.2.4.3 *A word on “debriefing”*

The process of debriefing is used in a number of many ways such as, for example, being debriefed prior to a business meeting. Nonetheless, in the realm of psychological treatment a particular strategy of “debriefing” has been developed by Dr Jeffrey Mitchell (n.d.). He developed a strategy specifically for groups who have been critically traumatised (i.e., firemen, ambulance personnel). The strategy Dr Mitchell developed for group traumatic experiences is known as Critical Incident Stress Debriefing (CISD) (Mitchell, n.d.). The objective of the strategy is twofold: (1) “to normalise group member reactions to a critical incident; and (2) to facilitate their recovery” (Mitchell, n.d., no page number). Bowes, Fikowski and O’Neill state (2007) that Dr Jeffrey Mitchell is the original developer of CISD.

3.2.4.4 *In the best interests of the client*

My understanding of the views of Andersen regarding the differences in counselling approaches simmers down to two points. In the first place, it stands to reason that the frame of reference of a trauma counsellor would be to centre on traumatic experiences while simultaneously considering addiction. Given the presenting problem and subsequent counselling, the possibility of addiction might arise. Secondly, it stands to reason that an addictions counsellor would focus on substance abuse/use behaviour first and then address the trauma. Here again, depending on the circumstances underlying the addictive behaviour of the client and the ensuing counselling, there might be the possibility of some psychological trauma. In the context of their particular professions, training and experience, my understanding of the difference between an addictions counsellor and a trauma counsellor appears to be logical. The client may

present with addiction and trauma or vice versa and, in which case, an identification of comorbidity may be necessary. The crux of the matter is that the client/patient is provided with the most appropriate and effective treatment.

According to Andersen (personal communication, June, 2014, p.2), and I quote verbatim:

Regardless of whether the trauma was present before or during the addiction, an admission to a primary care facility for SUD means that the SUD must be addressed first in counselling and the trauma still needs to be addressed to improve chances for recovery. Nevertheless, trauma is present in virtually all addiction patients and hence the interlinked relationship between the two. Recovery from addiction itself has been likened to the most intense grief process the addicted individual is likely to undergo so the dynamics are present of trauma in [and] of itself within this context.

Andersen's view is substantiated by Bollinger, Read and Sharkansky (2003, p. 111) in that "any assessment of PTSD (posttraumatic stress disorder) should not occur while patients are actively drinking or drugging. PTSD should ideally be conducted after the addicted individual has completed withdrawal." At the end of the day, what we are both alluding to—and we have discussed this ad infinitum—is a coming together of addiction and trauma given the context and status of their occurrences. In her personal communication (June, 21, 2014), she mentioned that this arrangement occurs in some countries like America for instance. I have come across a body of literature on trauma and addiction, most of which

also comes out of the same country (for instance, Carruth, 2006; Dayton, 2000; Miller & Guidry, 2001; Najavits, 2007; Ouimette & Brown, 2003 & Shapiro, 2001). Currently, there is a paucity of literature on the subject matter in South Africa.

As far as childhood or adolescent trauma and addiction is concerned (see Chapter 4), there are a number of views in favour of this connection (trauma and addiction) For instance, Dayton (2000) emphasises the seriousness of trauma that originates in childhood and/or adolescence and the role such atrocities seem to play in the advent and continuance of addictive behaviour.

Trauma-related stress and substance use are described in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013). Firstly I will consider some of the guidelines of substance-related and addictive disorders (SUDs) as provided by the DSM-5. Thereafter, I have taken the liberty of outlining trauma-related stress in accordance with the essence of not only this chapter but also in keeping with the spirit of my research.

3.3 SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

3.3.1 Introduction

The DSM-5 (APA, 2013) differentiates between substance use disorders (SUDs) and substance-induced disorders (SIDs). The former covers symptoms that relate to cognition, behaviour and physiological reactions as a consequence of continued use despite the dangers involved. The latter refers to intoxication, withdrawal and “other substance-medication induced mental disorders” (APA, p. 485). For this research, I have only addressed the former and have added a section on withdrawal and

tolerance of substances. Andersen, in her personal communication of September, 28, 2014, sheds some light on these two aspects of SUDs.

3.3.2 Substance Use Disorders (SUDs)

In the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (APA, 2013), the various substance use disorders are grouped together. These different disorders relate to ten classes of substances of abuse. For the purposes of this chapter, seven of these are mentioned, namely alcohol; cannabis; hallucinogens (phencyclidine/PCP and other hallucinogens such as LSD); inhalants (for instance, glue); opioids (e.g., heroin); sedatives, hypnotics or anxiolytics; and stimulants (for example, cocaine). Caffeine, tobacco and other/unknown substances are not included as they are not necessary for my research. The following sections cover substance use behaviour; change in brain circuitry as a consequence of substance use; and the effects of drugs and alcohol on the human brain.

3.3.2.1 Substance use behaviour

The use of intoxicating substances is invariably characteristic of particular kinds of pathological reactions exhibited by the user. Usually these include a decreased or lack of personal control (impaired control); noticeable weakening in social activities or attitudes (social impairment); taking chances with the use of substances (risky use); and symptoms of tolerance and withdrawal (pharmacological criteria). These behaviours are described below in accordance with the DSM-5 (APA, 2013).

- **Impaired control**

Impaired control of the user is determined according to four criteria. The first condition is when the individual is using the substance in larger

quantities or longer than intended to at first. Next, the individual is always thinking about cutting down and also says that s/he has had many failed attempts in reducing or stopping. The third condition relates to how much time is spent finding the substance, actually using it and getting over its effects. In serious cases, individuals are consumed daily with matters about the substance. Lastly, there is apparent craving for the drug especially when in an environment or situation where the substance was found or taken (known as trigger situations).

- **Social impairment**

Users may experience social weakening as a consequence of substance use. Such situations may arise despite the detrimental impact it has on major areas around work, school or in the home life. Yet despite these impositions on personal and work/school life, the individual may nevertheless continue using substances that serve to worsen their lives. Eventually it may happen that over time, individuals withdraw from family activities or pastimes in favour of substance use.

- **Risky use**

Regular use of substances may sometimes end up in behaviour that is physically dangerous for the user. Even though some individuals are aware that a frequent physical or psychological problem could be related to or even caused by their substance use, they continue using. The bottom line here is that the person may continue using in spite of the physical and psychological dangers involved.

- **Pharmacological criteria**

The two aspects of the criteria are tolerance and withdrawal. The DSM5 (APA, 2013) informs us that the diagnosis/identification of a substance

use disorder is not dependent on tolerance or withdrawal. Nevertheless, these concepts are included here for two reasons: one, for the convenience of the reader; and secondly because these two concepts crop up in most of the literature and also in the vernacular. Case in point, when working with addiction, withdrawal symptoms play a significant role in treatment and recovery.

- **Tolerance**

The tolerance levels tend to change with the use of substances over a period of time. They may find that the substance no longer does the trick nor hits the spot—that is, it fails to achieve the desired effect. It is also important to bear in mind that levels of tolerance varies from person to person. Tolerance also depends on the substances used and their effects on the human central nervous system. The American National Institute on Drug Abuse (n.d.) defines tolerance as a situation in which the user no longer responds to a drug. It also adds that a higher dose is then needed to achieve the same effect.

- **Withdrawal**

Withdrawal symptoms vary depending on the substance used. To illustrate, courtesy of the National Institute on Drug Abuse (2015), an example of the withdrawal symptoms of marijuana is manifested in irritability, difficulty sleeping, strange nightmares, craving, and anxiety. Alcohol withdrawal symptoms may include sweating or an elevated pulse rate (more than 100 bpm); DTs (dementia tremens or ‘the shakes’); insomnia; nausea or vomiting; brief visual, tactile or auditory hallucinations or illusions (seeing, touching or hearing things that are not actually real); psychomotor agitation (restlessness, pacing, tapping fingers or feet, abruptly starting and stopping

tasks, meaninglessly moving objects around, and so on); and generalised tonic-clonic seizures (seizures brought on by stopping) (APA, 2013, Rogawski, 2005 & Drinkaware, n.d.).

The downside of withdrawal is the problematic changes associated with the specific drug ingested. Not only is behaviour compromised as there are also physiological and cognitive problems when the person stops or reduces the drug and/or alcohol. Such conditions may lead to re-use of the substance to reduce the symptoms (APA, 2013). A heroin addict I worked with some time ago was in incredible pain when she stopped using. Sadly, when she returned to the streets, she started using again as she was unable to endure the dichotomous pain. Andersen (personal communication, September, 28, 2014) adds that this is due to heroin being the number one painkiller in the world. Thus withdrawals, and any type of pain associated with withdrawals, leaves the individual experiencing incredible pain that only more of the drug itself can bring relief.

3.3.3 Change in brain circuitry

One of the most serious dangers of SUDs as cited in the DSM-5 is a change in brain circuitry (APA, 2013). This serious and damaging change is also reified by the American Society of Addiction Medicine (ASAM) (2011). Once the damage to the brain is done, it cannot be repaired even after the person has stopped using. This significant change in the brain is also highlighted by Andersen (personal communication, 2014) as well as a number of other experts in the field of addiction (for instance, Kulewicz, 1996; Lewis, 2013 & White, 1998).

As mentioned above, in 2011, the American Society of Addiction Medication (ASAM) defined addiction as “a primary, chronic disease of brain reward,

motivation, memory and related circuitry.” From a personal point of view, my understanding of addiction was that it was a problem with self-control. The first time I heard that addiction is related to a problem with brain circuitry was at an addictions course I went to a few years ago. The course was co-hosted by Andersen and facilitated by an invited addictions specialist from the United Kingdom (personal communication, June 21, 2014).

3.4 TRAUMA-RELATED STRESS DISORDERS

3.4.1 Introduction

Carl Rogers (1951) is well known for his view of human nature as unique individuals. Our misfortune in the aftermath of traumatic or stressful events does not seem to have escaped his view of what it is to be mortal. The likelihood that we react differently in response to such events is perhaps synonymous with our genotype. Conversely there appears to be some common ground in our overt behaviour. Congruent with our phenotypes, human behaviour is generally observable to see or hear—traumatised behaviour is most likely to be no exception.

Since most people are familiar with posttraumatic stress disorder (PTSD), I have concentrated particularly on the symptoms related to this identification. Furthermore, the focus is more on the symptoms of adults rather than those of children (6 years and younger). The reason for this is because my dissertation is mostly about adults within the gambit of addiction and trauma. There is no doubt that children do become traumatised in many ways yet it is unlikely that they could be addicted at a tender age. Dayton (2000) has written about children who were traumatised as toddlers or older. Later on in life, perhaps during

adolescence or adulthood, they unwittingly find themselves drugging and drinking for no apparent reason.

3.4.2 Symptoms of posttraumatic stress disorder (PTSD)

There is a proliferation of websites offering explanations of the symptoms of PTSD. I have homed in on Smith and Segal (2014) who have neatly grouped the symptoms into three main types of PTSD that are, in my view, easy to read and understand. These types are re-experiencing the traumatic event; avoiding reminders of the trauma; and increased anxiety and emotional arousal. Each are accompanied by their own set of symptoms and for all intense and purposes can be termed sub-symptoms. The groupings or clusters have been augmented with supportive data from the DSM-5 (APA, 2013).

3.4.2.1 Re-experiencing the traumatic event

Intrusive, upsetting memories of the event; flashbacks (acting or feeling like the event is happening again); nightmares (either of the event itself or of other frightening things); feelings of intense anguish when reminded of the trauma; and intense physical reactions to reminders of the event (e.g., pounding heart, rapid breathing, nausea, muscle tension, sweating) (Smith & Segal, 2014). Upsetting or distressing memories are what the DSM-5 (APA, 2013) refers to as intrusion symptoms that may be noticeable after experiencing something traumatic. Similarly, flashbacks in the DSM-5 (APA, 2013) are known as dissociative reactions.

3.4.2.2 Avoiding reminders of the trauma

Survivors of traumatic experiences tend to engage in behaviour such as avoiding activities, places, thoughts, or feelings that are reminders of the trauma; unable to remember important parts of the trauma; loss of interest

in activities and life in general; feeling detached from others and emotionally numb; and a sense of a limited future (for instance, not expecting to live a normal life span, get married, have a career) (Smith & Segal, 2014). The DSM (APA, 2013) cites avoidance behaviour, or at least attempts to do so, concerning any memories, thoughts or feelings about the trauma. When people are not able to remember important parts of the trauma, the DSM put this down to negative changes in cognitions or mood as a consequence of their traumatic experiences (APA, 2013). Recall that Andersen mentioned (personal communication, September 28, 2014) that patients who come into rehabilitation centres have minimum recall of their traumatic experiences.

3.4.2.3 Increased anxiety and emotional arousal

As far as increased anxiety and emotional arousal are concerned, Smith and Segal (2014) explain that these reactions can be seen in difficulty falling or staying asleep; irritability or outbursts of anger; difficulty concentrating; hypervigilance (on constant “red alert”); and/or feeling jumpy and easily startled.

3.5 ADDICTIONS COUNSELLOR TRAINING

3.5.1 Introduction

In 2009, Andersen (personal communication, June, 21, 2014) was offered an opportunity to develop a centre in Durban. At this centre, she decided to continue training opportunities for professionals wishing to specialise in the treatment of addiction. She invited an international, highly qualified trainer from the United Kingdom to come and kick-start this venture in Kwazulu-Natal. She had done something similar in Cape Town where she ran a rehabilitation centre as well as training for many years. Below is

her view of addiction counsellor training in South Africa (personal communication, September 30, 2014).

3.5.2 Becoming an addictions counsellor in South Africa

Training to becoming a qualified accredited addiction counsellor, which is very different to those with postgraduate degrees looking to specialise in the field, is very limited within South Africa. The vast majority of the training is currently provided by rehabilitation centres, colleges and private individuals, all specialising within the field. Courses towards accreditation points that are accredited with Health Professions Council of South Africa (HPCSA) are few and far between. Courses offered on different levels catering for those wishing to become accredited and those who are looking to specialise and use the courses for ongoing Continuing Professional Development (CPDs), even more so.

Numerous advertisements of addiction counselling courses—some from so called reputable organisations, continue to circulate promoting qualification as an addictions counsellor. However, their study courses offer no accreditation with the HPSCA. Notwithstanding, a number of courses and boards operate without the proper support from the sectors in South Africa. Currently, one should be accredited by a reputable study board which does not only involve study online but offers classroom hours, supervision and practical hours. These standards are necessary in order to be considered as an accredited addictions counsellor. International accreditations often are a professional accreditation not limited to "lay counsellors." They also include other professionals such as social workers, registered counsellors and psychologists looking to specialise within this field (Andersen, personal communication, September 28, 2014).

According to Andersen (personal communication, September 28, 2014), certification as professional addiction counsellors in the United Kingdom can register with the Federation of Drug and Alcohol Professionals (FDAP) or the United Kingdom Professional Certificate Board of Alcohol and Drug Counsellors Certificate (UKPCBADC). In the United States of America, interested individuals can apply to the Association for Addiction Professionals (NAADAC). Once they graduate, candidates can register with the relevant Counsellor and Psychotherapy Boards. The accreditation has to be lodged with a reputable Board accepted by the Mental Health Professionals within the respective country. This is the vision for the South African Board which is currently in the process of obtaining these supports and inclusions. Andersen (personal communication, October 6, 2014) advises that this is currently a work-in-progress.

Addiction Consultancy and Training including Trauma (ACT) may be one of the only organisations to have their courses accredited through the University of Pretoria in conjunction with the Health Professions Council of South Africa (HPCSA). ACT offers courses that are delivered on different levels of expertise. The organisation currently follows the correct procedures to obtain inclusion and support into the mental health system within South Africa. This process, including development of courses and accreditation, is to ensure that addiction counsellors are recognised by the mental health system and government departments. Furthermore, it serves to create a Board for the addiction counsellor profession as well adherence to ethical considerations.

The very first addiction counsellors to be accredited in South Africa in 2000 was processed through NAADAC (National Association of Alcohol and Drug Abuse Counsellors). NAADAC is a certification and accreditation

board based in the United Kingdom which subsequently became the Federation of Drug and Alcohol Professionals (FDAP). This organisation remains linked to the NAADAC in the United Kingdom. The training was largely driven by Dave Goodlad, co-owner of one of England's largest health care providers, Triage Healthcare. Goodland, a true pioneer in South Africa on the development of the addiction counsellor profession, spent some time in this country driving training and expertise in the field of interest.

The classroom training and practical experience is over a 3-year period. This included a vast amount of classroom study hours; modules with practical exercises; assignments and essays; study supervision; a practical internship and supervision of individual counselling; group work and family conjoint normally facilitated by clinical psychologists, including external supervision. Included in the final application (notwithstanding the abovementioned), is a philosophy essay as well as an extensive case study. This set the stage for a gruelling oral examination, spearheaded by three examiners—one international and two local, all experts in their field.

At this time there are eight addiction counsellors in South Africa who qualified for their accreditation and became internationally recognised. Many of them obtained reciprocity from the United Kingdom Professional Certification Board of Alcohol and Drug Counsellors (UKPCBADC) who operate according to the United States of American standards offered by the International Certification and Reciprocity Consortium (IC&RC). In essence, the standards set were based on both United Kingdom and United States international levels, setting a solid framework for further development within the country.

These boards require ongoing supervision, continued professional development hours including ethics in order to maintain and uphold the qualification as well as the profession. This appears to be rather similar to the standards required for registered counsellors within South Africa. The ethics and standards of practise are similar in nature and require a marrying of the standards of practise and ethics set out by the Health Professions Council of South Africa (HPCSA).

Addiction counsellors are looking to be recognised professionals within the mental health professional system in South Africa to allow for correct billing, monitoring and regulatory process. This arrangement could possibly be in keeping with the HPCSA protocol of the category of registered counsellors.

3.5.3 Addiction and trauma specialist courses

Over the years, ACT (Addiction Counselling and Training and Trauma) has developed specialist courses covering addiction and trauma which have been accredited for Continuing Professional Development (CPD) points through the University of Pretoria. These courses are specifically designed for those wishing to specialise in addiction and trauma as well as for individuals wishing to gain accreditation as addiction counsellors. A central feature of the training is based on the work of Kulewicz's Twelve Core Functions of a Counselor (1996) as well as group psychotherapy (Yalom, 2005).

3.6 CONCLUSION

Given the oscillation between addiction and trauma, one cannot be worked on without addressing the other. This seemingly robust bond between the two may be apparent from addicted individuals who, in their stories, often

cite how they have consumed more substances as a consequence of traumas evident either pre- or during addiction. According to Andersen in her personal communication of June 21, 2014: "I have a high level of interest in the relationship between the two (addiction and trauma). More and more, I am seeing international research and other professionals also leaning in the same direction to treat addiction effectively. Whilst this may be used in the context of "any reason will do", it nonetheless plays an important driving factor."

Chapter 4

CIRCLE OF FRIENDS

4.1 INTRODUCTION

Each of the unique stories in this chapter is about the personal experiences of the research participants. Their involvements around addiction and trauma herald in circumstances that may intermingle in some uncanny ways. Some stories are about those who have experienced trauma that gave rise to substance use. Others are clearly based in the camp of addiction with not much thought given to any specific trauma in their lives. In terms of the latter, I picked up some implicit experiences of trauma and have included these here.

4.2 BRAD

4.2.1 Background

This case is about a young man's past shenanigans with alcohol, narcotic drugs and prescription as well as over-the-counter (OTC) medication. It is also about his long walk to freedom from his addiction to these substances of abuse. From as far back as he can remember, Brad says that he has always been an anxious and fearful individual. To date, he has been a recovering addict for over six years and is an active member of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). He religiously follows and adheres to each of their 12-step philosophies (Appendices A and B). Brad claims that he has not experienced any traumatic incidents. However, at a later stage he recalled some of his experiences that sounded traumatic.

In retrospect and in keeping with the American Society of Addiction Medicine (2011), Brad believes that his addiction is a disease. He also believes that such an addiction can creep into just about every facet of one's life, particularly family life. Families tend to become inextricably affected and involved in one way or another. Like most families who have an addict in their midst, Brad and his family seem to be no exception.

4.2.2 Family support

Brad is the youngest of three siblings and hails from a stable, staunch Catholic family background. For the most part, his family were supportive of him while he was using and tried their level best to help him. When things got drastically out of hand, his older brother (the eldest sibling) became less supportive and basically wrote Brad off. His older sister of four years remained faithful to him until towards the end when his addiction had reached an all-time high.

He always thought of his sister as a soft and loving person and was shocked when she gave their mother an ultimatum. His sister dictated that she (their mother) had to choose between him and her. Brad didn't think this was fair as he felt that this put his mother in a rather "horrible position". He admits that his mother was probably a typical enabler and she never gave up on him. Brad didn't say anything specific about his father being an enabler. However, he mentioned that his father came to his rescue whenever he was in serious trouble with his drug taking.

4.2.2.1 Enablers

Enabling behaviour is generally associated with a relationship between an addict and another person. The enabler, in all good faith, identifies with

the behaviour of the addict to help him or her on the road to recovery. The practice of addiction-enabling behaviour appears to hijack the addict's ability to ultimately take control of his or own life to become clean and/or sober. This is the primary reason that enabling is not recommended during the recovery process. Another term for the enabler is a co-dependent and, in the context of addiction, these individuals try to solve the addict's problems by assuming their responsibilities. Co-dependents tend to feel guilty when they do not help addicts (Drug Abuse Treatment, n.d.; Lancer, 2013; Navarra, 1995).

4.2.3 The rocky road to addiction

Brad started experimenting with alcohol from the early age of 8. His drinking continued and escalated into his adolescence and early adulthood. When he was younger, he realised that he was quite an anxious and fearful individual which gave rise to his low self-confidence. When he drank he felt much better about himself and hence, more self-assured. Alcohol seemed to give him what most people know as "Dutch courage". This seemingly well-known English colloquialism refers to the use of alcohol to bolster courage and confidence (Byrne, 2013).

Brad explained that his addiction completely over-powered him. Where his friends stopped using drugs after they got caught in possession, he continued to pursue and use irrespective of the dire consequences. He stole from his parents and from random strangers. His need for a hit was so powerful that he would literally do anything to get and use drugs. There were times when he even thought of selling himself to support his habit.

Brad's self-confidence with the opposite sex, fearful of them when sober, grew greatly while under the influence. On the downside of his

relationships, he reflected that he tended to be needy. He thought of himself as being addicted to and obsessed with his partners—as we shall see in Relationship One.

4.2.4 Relationship One

It was during this relationship that he graduated from alcohol to hard drugs. Mandy, the girl he hooked up with was apparently abused as a child and was gang raped. According to Brad, at 16, she was a full blown crack cocaine addict. He was in an 8-year roller-coaster relationship with her and they did drugs from the day they first met. He confessed that he became obsessed with her and crack cocaine.

During this romantic, cocaine-infused relationship, Brad felt that Mandy became like a drug as well. In the long run, he sensed that his obsession with her pushed her way because he was so needy. He described her as a very pretty girl and she made him feel good about himself. She was for all intents and purposes his fix which he acknowledges was not a healthy place to be in. His need for crack cocaine seems to have been equally damaging given the effects of its addictive psychoactive effects.

4.2.4.1 *Effects of crack cocaine*

Crack cocaine is known to be more addictive than cocaine powder (Drug Aware, n.d.a; NIDA—National Institute on Drug Abuse, 2013) and just about as habitual as Brad’s pull to this particular relationship. It is a stimulant drug which means that, like all drugs, it has an effect on the brain. It increases the levels of the neurotransmitter dopamine that controls pleasure and movement. Use of the drug typically results in hyperactivity, high levels of energy and a reduction in inhibitions (NIDA, 2013). A

reduction in inhibitions is exactly what the doctor ordered for Brad—at least while Relationship One lasted.

4.2.4.2 *Relationship One breaks up to make up*

Sadly, when this relationship broke up, Brad took more drugs to ease the pain of his loss. Mandy started seeing another guy who was a heroin addict and she also started using heroin. Brad still hankered for her and had difficulty letting go of her. As a consequence, he tried to sabotage her relationships. He had also come to the realisation that he struggled to function effectively without her. Eventually he got her back which was his plan all along. When she called him to say she was struggling with heroin withdrawal, he instantly came to her rescue. She played right into his hands.

4.2.4.3 *An up-grade to heroin*

Whilst Relationship One got back on track, Brad's life took on a rather hazardous detour. Within one week of his reconciliation with Mandy, he was using heroin as well. Brad ruminates that heroin grabbed his life almost instantaneously. It was as quick as the snap of one's fingers. At the time when he first started using the drug, he vowed he would never take heroin intravenously. To begin with, he smoked heroin and then graduated to snorting over a period of about two to three years.

Despite Brad's adamant vow that he would not take heroin by means of the injection method, things changed for the worse. Brad and his girlfriend met a guy who was using intravenously and he showed them the way. After that there was no going back according to Brad. His girlfriend, who subsequently broke up with him, shared needles with guys who were gay prostitutes. He is baffled as to how he never contracted

HIV. Reflecting on his experiences, he shares that if ever there was a candidate for HIV, it would be a gay prostitute. People who inject drugs (known as PWIDs) are at risk of contracting Hepatitis B virus (HBV) and Hepatitis C virus (HCV) infection (Centres for Disease Control and Prevention, n.d.; NIDA, 2014).

Apparently the person that “showed him the way” with injecting heroin wasn’t even gay and Brad reflected on how far his addiction had gone. According to Brad, the person in question was sleeping with guys left right and centre to fund and feed his addiction. He said that he was willing to share a needle with this person and didn’t even bat an eyelid about the risks involved. At the time there was only one syringe and he desperately needed a hit. He was not prepared to snort the heroin because it was a waste of time and it would not be potent enough. From Brad’s disturbing experiences one gets an inkling of how the effects of heroin can take control of one’s life.

4.2.4.4 *Effects of heroin*

Heroin is a downer which means that it slows down the activities of the brain. When used intravenously, the user first experiences a sense of euphoria (a “rush”) followed by wakeful and drowsy states (the person goes “on the nod”). Short-term effects include slowed breathing; clouded mental functioning, nausea and vomiting; sedation and drowsiness; hypothermia (body temperature is lower than normal); and possibly a coma or death (due to an overdose) (Drug Aware, n.d.b).

The use of heroin over a long period includes bad teeth; inflammation of the gums; constipation; cold sweats; itching; weakening of the immune system; coma; respiratory illnesses; muscular weakness; partial paralysis;

reduced sexual capacity and long-term impotence in men; menstrual disturbance in women; inability to achieve orgasm (women and men); loss of memory and intellectual performance; introversion; depression; pustules on the face; loss of appetite; and insomnia (Foundation for a Drug-Free World, n.d.c; NIDA, 2013).

4.2.5 A horrible parting with heroin

This is what Brad had to say about withdrawal from and craving for heroin: “The craving really seems to set in once you are physically dependent. With me, it was the way I felt when I was off it. The withdrawal symptoms started to develop and that’s when the craving really sets in and the physical pain that you feel. Some describe it (the craving) as a bout of the ‘flu but this doesn’t really do justice to it. Everything cramps out; your muscles shorten; you have a fever; you feel cold and hot at the same time; you can’t have people touch you; you are over-sensitive; deep depression sets in; and it really is a horrible feeling.”

4.2.5.1 Heroin withdrawal symptoms

The withdrawal symptoms of heroin include restlessness, aches and pains in the bones, diarrhoea, vomiting and severe discomfort (Foundation for a Drug-Free World, n.d.c; The Naked Truth), n.d. I have spoken to a number of people who were trying to come off heroin and all of them vividly described the severe agony they experienced with withdrawal symptoms. Table 4.1 summarises the early and late withdrawal symptoms associated with coming off heroin.

From time to time, methadone or buprenorphine (Subutex) (U.S. National Library of Medicine, n.d.a) is prescribed for opioid management treatment

(OMT) to alleviate the pain of withdrawal symptoms (Havnes, Clausen & Middlethorpe, 2013). The human brain understands modern medicine such as methadone as the morphine molecules of methadone produces heroin and codeine (Earley, n.d.). What this means is that prescribed medication such as methadone mimics the effects of heroin. This is how the OMT seems to work for those wishing to stop using heroin. Bourgois (in Havnes et al, 2013) believes that one cannot morally ignore someone who is “dopesick” and who is clearly in need of help. At the end of the day, there is no doubt that coming off heroin is painful but it is not fatal (U.S. National Library of Medicine, n.d.a).

It would appear that the most common form of treatment for opiate dependency (such as heroin) is methadone that is taken orally (in liquid or oral form) and preferably prescribed by medical doctors (Li, 2015; Metrebian, Shanahan, Wells & Stimson, 1998; WebMD, 2014).

4.2.6 Transition from heroin to prescription medication

In one of his rare attempts to give up, Brad went to see a doctor who introduced him to methadone and tranquillisers. One of the most effective

Table 4.1 Heroin withdrawal symptoms (U.S. National Library of Medicine, n.d.b)

EARLY SYMPTOMS	LATE SYMPTOMS
Agitation	Abdominal cramping
Anxiety	Diarrhoea
Increased tearing	Dilated pupils
Insomnia	Goose bumps
Runny nose	Nausea
Sweating	Vomiting

effects of methadone is that it helps with the painful withdrawal symptoms of heroin as mentioned previously (Smye, Brown, Varcoe & Josewski,

2011; Weich, 2010; Weich, Perkel, van Zyl, Rataemane & Naidoo, n.d.). While the methadone worked for Brad, regrettably the prescribed tranquillisers backfired. Ultimately, he confessed that he became a prescription junkie as he became addicted to the notorious benzodiazepine, Valium. His usage reached an all-time high when he was taking up to 30 tablets a day. On reflection and speaking from his experience, getting off medication (i.e., Valium) and OTC drugs (for instance, certain cough mixtures) is way harder than coming off heroin.

According to SACENDU (the South African Community Epidemiology Network on Drug Use, in Weich et al., n.d.), between 4% and 12% of patients in addiction centres are treated for their OTC or prescribed medication misuse. This type of abuse can either be their primary or secondary choice of medicines (for example, codeine and dextropropoxyphene that contain analgesics, cough mixtures, paracetamol). These medications were Brad's primary choice as he was no longer using heroin. In South Africa dextropropoxyphene (an opioid analgesic/painkiller) is manufactured by the pharmaceutical company Aspen Pharmacare and marketed as Dolene (Drugs.com, n.d.). Alternatively dextromethorphan, a synthetic cough medicine is a safer option as it has no analgesic action and therefore is less likely to be abused (Li, 2015).

4.2.7 The final straw

Brad had hit rock bottom when he finally decided that he would once again, check himself into a rehabilitation facility. He managed to stay clean for ten months which was the longest stretch of his abstinence. He was feeling really good about his achievement and so were his parents. During the first year of his sobriety, he was advised by his sponsor to stay away from relationships which he duly did. He had also

seen for himself that when recovered addicts get involved in a relationship and it goes belly up, they tend to relapse. His sponsors repeatedly warned him that if he did get involved in a relationship and it went sour, he too would be at risk of returning to a life drugs. Brad didn't heed this advice and before he knew it, he was in serious trouble. Enter Relationship Number Two.

4.2.8 Relationship Two

Brad met a girl who lived some distance away from his home. One Friday evening he got on a bus and went to spend the weekend with her. According to him, this girl loved going out and drinking. He used to go with her but he didn't drink any alcohol. He seems to have been aware that going to a pub could be a trigger that could lead to relapse. He didn't trust his girlfriend and decided to ride with the risk. He escaped temptation on this occasion.

4.2.8.1 *The fatal pharmacy*

The next day Brad's girlfriend went to work but Brad didn't really want to go with her. He would have preferred to stay at her house but she didn't trust him. So he capitulated and ended up walking around a mall wondering what he was going to do for the next six hours. He was at a loss and unsure as to what to do with himself. He was also terrified until he saw a pharmacy, upon which he decided to buy a few bottles of cough syrup.

Brad tried to argue with himself but the decision was already made. He walked around the pharmacy about three or four times and eventually went in and bought two bottles of cough syrup. He then went to a restroom and drank the potion and as soon as he had drunk them, he

felt terrible. He figured that the only way to feel better was to go and buy more but the pharmacist would not sell him anymore. Things got worse from here on out.

4.2.8.2 Bathroom blitz

After his girlfriend finished work they went back to her place. He knew she had a bathroom cabinet full of tranquillisers and when he got home, he got stuck into them. He went into a complete blackout and when he came out of the bathroom, he came head-to-head with her parents who had just arrived from overseas. His girlfriend screamed at him and told him to get out and somehow, he managed to send a garbled message to his parents who came to fetch him. He felt incredibly guilty and that was the last time he touched any drugs. Brad has given up all drugs including smoking cigarettes. His journey to sobriety has been far from a walk in the park.

4.3 COUCHED TRAUMA

Despite the fact that Brad believed he was free of any specific traumatic life episodes, I did pick up on some of his harrowing experiences.

4.3.1 Driving under the influence

Brad was also in a car accident in which, by all accounts, he could have been killed. At the time, he was driving under the influence of Valium and on his way to score some heroin. To this day, he says he has absolutely no recollection of the accident and he is stunned that he sustained no injuries—not a scratch. The car, on the other hand, was a right off.

4.3.2 Drug-induced stroke

After another one of his many heroin and prescription and/or OTC

medication binges, Brad had a drug-induced stroke. It took some time before he could walk properly again. Recall that one of the long term effects of heroin is partial paralysis complicated perhaps by prescription and/or OTC medication.

4.3.3 Heroin overdoses

Brad experienced a number of heroin overdoses and one in which he almost died (NIDA, 2014). The prognosis for recovery from cerebral or brain hypoxia depends on how long the organ has been deprived of oxygen and the extent of the damage. The longer the person is unconscious, the more likely the person will die or suffer brain death (National Institute of Neurological Disorders and Stroke, n.d.). Brad is very much alive.

Darke and Zador (2006) contest that heroin alone is not entirely responsible for overdose deaths. Their study suggests that other central nervous system depressants such as alcohol and benzodiazepines together with heroin may also be responsible for such deaths. Fortunately Brad lived to tell the story of his heroin, alcohol and benzodiazepine days.

4.3.4 Kidnapped and held to ransom

Brad was kidnapped by his drug dealers for not paying his bill. They threatened to kill him if he didn't settle his account immediately. Somehow during his drugged haze, he managed to text his dad who, at 4 in the morning, came to pay the dealers and rescue his son. Anyone else in their right mind may well have experienced being kidnapped as traumatic, but no, not Brad. Brad was also at risk of contracting HIV/Aids when he shared a needle to shoot heroin into his system.

4.4 LIFE AFTER ADDICTION

Brad believes that addiction seems to creep into other areas of one's life. The two particular areas he cites are his obsession with relationships and exercise. He says that moderation is not in his vocabulary. Although he needs to have a relationship to feel real, he is learning to accept himself as he is. To date, he has not had a relationship in over two years and he is grateful to his family and sponsor for their incredible support.

Recall in the beginning I mentioned that Brad is currently in gainful employment? He works at a gym where he became qualified as a personal trainer. Brad finds this rather ironic as during his school days, he had absolutely no interest in sport or any physical exercise.

During the past, Brad felt that he was very self-absorbed with little regard for others. Part of his own recovery is to help others and he does this by sharing his story and sponsoring other like-minded recovering addicts. He has come a long way and his journey was and continues to be far from easy. Brad believes that his addiction has been instrumental in shaping who he has become today.

4.3 LILLY

4.3.1 Background

Lilly is a 30-year old female who was addicted to drugs and alcohol. When I first met her she had recently (3 days) given up alcohol by going cold turkey but was still using "weed" (cannabis). Prior to our meeting, she was staying with friends who had given her a job and somewhere to stay. When they noticed that she was drinking excessively

they encouraged her to get help. Lilly did her homework and found the Centre where we ultimately met.

4.3.2 Family and friends

Lilly is an only child and is adopted and by all accounts, she had a close relationship with her parents. Strangely enough, she didn't say much about their views about her addiction. She openly admits that she wanted for nothing and that her parents doted on her. All through her rebellious teenage days, they stood by her. They made no comments about the friends she had and whether they knew they were into drugs seems to be a mystery. From about 16, Lilly did just what she wanted. She spent considerable time with her friends and was using ecstasy and weed. In these early days, alcohol was not on her menu.

During the time we spent together, she talked about how much she missed her parents. Lilly was very concerned about her mother as she was not well. She planned to visit her and eventually she did in spite of the distance she had to travel. Her mother reciprocated and visited Lilly in the city. Her father is deceased.

4.3.3 The tragic death of a loved one

Sadly, Lilly's father was murdered outside the family restaurant and his sudden and violent death was devastating for the family. She was 18 at the time and had been taking drugs but she was not drinking alcohol. She felt that her father's untimely death led to an increase in her drug usage. The unfortunate death of a loved one and particularly the nature of the death, can sometimes trigger an increase in or an escape to substance use (American Psychiatric Association, 2013; Zinzow, Rheingold, Hawkins, Saunders & Kilpatrick, 2009).

4.3.4 Lilly's drugs of choice

Lilly's declaration on her drug use goes something like this: "I have done most drugs except heroin." She didn't elaborate on her reason for not using the latter and I didn't press the issue. The drugs that Lilly used included her infamous alcohol, crack cocaine, crystal meth, ecstasy and weed. The effects of crack cocaine are described in more detail in the next story in Table 4.2. A brief introduction of Lilly's other drugs of choice and their effects are discussed below. She used the term "weed" (as many people do) to refer to cannabis and from here on, I will refer to the drug in the same way.

4.3.4.1 Alcohol

Lilly's first choice of drugs was not alcohol. The most important reason I started with a discussion on her alcohol misuse is because it was the problem she presented with. There are four specific areas I would like to share with the reader. Firstly, the effects of drinking alcohol; then how alcohol affected Lilly's health; followed by alcohol withdrawal; and finally, the dangers of self-detoxification or "going cold turkey".

- **The effects of alcohol**

Pietrangelo (2014) provides a useful synopsis of the enormous effects alcohol has on the human brain and body. The long and the short of it is that alcohol used in abundance can lead to pancreatitis; severe strain on the liver; diabetic complications; slurred speech; clumsy attempts at walking straight; impaired judgement because of brain shrinkage; blackouts where parts are missing from memory; strange sensations such as numbness and pain in the hands and feet; involuntary eye movements; hallucinations especially from withdrawal; dependence; serious mouth problems; stomach problems; malnutrition; a damaged digestive tract;

damage to the heart rhythm; anaemia; sexual dysfunction; infertility; birth defects; thinning bones that fracture easily; muscle cramps; and lung infections such as tuberculosis.

- **How alcohol affected Lilly's health**

The effects of alcohol consumption on Lilly's health I believe were manifested in a number of ways. She had asthma and a chest infection at the time of the interview and she needed medication. She was skinny and over the month or so when she was sober, she managed to put some meat on her skinny skeleton.

- **How alcohol affected Lilly's health**

The effects of alcohol consumption on Lilly's health I believe were manifested in a number of ways. She had asthma and a chest infection at the time of the interview and she needed medication. She was skinny and over the month or so when she was sober, she managed to put some meat on her skinny skeleton.

On one occasion she met a friend and drank alcohol. It wasn't supposed to happen but it did. In the Centre where she was being rehabilitated, this behaviour was strictly forbidden and she was given her first warning. She drank again and subsequently checked herself out of the Centre leaving us no time to continue with her treatment.

- **Going cold turkey**

The phrase "going cold turkey" has a number of meanings but in the addiction world it generally refers to the severe withdrawal symptoms of coming off drugs and/or alcohol suddenly and quickly. When addicts are going through these symptoms, their blood goes to their internal organs. As a consequence, their skin becomes lighter and goose bumps appear

in much the same manner as the carcass of a turkey—hence cold turkey (Leogetti, 2005; Martin, 1996-2014).

Going cold turkey seemed to appeal to Lilly. She was really scared that her drinking could lead to taking hard drugs again and that she would end up killing herself in the process. It seems for her that desperate times called for desperate measures and she went cold turkey to bring her run-away obsession with alcohol under control. In our first session, we talked about the dangers of alcohol withdrawal symptoms and self-detoxification (i.e., going cold turkey). Then we looked at the 12-step programme of Alcoholics Anonymous (AA) (Appendix A). The next step was to start going to Alcoholics Anonymous (AA) meetings. We actually went to visit an AA site very shortly thereafter and Lilly was given the AA Big Blue Book.

- **The danger of going cold turkey**

The literature seems to indicate that the choice to go cold turkey with the intention of giving up alcohol is not a wise decision (Addiction Blog.Org., 2011). In fact it seems as if it is a dangerous choice and that proper detoxification is a smarter and a less life-threatening option.

When people like Lilly chose to go cold turkey for alcoholism, they are more than likely to experience what is known as Alcohol Withdrawal Syndrome (AWS). The exhaustive literature (for example, the NHS Foundation Trust, n.d. in London, UK) on AWS describes the symptoms that manifest when a heavy drinker completely stops drinking or significantly reduces alcohol consumption. There is a combination of physical symptoms such as nausea and fatigue and emotions such as anxiety that varies from mild to severe. According to Laffan (2013),

additional signs and symptoms could be anorexia; chills; craving for alcohol; muscle cramps; irritability; palpitations; excessive sweating; tachycardia; hypertension; lowgrade fever; impaired gait or motor skills; and mood or mental changes.

Severe symptoms of AWS are hallucinations and seizures and at the most extreme, AWS is life-threatening. When the symptoms are mild, it is best to seek medical treatment as the initial symptoms can worsen rather rapidly. It is also very important to see a doctor if there are infections such as heart disease, lung disease or a history of seizures (Finn & Crabbe, 1997; Karriem-Norwood, 2013).

4.3.4.2 *"I am Meth"*

I destroy homes, I tear families apart
I take your children and that's just the start
I'm more costly than diamonds, more precious than gold
The sorrow I bring is a sight to behold
If you need me, remember I'm easily found
I live all around you—in schools and in town
I live with the rich, I live with the poor
I live down the street and maybe next door
I'm made in a lab but not like you think
I can be made under the kitchen sink
In your child's closet and even in the woods
If this scares you to death, well it certainly should
I have many names but there's one you know best
I'm sure you've heard of me, my name is crystal meth

This poem was originally written by a young Indian girl who was in jail for drugs and who was addicted to crystal methamphetamine (crystal meth). After she was released from jail, "the meth" hooked up with her once again and she ultimately died from an overdose. There are a number of sites on the Internet with this poem and I have chosen the Snopes.com (n.d.) to reference this haunting story of how crystal meth can ruin lives. Although the poem is much longer than quoted here, I

only included the first 14 lines as they bring the message home quite clearly.

- **What is crystal methamphetamine?**

Returning to the drug itself, most of the data I found about crystal methamphetamine comes from the Foundation for a Drug-Free World (n.d.a). As a matter of interest, the dreaded drug was first discovered in Japan in 1919 (Science in Africa, 2005). Crystal meth (including the drug ecstasy—see below) is reputedly drugs used to rave and party throughout the night. People who use this drug become hooked almost instantaneously making it the hardest addiction to treat. The devastating consequence is that users can die from using this drug.

- **Tik/crystal meth**

Crystal meth is a form of the drug methamphetamine (METH) which is a stimulant drug that is highly addictive. In South Africa, the street name for crystal meth is tik. It has been given this name because of the sound the crystals make when they are lit (Smart Cape, 2010). According to Volkow and others (in Hadlock, Chu, Walters, Hanson & Fleckenstein, 2010), crystal meth is associated with motor slowing or psychomotor retardation as well as memory loss. Reber, Allen and Reber (2009, p. 636), define psychomotor retardation as “a general slowing down of motor action, movements and speech”.

- **The effects of crystal meth**

The short-term of effects of crystal meth includes disturbed sleep patterns; hyperactivity; nausea; delusions of power; increased aggressiveness; irritability; insomnia; confusion; hallucinations; anxiety and paranoia. The drug can also cause convulsions which might lead to death. Users lose

their appetite for food when they use the drug resulting in weight loss. When higher doses are used and after the ensuing “rush” is over, tension and sometimes violence follows.

The long-term effects of the drug are equally as damaging as the drug adversely affects heart rate and blood pressure. There is also damage to the blood vessels in the brain that could lead to a stroke or irregular heart beat and cardiovascular problems. This impairment could result in collapse or even death. In addition, the drug can damage the liver, kidneys and lungs as well as pose a serious risk of damage to the brain (i.e., memory impairment and an inability to understand abstract thoughts (Foundation for a Drug-Free World, n.d.a).

4.3.4.3 What is ecstasy?

The word ecstasy itself is defined as being in a state of intense joy or delight (Free Dictionary, n.d.). What the drug ecstasy does to the human mind can be described in much the same way. In order to demonstrate this comparison, I have once again drawn on the data provided by the Foundation for a Drug-Free World (n.d.b). Since the 1970s and into the 80s, ecstasy has earned a reputation as being a party or a rave drug (like crystal meth). The drug enables users to dance through the night and is reputed to improve mood states. Both crystal meth and ecstasy are known in the narcotic fraternity as uppers or stimulants. In its original, chemical form it is known as MDMA (3, 4methylenedioxymethamphetamine).

On the street, it has numerous names such as E, XTC, and so forth. It is listed as a Schedule I drug—pitching the drug in the same ranks as heroin and LSD/acid (lysergic acid diethylamide) (NIDA, 2006).

4.3.4.4 Weed and its effects

Before Lilly checked into the Centre for the first time, she confesses that she had “a big, fat joint.” Weed, dagga, cannabis and marijuana are one and the same drug and I use the terms interchangeably. As mentioned in Chapter 1, it is common knowledge that cannabis is an illicit drug in most countries. What I also wrote about in the same chapter is that in South Africa an attempt to legalise dagga was spearheaded by the Inkatha Freedom Party (IFP) MP, Mario OrianiAmbrosini. The MP was diagnosed with stage four cancer and canvassed that if marijuana was not legalised for medical reasons “it would be a crime against humanity” (SAnews, n.d.). Sadly, the MP passed away some time after making this statement. South African news sources reports that the MP had "decided to end his long battle" with cancer (Sapa, 2014, no page number).

- **THC (tetrahydrocannabinol)**

According to the Foundation for a Drug-Free World (n.d.d), the list of the harmful effects of marijuana is extensive. It appears that the chemical THC (tetrahydrocannabinol) in weed is responsible for the most of its psychological effects. THC stimulates cells in the brain resulting in the release of dopamine. A consequence of the release of this neurotransmitter is a feeling of euphoria. THC affects memory, brings on hallucinations, changes thinking and causes delusions (Cox, 2014; Graves & Associates, 2014). The roller-coaster effects of THC in cannabis can be summarised along three dimensions (immediate, short-term and long-term) as depicted in Table 4.1.

4.3.5 A carnival of drugs and drinking

Lilly went to work in America where she was employed as an amusement park attendant for about two years. She managed various rides and manned ticket sales but operating the roller coaster was her biggest thrill. She travelled all around the USA with the carnival and started doing more illicit drugs such as crystal meth and crack cocaine. According to Lilly, drugs are cheap over there and easily accessible. South Africa is no different. By the time she returned home, she had become a fullblown drug addict. She was as skinny as a rake and to make matters worse, she was drinking. Before she went to America, she was not drinking at all.

4.3.5.1 The gateway theory of drugs

The gateway theory of drugs is defined by Gold and Blakely (2002, no page number) in the Encyclopaedia of Public Health as “the phenomenon in which an introduction to drug-using behaviour through the use of tobacco, alcohol or marijuana is related to subsequent use of other illicit drugs.”

Lilly started using weed and ecstasy when she was in her teens. She also smoked cigarettes but she was not using alcohol. A vast majority of the literature that I reviewed showed that mild drugs (cigarettes, alcohol and cannabis) are referred to as “soft drugs”. These types of drugs are typically labelled as gateway drugs. Drugs such as cocaine, heroin, crystal methamphetamine (to name a few) are labelled as “hard drugs” (for example, Maldonado-Molina & Lanza, 2010).

The hypothesis is that the use of certain drugs may lead to an increase in the use of other drugs. What this seems to indicate is that cigarettes,

alcohol and cannabis may open the door to the use of stronger, illicit drugs such as cocaine, heroin, crystal meth and others. Lilly's transition from cannabis use and cigarette smoking to using cocaine and crystal meth seems to fit in with the gateway theory. Her transition correlates with the results of a study by Reid, Elifson and Sterk (2007). Their research showed that the age at which ecstasy was first used may encourage the use of cocaine and methamphetamine at a later age. Similarly, the use of alcohol and marijuana usage may lead the way for cocaine and methamphetamine use. However, and according to these researchers, it is only marijuana that can pave the way towards using heroin at some stage.

Lilly mentioned that she did most drugs but not heroin so the research by Reid et al. (2007) does not fully apply to her. However, she did use cocaine and crystal meth. It is relevant to bear in mind that Lilly was not a drinker when she was in her teens. Accordingly, the gateway theory does not hold in terms of her consumption of alcohol. She started drinking and upped her game when she was in America post-teens. On her return home to South Africa, she continued to drink except during her two-year prison sentence.

4.3.6 Doing time

Having returned to South Africa, she needed to find a way to support her now advanced drugging and drinking. This she did by stealing from her mother and also conning people for money. Within a short space of time, she got into trouble with the law and got arrested for theft. She got out on bail but failed to appear in court on the due date for sentencing. When she subsequently got caught for possession of drugs, the judge took into consideration that she did not appear for her first

court sentencing. As a consequence, Lilly was sentenced to two years in prison. During her incarceration, she abstained from using drugs but when she got out, she started drinking again but she but she never touched “hard” drugs.

As a consequence, Lilly was sentenced to two years in prison. During her incarceration, she abstained from using drugs but when she got out,

Table 4.2 Effects of marijuana (Foundation for a Drug-Free World, n.d.d)

Immediate effects	Short-terms effects	Long-term effects
Rapid heartbeat; disorientation; lack of physical co-ordination often followed by depression or sleepiness	Sensory distortion; panic; anxiety; poor co-ordination of movement; lowered reaction time; after an initial “up”, the user feels sleepy or depressed; increased heart beat and risk of heart attack	Reduced resistance to common illnesses (colds, bronchitis, etc.); suppression of the immune system; growth disorder; increase of abnormally structured cells in the body; reduction of male sex hormones; rapid destruction of lung fibres and lesions (injuries) to the brain could be permanent; reduced sexual capacity; study difficulties—reduced ability to learn and retain information; apathy; drowsiness, lack of motivation; personality and mood changes; and an inability to understand things clearly

she started drinking again but she never touched “hard” drugs. She was too scared to and perhaps this was a blessing in disguise. Lilly was

terrified that if she used “hard” drugs again that she would die. She also had no intention of going back to prison.

4.3.7 Lilly’s unresolved trauma

As far as Lilly’s addiction treatment was concerned, we focused primarily on her trying to stay sober. As mentioned before, she did have some relapses or slips and we managed to work through these. Sadly, she had another slip during the treatment and shortly after this incident she disappeared. The downside of this is that we didn’t get the opportunity to work through the tragic and traumatic loss of her father. In hindsight and if she had consented, we could have worked through her trauma. Recall that her father was murdered when she was 18 years and she disclosed that her drug-taking increased following his death. The loss of a family member is classified in the DSM-5 as a traumatic life experience (American Psychiatric Association, 2013).

4.3.8 Plans for the future

Lilly had a plan for her way forward and that was to work in a restaurant. She spoke animatedly about how she enjoys working with people and cooking. Having worked with her mother in her catering business and then the family restaurant, her passion for cooking and working with people comes as no surprise.

Sadly, Lilly disappeared from the Centre where she sought help for her alcoholism. The Centre offers assistance to addicts; abandoned and abused children and adults; domestic violence survivors; people who have been trafficked; and anyone who is in need of help. When she mysteriously vanished, the main concern was that she had been trafficked. Thankfully this assumption proved to be wrong. Ostensibly, she had found a job

and somewhere to live. It is heartening to hear that Lilly's plans for her future have, in some measure, materialised.

4.4 JOHNNY

4.4.1 Background

Johnny, a client and participant, is a young male who was addicted to "sugars". He has signed written informed consent to relay his story of his months of drugging and his battle towards recovery. Before his arrest for being in possession of drugs, he was gainfully employed as a life saver on his hometown beach. Together with his best friend, they were arrested and spent two nights behind bars before going to court. The two young men were released on bail and a fine as they were first time offenders and a date was set for sentencing. His mother was gravely concerned about the outcome of his sentencing and made an appointment for a consultation.

Reality struck a chord with Johnny when he recognised that drug addiction can affect so many people, particularly his family. He openly admits that he had given little thought to the future when it came to smoking heroin. Essentially, he was thinking in the here-and-now and when and by what means he would get his next fix. He figured that if he smoked, it will make all his troubles go away until he was compelled to use again.

4.4.2 Family

Johnny is the younger of two brothers and his parents are divorced and his mother has remarried. His memory of his biological father is somewhat scant and he has had little contact with him. It seems that his mother is reluctant to talk about her estranged ex-husband. She also preferred if Johnny did not disclose any information about him. There was a time

that Johnny wanted to go and visit his father and his paternal family but his mother was reluctant.

4.4.3 So-called friends

Johnny was truly under the impression that he had a solid friendship with his co-life savers. He was also confident that he had genuine friends at the time of his 21st birthday but unfortunately, he was sorely disappointed. For his turning of age celebration, a friend gave him a drug known as “sugars” as a gift claiming it will make him feel really good. At his party, they smoked the drug for most of the night. Up until this time, Johnny was only smoking weed.

His next and most damaging let-down from a friend was when his co-life saver sold him down the river. When the two friends were arrested for drug possession, this “friend” told the police that Johnny had stolen a cell phone and other goods to buy drugs. The drug possession was squarely put on Johnny as he had the drugs in his hand while his friend managed to hide his stash away. The drug that his so-called friend adeptly kept out of the eyes of the arresting police officer was “sugars”.

4.4.4 “Sugars”

4.4.4.1 A spoon full of sugar makes the medicine go down

The culprit drug that got Johnny into so much trouble is “sugars”, a drug exclusively designed for the South African market. Originally, this drug contained cocaine and heroin. These days and according to South African Police Services (SAPS/Forensics in *The Naked Truth—TNT*, n.d.), the main ingredient in “sugars” is heroin. In this sophisticated and upgraded form, the drug nevertheless continues to be cut with other

substances (see Table 4.3) to bulk it out—in other words, to make it bigger.

Most of the literature that I reviewed (primarily via the Internet), provides data relating to the concoction of heroin and cocaine. It retails for between R10 to R30 for a “loop” (for 4 or 5 hits) depending on how it is cut (Henley, Hoffman & Naidoo, 2011; Tolsi, 2006; Vitacare, n.d.). Other drugs, such as dagga (cannabis) are added to bulk up the “sugars”. On the less salubrious side, the concoction is sometimes cut with other substances such as rat poison (strychnine) to make the drug more potent and to bulk it out (Vitacare, n.d.).

This street drug has taken Durban (South Africa) by storm particularly in the suburb of Chatsworth where it was first designed. This is where Johnny’s friend bought the drug for his 21st. Attempts by the Westcliff Flats Residents Association in Chatsworth to reduce the drug problem met with little success (Henley et al., 2011). “Sugars” is now readily available across South Africa and, according to Vitacare (n.d.) is also known as “ungah”, “nyaope” and “pinch”. It would seem that “sugars” and “whoonga” are one and the same with a few differences.

• **So what’s the difference between “sugars” and “whoonga”?**

When I asked Johnny about this, his response was: “Sugars” are not the same as “whoonga”. Contrastingly, the general consensus from the literature reviewed indicates that “sugars” preceded “whoonga” (Boomgard, 2010; Chapman, 2013). The elements that go into both drugs are very similar, if not identical and Table 4.2 illustrates this observation (Boomgard, 2010; Chapman, 2013; Department of Health, n.d.; Hunsewraj, 2005; Shembe, 2013; Tolsi, 2006; Tranquility Home, n.d.; Vitacare, n.d.).

• **Contents**

The most notable differences between the two drugs indicate that “whoonga” contains crystal methamphetamine whereas “sugars” contains waste cocaine. Sometime ago it was rumoured that “whoonga” contained ARVs such as Efavirenz (Stocrin) and Ritonavir supposedly to augment the high of the drugs. The ARVs rumour, it turns out, has simply been an urban legend. The rumour has since been debunked as ARVs were apparently used primarily to bulk or mass out the drug cocktail (Department of Health, n.d.).

The most active chemicals in both “sugars and “whoonga” is reported to be heroin, cocaine (“sugars’), crystal meth (“whoonga”) and rat poisoning (Department of Health, n.d.). Across these two drugs, these are the culprits that appear to be causing the most damage to life and limb.

Table 4.3 What goes into “sugars” and “whoonga”

“SUGARS”	“WHOONGA”
Heroin	Low grade/residual heroin
Residual cocaine	Crystal methamphetamine
Dagga/cannabis	Dagga/cannabis
Rat poison (strychnine)	Rat poison (strychnine)
Bicarbonate soda	Bicarbonate soda
Teething powders	Teething powders
Household detergents	Household detergents (i.e. bleach/ammonia)
Baby powder	Talcum powder

• **Cost**

As far as cost is concerned, the differential between drugs is negligible. “Sugars” retails at between R10 and R35 a hit and “whoonga” at around R30 (Tau, 2014; Tolsi, 2006; Vitacare, n.d). Some would argue that “sugars” would be the first choice as it can be bought for as little as

R10 a “straw” or “loop”. Furthermore, if the user is suffering from incredible craving and withdrawal and only had R10 to his or her name, “sugars” might just be the elixir of the excruciating pain.

Coming off heroin is one of the most difficult things a user can experience. A heroin addict I met some time ago likened his painful withdrawal as demonic and that only exorcising could relieve his excruciating pain. He decided to go cold turkey and locked himself in a room for weeks. During this time, he felt his body rise and fall and at other times, he felt like his body was recoiling like a spitting cobra. Somehow he persevered through the ordeal and about three or four weeks later, he was relatively clean. Johnny’s description of his withdrawal from heroin was very similar when he found himself in a jail cell for two very long and painful nights. I’ll come back to this later.

- **Locale**

Whoonga (also known as wunga or nyaope) apparently entered the drug scene between 2000 and 2006 in the Tshwane townships of Soshanguve, Atteridgeville and Mamelodi. The drug then decided to go on a seaside holiday to Durban in 2010. From here on out, it took the rest of South Africa by storm (Tau, 2014).

It seems as if “sugars” originated in Chatsworth, south of Durban in Kwazulu-Natal. The drug then spread to Wentworth which is logistically and relatively close to Chatsworth. It also spread its wings further and migrated to Phoenix, north-west of Durban (Department of Health, n.d.). The use of “whoonga” seems to be happening mostly in the west of Durban (e.g., Claremont, Kwa-Dabeka, Umlazi, Shongweni). There was

also quite a hive of activity in Central Durban (Shembe, 2013), notably “Whoonga Park”.

- **A word on “Whoonga Park” in Durban**

James Nxumalo Mayor of the Ethekeweni Municipality, in the Budget Speech of 2013 highlighted the chronic “whoonga” drug problem at Albert Park (a.k.a. “Whoonga Park”) in the centre of Durban. This document also included the Municipality’s “Clean My City Programme” which included, amongst other important initiatives, the challenge of crime and drug abuse in the city. The infamous “Whoonga Park” was shut down by Durban Metro Police at the end of 2014.

4.4.4.2 *Supporting the habit*

To begin with, Johnny disclosed that he was addicted immediately to “sugars”. It is rumoured that people can get hooked to this drug after smoking as little as two “hits” (Tolsi, 2006). He believed that because the drug had no smell, other people would not know that he was smoking. He claims it was easy to use and its effects were quick and more convenient than smoking weed. He could smoke more and easily get away with it with no-one even being aware that he was high.

Johnny and his friends started smoking at work on a regular basis. They often asked the friend that introduced him to “sugars” to go out and buy more straws for them. Eventually he bought directly from the dealers which meant that they could smoke whenever they felt like it.

When his family found out that he was using drugs, they were devastated. Johnny was stealing from his mother to support his habit. Theft that occurs in the home (stealing money, valuables, etc.) is one of the truetell signs of supporting the habit (Vitacare, n.d.). To begin with, he

categorically denied that he was taking money from his mother's handbag. Over time, she became more and more suspicious, not to mention disappointed as her son was lying to her—something he very rarely did. Then Johnny got into trouble for stealing at work and he eventually lost his job. But it wasn't just the stealing that got him into trouble at work—he was also caught in possession of drugs when he was on duty.

4.4.5 The sour side of “sugars”

4.4.5.1 The first arrest

The first time Johnny got arrested was for the supposed theft of a cell phone. He had some marijuana in his bag but the police didn't search him. One of his so-called friends was actually the person who accused him of stealing the cell phone. Johnny went willingly to the police station safe in the fact that he was innocent. This didn't go down as he expected and he was held overnight in a holding cell at the station. Come morning, the police released him as it turned out that he was not the one who stole the cell phone.

This is when things started going sour at work. His colleagues limited their conversations and dialogues with him and distanced themselves. He got the feeling that they were under the impression that he had given them up to the police saying that they were selling and using drugs. So things weren't exactly hunky dory at work when the next arrest occurred.

4.4.5.2 The second arrest

The second time Johnny got arrested was when the police actually caught him red-handed with heroin in his possession. He was at work and he had gone with his friend to buy “sugars”. Shortly after they got

back, the police appeared at their place of work. He was in his “best friend’s” car and they were both smoking heroin. This supposed friend, with sleight of hand, managed to dump his stash of heroin “straws” down the ventilation of his car. Unfortunately, Johnny wasn’t as quick and still had his “sugars” on his lap and before he could say “Bob’s your uncle”, the police officer was standing at his window.

Johnny was paralysed and could do nothing to get rid of the damning evidence. His hands were tied and they were marched off to the police station. Following two days of lengthy questioning, his friend got off on a technicality but Johnny was not that lucky. He was taken back to the holding cell while his “friend” went home. They both were subpoenaed to appear in court the next day.

When Johnny appeared in the courtroom, he felt that he looked like he had been to war—he was dirty, smelly and bedraggled. In stark contrast, his “bosom buddy” of seven years or so was clean-shaven and looking far more respectable according to Johnny. He was keenly aware that he must’ve looked like hell when he entered the court. Of course, the long 48 hours in the cell spent writhing in gripping heroin withdrawal did nothing to assuage his bedraggled appearance.

4.4.5.3 *Heroin withdrawal—the “roster”*

Heroin withdrawal is nasty. The Naked Truth (n.d.) provides some interesting observations about the withdrawal symptoms of heroin. Recall that previously I quoted from this website who report that nowadays, the primary ingredient in “sugars” is heroin. Previously, it was believed that the drugs contained heroin and cocaine. This organisation (The Naked Truth, n.d.) explosively suggests that there are five stages of heroin

withdrawal which they describe in terms of the hours lapsed since the last use (see Table 4.3).

Previously in Brad's narrative, I mentioned some of the heroin withdrawal symptoms. I have also briefly touched on another user who described his pains of withdrawal resulting from coming off "sugars". In this section these symptoms are discussed in some detail according to the DSM-5 (American Psychiatric Association, 2013) who refer to opioid withdrawal rather than heroin withdrawal per se.

4.4.5.4 *DSM-5 opioid withdrawal*

There are four clusters of symptoms (criteria), each with their respective set of symptoms. Moreover, when diagnosing or identifying the symptoms, it is important to note that the user does not have to present with all the symptoms listed. Rather, each cluster specifies a minimum number of symptoms for the identification or diagnosis (American Psychiatric Association, 2013).

- **Criterion A**

In the first instance, two scenarios can play out but only one needs to be present. The first criterion could be when the drug is no longer being used or when there is a reduction of the amount being used. The user has to have been using the opioid (i.e., heroin) in large quantities and for a very long time. The time period we are talking about here is between several weeks or perhaps even longer. The second criterion is applicable when the user has been prescribed medication to rival the effects of the withdrawal effects after coming off the opioid (American Psychiatric Association, 2013).

As far as Johnny is concerned, I selected the second option. My identification is based on the premise that he had already been prescribed with medication for detoxification. Therefore, in my view, the doctor would have made the diagnosis and Johnny's attempts to stop using.

Some of the detoxification medication to alleviate the effects of opioid drug use includes buprenorphine (brand name Subutex) (U.S. National Library of Medicine, n.d.a) and methadone. Despite that these two medications are used for the treatment of opioid (i.e., heroin) withdrawal, they are in themselves equally addictive. The good news is that the former is less addictive than the latter. Sometimes naloxone is combined with buprenorphine to prevent addiction abuse (Whalen, 2015). The doctor Johnny was seeing prescribed Subutex for his heroin withdrawal symptoms.

- **Criterion B**

As far as this criterion is concerned, three or more symptoms need to manifest. These symptoms must occur within minutes or several days following one of the two conditions in Criterion A are identified. The possible symptoms, in alphabetical order, are diarrhoea; dysphoric mood (i.e., anxiety, depression and restlessness); fever; insomnia; lacrimation (secretion of tears or teary eyes) or rhinorrhoea (runny nose); muscle aches; nausea or vomiting; pupillary dilation; piloerection (goose bumps or goose flesh); or sweating and/or yawning (American Psychiatric Association, 2013).

Johnny complained that his muscles ached and that he had difficulty sleeping as well as he used to when he was using. He admitted that he often had nausea and sometimes actually vomited and he also complained of dysphoric mood (feeling down and sad).

Table 4.4 Stages of heroin withdrawal

Stage	Hours	Withdrawal symptoms
01	04	Anxiety and craving
02	08	Yawning, gooseflesh, runny nose, sweating and teary eyes
03	12	Stretching of muscles, runny nose, hot and cold flushes, muscle cramps, irritability, lack of energy, tremours and loss of appetite
04	18-24	Nausea, increased blood pressure and pulse rate, fever, rapid deep breaths, sleeplessness and restless
05	24-36	Abnormal pain, curled up in foetal position, vomiting, diarrhoea, severe dehydration due to vomiting and diarrhoea, may cause death, might be delirious, hallucinations, hypoglycaemia (low blood sugar), severe weight loss (as much as 2 kilograms per day)

• **Criterion C**

This criterion is related to the signs of withdrawal listed in Criterion B. What this amounts to is that Criterion B symptoms may trigger serious clinical problems in important aspects of life such as work and/or other important facets of life functioning such as family life (American Psychiatric Association, 2013). Since Johnny was no longer working, one cannot say that this area of functioning was jeopardised. He was however, having difficulties at home and was particularly irritated with his older brother who he often picked on. Johnny’s behaviour towards his brother tended to spark problems in the family, often ending up in heated arguments.

• **Criterion D**

Criteria D refers to whether the user was using any other drugs together with the primary drug (American Psychiatric Association, 2013). As the reader is already aware, Johnny’s primary drug was “sugars.” During his counselling, he disclosed that he was not using any other drugs. He did however, mention that he had used dagga before he started using “sugars”. He made no mention of whether he was still using dagga at

the time he was in counselling. He also admitted that he did drink beer from time to time but that he was not into alcohol in the same way as drugs.

4.4.6 The road to recovery

Johnny attended counselling sessions on a weekly basis. At the time, he had been prescribed Subutex (as mentioned above) by his doctor and was also using tranquillisers to help him with the “roster” of the withdrawal systems. The “roster” refers to the withdrawal symptoms which manifest within four hours of last use. The symptoms of withdrawal are worse when the user wakes from an eight-hour sleep (Tolsi, 2006).

This is what Johnny had to say about his withdrawal symptoms:

The withdrawals were pretty bad because the first night I spent in jail I had just smoked [and] the police had caught us when we were busy smoking. The first night wasn't too bad but the second night absolutely drained me. The last night that I spent in jail I got horribly sick from the withdrawals. I battled to sleep.

We started working on the 12-step programme of Narcotics Anonymous (aka NA) (The Narcotics Anonymous Step Working Guides, 1998) and he attended NA meetings where he was assigned a sponsor. He wrote out his life history and kept a diary of his feelings and thoughts on a daily basis. I recommended that he also see a psychiatrist which he did. The psychiatrist compiled a psychological report and Johnny presented it to the magistrate when he went for sentencing.

Johnny was given a suspended sentence and a R500 fine. The magistrate further decreed that if he was caught in possession of drugs, he would go to prison. Johnny's mother was beside herself and was determined

to prevent her son from going into prison and as a consequence, his counselling sessions continued.

4.4.6.1 “House arrest” with tough love

Johnny was clearly frustrated after his sentencing. If he wanted to go anywhere, his parents had to accompany him wherever he went. Although he felt that his parents had no trust in him, he had confidence that things would improve in the long run. His parents watched him like a hawk and he was appreciative of how much they have done and continued to do for him. They stood by him after all they had been through and at one stage, took him to indulge in his favourite sport. He was very grateful for this outing which brought him immense pleasure and satisfaction.

4.4.6.2 Relapse record

This is not the first time Johnny has given up smoking “sugars”. To date, he has given up using the drug three times.

- **Relapse No. 1**

The first time he stopped using was when he moved in with his girlfriend and she asked him to give up. This time round he stopped for three weeks but started up again. His girlfriend packed her bags and left and that was the end of that relationship.

- **Relapse No. 2**

He laid bare that he smoked for about five to six months and then stopped again for three months. At this juncture, it seems his parents were under the illusion that he had stopped using the drug. However, behind closed doors, he was selling his tablets to buy more drugs.

Johnny gave up for the third time after he was caught red-handed with possession of “sugars”. But that was not the end.

- **Relapse No. 3**

Johnny was warned by the court that if he got caught in possession again, he would go to prison. Johnny did use again but as he was not caught in possession of drugs, prison was not an option. He made an appointment and during this session we arranged for Johnny to go to a rehabilitation treatment centre for a month.

4.4.7 Unresolved trauma

Prior to cleaning up his act, Johnny disclosed that there were a number of events that occurred in his life. When he reflected on his earliest memories, he is reminded of when his father shot himself but he survived the incident. He also reminisces of when, at the age of 12 years, he was sexually taken advantage of. This was pretty tall order insofar as childhood traumatic experiences go. His voice became a bit croaky when he spoke about these two rather sinister experiences of his life. Johnny has spoken to others (not in detail) about what happened to him in the public restroom where he was accosted.

He never told his parents and he believes that if he had, perhaps things would have turned out differently. He says that this is something that has really hurt him. It is unclear whether he was (a) referring to his biological parents not getting divorced if he disclosed; or (b) if his mother and step-father would understand his drug addiction. Whichever way I look at his situation, in my view as a counsellor, Johnny has had to deal with his trauma and his addiction in his own way.

4.4.8 Back on board

By all reports, I believe that Johnny continues to be clean and free of his “sugars” drug addiction. I base my belief on reports from people in the community who have seen him at the Narcotics Anonymous weekly sessions. I personally have not seen much of him since he went into rehabilitation and the only news I have is what I read on Facebook! And he is most definitely back on board from the photos I saw of him on the ocean riding the waves. Not only that, Johnny and his friends exchange Facebook comments about their meetings and outings with likeminded people. So he seems to be moving with a different group of people who are embracing the fellowship of being clean from drugs and alcohol.

4.5 MONA

4.5.1 Background

Mona is a 39-year old female widow who was referred to the Centre for addiction recovery and prostitution. She has been medically diagnosed with Borderline Personality Disorder (BPD) and Undifferentiated Schizophrenia. Mona spent about three months at the Centre and then decided it was time to move on. To this day, she continues to be my client and attends one-on-one sessions as well as group sessions at the Centre. She had a traumatic childhood and describes her estranged family of origin as grossly unstable. It seems that little has changed over the years with the exception of a single family member.

4.5.2 Rocky family foundations

Mona is the youngest of five children with two step-sister sisters, a stepbrother and a biological brother. She has limited contact with her

step-sisters and describes them as “one that is bad” and the other as “the good sister”. It seems as if Mona has little to no contact with her brothers.

Mona’s mother is late and her father is still alive. She speaks to him now and then and visits him every so often. She has a grand-daughter from her estranged daughter and they live with her older step-sister. When her daughter was 2 years old, she gave her up for adoption to her older step-sister. Her grandfather lived in the family home and he is also passed on. The only family member she is close to is her niece who she sees from time to time. Her niece is the daughter of her older step-sister.

4.5.2.1 Mona’s mother

According to Mona, her mother was a cold and unapproachable woman who demonstrated no affection or love. She was suicidal and after several failed attempts, Mona found her hanging with her eyes bulging and her neck contorted. To this day, she says that she can still see the image of her hanging, dead mother.

4.5.2.2 Mona’s “Hitler” grandfather

When Mona was 7 years old, she was physically and sexually abused by her maternal grandfather. On telling her mother the first time it happened, her mother said that she was lying. It turns out that a number of family members were also sexually and physically abused by their grandfather, including her mother. Mona describes her grandfather somewhat graphically and says that he was German and that he was probably “related to Hitler”.

4.5.2.3 *The “bad” step-sister*

When Mona was 15 years old, she left home and went to live with the older of her two step-sisters. At this time, this step-sister was in the prostitution business and before long, Mona joined the ranks of the same industry. Not only did Mona become a sex worker, she also started using drugs.

4.5.2.4 *Mona’s husband*

Mona was happily married for approximately 8 years to the only person she says she has ever loved. She is astounded at how he managed to put up with her given her difficult and complicated disposition. The couple went on holiday to Thailand where her husband suddenly collapsed and died of a heart attack. Mona was about 37 years old at the time. To make matters worse, she was horrified at the way the Thais handled his body and subsequent cremation. Mona returned to South Africa with her husband’s ashes in tow. On her previous visit to his last resting place, Mona said that she had made peace with her late husband. She needed to come to terms with herself that he was not responsible for his untimely death and for abandoning her.

4.5.3 *Mona’s addiction history in a nutshell*

Mona started using weed and ecstasy when she was 15 years old. She then progressed to cocaine when she was about 17 years old at a time when her prostitution days had reached an all-time high. After her husband passed away, she moved on to heroin and continued to work in the sex industry. It was her only source of income, not only to support her habit but also to survive. Mona didn’t use heroin when she was on duty—only after working hours.

4.5.3.1 Cocaine, human trafficking and sex workers

In South Africa as well as many other countries, cocaine is the drug most often used by both urban and street sex workers (Leggett, 2000). Cocaine (powder or crack) is a drug that lowers inhibitions. The problem with this is that it can sometimes lead users to commit violent acts (including sexual assaults) or spend money recklessly. This feeling of being all-powerful can get users into serious trouble (NIDA, 2013; Page, 1989).

- **Victims of human trafficking**

Cocaine is also the drug usually given to victims of human trafficking who are used for sexual exploitation. If the victims are not on cocaine when they are kidnapped, they are forced to do the drug for “business” reasons. As a consequence, they become addicted to it which serves to tighten the hold their captors have over them. They end up having to pay for their drugs through continued and forced prostitution.

- **Sex workers**

People who work in the sex industry are also easy pickings for human trafficking (Tandon, Armas-Cardona & Grove, 2014). Most of the sex workers I have counselled, with the exception of Mona, were on crack cocaine and more often than not, this form of cocaine is used because it is cheaper. According to the website Locked Up (2011), cocaine hydrochloride can cost between R300 to R500 a gram compared with R50 a “piece” for crack cocaine/crystals. Victims of human trafficking are not only bonded in modern day slavery, but they have now become new drug addicts or advanced ones. The buck doesn’t stop here, as they become more tied to their captors because they are now debt bonded to them for their drugs.

A long time ago, Mona had a drug debt to a dealer. At the time, if she didn't turn tricks to pay him for her drug supply, he abused her. To secure her supply of drugs, she had to physically and financially succumb to his demands. This kind of "arrangement" is referred to as debt bondage particularly with regard to the trafficking of persons for sexual exploitation (Prevention and Combating of Trafficking in Persons Act, 2013). So in a sense, Mona was a victim of human trafficking but she was shrewd enough to escape the chains of her handler.

- **Debt bondage**

The Prevention and Combating of Trafficking in Persons Act (2013, p. 5) define debt bondage as follows:

Debt bondage means the involuntary status or condition that arises from a pledge by a person of—(a) his or her personal services; or (b) the personal services of another person under his or her control, as security for a debt owed, or claimed to be owed, including any debt incurred or claim to be incurred after the pledge is given

The Act (2013) continues with debt bondage by adding that (1) whatever calculated debt is owed or supposedly owed is blatantly inflated; (2) the duration of the services as well as the nature of the services are not clearly set out and clarified; or (3) the value of the services provided is not set off against the real or supposed debt as owed when services are terminated.

In essence, debt bondage means that the provider of services is forever in debt to the business at hand. For instance, they have to pay for their keep; they have to pay for their constant supply of cocaine; and

those who are flown in from other countries have to pay for their airfares. There are many other ways in which way they owe money to the dealers and these are just some instances of debt bondage.

4.5.3.2 *Mona and heroin*

Mona has been on heroin approximately three years and tried once to overdose purposefully but failed. The anterior mid-arm sites are the most common places for heroin addicts to inject themselves. However, over time they are unable to inject in the same place as their veins collapse and become hard. Desperate times calls for desperate measures and when all else fails, injecting can also be done in unusual places such as behind the neck, knees and in the groin area (Drug Aware, n.d.b). Historically, Mona used mostly her hands and in between her toes but strangely enough, not her mid-arm sites. Most of the veins in these areas have since collapsed. On one occasion she injected herself in her neck and vowed she would never do that again. She found the pain incredibly unbearable.

Mona has passed out a number of times with a heroin needle lodged in her forehead. On one occasion, they had to break down the bathroom door to rescue her otherwise, she revealed, she probably would have died. Her veins on her hands in particular have calcified to such an extent that she had to have them attended to surgically to prevent them from clotting and breaking off into her system (Zule et al., in Ciccarone, 2013).

Mona only has to look at both her hands to remind her of the legacy of her heroin injecting. Her walk down memory lane, and hopefully passed heroin days, are similar to Brad's scarred cigarette burn courtesy of one

of his heroin-induced stupors. Although I must say that Mona's physical scars as well as her psychological and emotional ones seem somewhat more chronic.

4.5.3.3 *The heroin pandemic in South Africa*

A number of the hard and chilling facts of heroin was gathered by the Havocscope Black Market (2015). They report that there are 21 million heroin users worldwide with a "product" market value of US \$68 Billion. At the current rate of exchange, this amounts to a staggering ZA R796 Billion. Big business, big bucks and big addiction. They further report that in Europe in 2012, there were 6 100 overdoses. According to Bender (2014) in the United States, the Sinaloa drug cartel, the largest and most powerful drug trafficking organisation in the Western hemisphere, has discounted heroin to make it even cheaper than prescription analgesics. Discounted prices, in my view, tend to lure people into a false sense of security. This one tops it all.

Psalm of a Heroin addict (Angelfire, n.d.)

Heroin is my shepherd, it will always be wanting
He lays me down in a sewage ditch
To troubled waters he leads me
He destroys my sole
He leads me in the footsteps of wickedness,
Yes, I go through poverty and will fear all calamity
Because you are with me
Your needle and pellet comforts me
You pillage the table of my family
You make my head empty
My cup runs over with grief
Heroin addiction will follow me to the ends of my life
And I will live in the house of doom until the length of day

- **A gram of heroin in South Africa**

Over recent years, heroin has had more than ample opportunity to tighten its vice on South Africa (Weich, 2010). At the time this article was published, users or potential users could buy fairly good quality heroin in Cape Town for about R30 per gram (usually shipped in from Afghanistan). According to Drug Aware (n.d.b), the average dose of this popular opiate is between 5 to 15mg and sometimes up to 250mg a day. During the early days (circa 1980s), heroin was somewhat expensive (±R250 to R300 per gram) but currently addicts can buy heroin for far less. The selling price for a gram of heroin provided by Drug Aware (n.d.b) coincides with that of the study undertaken by Weich (2010). The study concentrated on 3 areas in South Africa, namely Cape Town, Kwazulu-Natal and Gauteng.

- **Cape Town**

Research undertaken by Pludderman et al., (in Weich, 2010), reveals that 9 or 10 years ago there were approximately 12 000 and 18 000 heroin users in Cape Town. These numbers coincide with the contingent of heroin users in treatment centres trying desperately to rid themselves of the hold of this immensely compelling drug.

- **Kwazulu-Natal**

In the same research by Pludderman et al., (in Weich, 2010), the heroin problem has been equally active in KwaZulu-Natal where its use has risen rapidly during a short period. In 2006, patients in treatment for heroin addiction was recorded as 2% (relatively low) and in 2009 this figure had shot up to a whopping 30%—a sizeable jump of 28% in a period of approximately three years. It is believed that some of this

increase can be attributed to the use of “sugars” (a combination of heroin and cocaine). “Sugars” seems to be the drug of choice for users less than 20 years old. Recall that Johnny was a “sugars” user and that he was given the drug as a 21st birthday present—a rather vitriolic gift from a so-called friend. He was a little over 20 years old but only just.

- **Gauteng**

Gauteng seems to have a predominantly high rate of injection drug use as indicated by the number of patients in treatment (31 to 51%). The more serious problem here is that a substantially large percentage of injection heroin users share needles with other users according to Pludderman et al., (in Weich, 2010). Sharing used needles, in some cases, encourages a life-threatening proclivity towards initiating or spreading HIV/AIDS which, in itself, has become precariously problematic worldwide. This catastrophic state of affairs reminds me (and I hope the reader as well) of when Brad shared his concern about how he miraculously escaped contracting HIV/AIDS when he was sharing needles to shoot heroin. Mona, on the other hand, was meticulous when it came to her needles. She made sure that her needles were clean and/or new. The research by Weich (2010) clearly indicates the problems inherent in these 3 areas surrounding needle sharing and the spread of HIV and AIDS.

Of course this problem is not only an issue in Cape Town, KwazuluNatal and Gauteng—it is a country- and worldwide issue (World Health Organisation, n.d.). AVERTing HIV and AIDS (AVERT, 2014) documents that South Africa has the highest and most dangerous epidemic of HIV in the world. It also rolls out the largest antiretroviral treatment in the

world. Similar to the research by Weich (2010), AVERT (2014) report that HIV is more prevalent in Kwazulu-Natal compared with the Northern Cape and Western Cape. One of the key affected populations in South Africa that AVERT (2014) lists is people who inject drugs and their dangerous link to HIV.

- **People who inject drugs (PWIDs) and HIV in South Africa**

Here again AVERT (2014) report that approximately 16.2% of PWIDs in South Africa have been affected by HIV. On the positive side, and according to this report, there also seems to be a low percentage of those with new HIV infections. On the downside, the available data on PWIDs and HIV prevalence is also low.

Nonetheless, a PEPFAR (2012, p. 3) publication reports that “there are approximately 16 million IDUs (injection drug users) worldwide, with an estimated 3 million living with HIV”. PEPFAR in the United States is the President’s Emergency Plan for AIDS Relief for people who inject drugs (PWIDs). On a global level, when drug users carelessly share needles with other people they know nothing about, they are selfishly contributing to the life-threatening spread of HIV and AIDS.

4.5.4 Mona’s psychological status

4.5.4.1 Introduction

As mentioned previously, Mona had been diagnosed with Borderline Personality Disorder (BPD) and Undifferentiated Schizophrenia. Her comorbid diagnosis was determined by a mental health worker at a hospital where she was also prescribed with medication. During her treatment with me, I did not question her psychological diagnosis (i.e., BPD and Undifferentiated Schizophrenia) and concentrated on her

substance abuse in relation to her diagnoses and particularly, her childhood traumatic experiences. Any and all interventions focused on keeping her grounded in the here-and-now.

Mona has somehow come to terms with her diagnosis of BPD but was, and still is reluctant to accept the finding regarding schizophrenia. She has been prescribed medication and diligently takes her BPD tablets and tranquillisers. In fact, she believes that if she doesn't take her medication every day, she will go berserk.

Rather than going into any great detail regarding Mona's various diagnoses, I have concentrated primarily on Borderline Personality Disorder (BPD) as well as my identification of her Substance Use Disorder (SUD). I will use the terms identification/diagnosis when referring to Mona's disorders. Both these disorders will be defined briefly in terms of the DSM-5 (American Psychiatric Association, 2013). The BPD segment includes the symptoms of the malady observed in Mona and two specific precipitating factors of BPD, namely genetics and environment. The SUD section discusses the criteria for an identification/diagnosis of the disorder and circumstances that could lead to a substance use problem.

4.5.4.2 Borderline Personality Disorder (BPD)

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013) outlines BPD on the basis of a pervasive pattern of (a) instability of interpersonal relationships; (b) a volatile self-image and unstable emotions; and (c) discernible impulsivity with its foundation becoming apparent by early adulthood. In order for an identification/diagnosis of BPD to be made

according to the DSM-5 (American Psychiatric Association, 2013), there has to be the presence of at least five of the symptoms listed below.

- **Symptomology of BPD**

- (1) Avoidance of real or imagined abandonment;
- (2) An array of unstable and intense interpersonal relationships;
- (3) Insecure self-image or sense of self;
- (4) Impulsivity in at least two potentially self-damaging areas (e.g., spending, sex, substance abuse, reckless driving, binge eating);
- (5) Regular suicidal behaviour (gestures or threats) or self-mutilating behaviour;
- (6) Emotional instability noticeable by mood reactions (e.g., intense episodic dysphoria [not feeling well or unhappy/sad], irritability or anxiety that usually lasts for a few hours and only rarely no more than a few days);
- (7) Chronic feelings of emptiness;
- (8) Untimely, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger or recurrent physical fights); and
- (9) Momentary, stress-related paranoid ideation or severe dissociative symptoms.

- **Precipitating factors of BPD**

The factors that could attribute to an identification/diagnosis of BPD appear to be genetics, neurotransmitters, neurobiology and environmental factors (NHS, 2014). If I was a betting person and Mona was a filly in a race, hypothetically I would put my money on genetic and environmental factors.

Since my knowledge of Mona's brain functioning is scant to non-existent, I am inclined to limit my bet on what she actually shared with me. To this end, I have focused primarily on the role of genetic features and environmental factors in her identification/diagnosis of BPD.

- **Genetic features**

Drawing once again on the data provided by the British NHS (2014), the genes we inherit from our parents together with environmental factors may make us vulnerable to developing BPD. Although research on identical twins may provide some evidence that genetics may play a role in BPD, there is, according to the NHS (2014), no indication that there is a gene for BPD. Contrary to this view, Distel, Hottenga, Trull and Boomsma (2008) found that genetic material on chromosome nine was linked to BPD features.

So perhaps there is some truth in the matter that genetics could play a role in the development of BPD. If we look at Mona's family, her mother was suicidal (as recounted by Mona) and as evidenced by her several attempts to realise the act which she eventually succeeded in. From our sessions, and if you recall, Mona mentioned that she herself once tried to commit suicide but it was a failed attempt.

Perhaps her mother could also have had a personality disturbance in the same way that Mona appears to have. She mentioned that her mother was also abused by her father (Mona's grandfather) which, like Mona, could have predisposed both of them to certain syndromes such as BPD. Mona's oldest step-sister was also sexually and physically abused by the same grandfather. She continues to work in the sex sector to which Mona was first introduced to when she was young. Her step-sister is

also on drugs and apparently is involved in fraudulent activities. Things certainly seemed to have gone awry in this family.

- **Environmental factors**

I reiterate that Mona's genetic features go hand-in-hand with her environmental factors. Her young days seem to have been the breeding ground for all sorts of adversities in her later life. If one looks at the possible environmental factors, Mona can tick just about every box in terms of her identification/diagnosis of BPD (NHS, 2014). The classical environmental factors that could have significantly impacted on Mona's life are unpacked below.

- As the reader is already aware, she was a victim of emotional, physical and sexual abuse courtesy of her grandfather.
- She was exposed to chronic fear and distress as a child not only from her grandfather, but also from other members of her family.
- Mona found her mother hanging which in itself, is a highly traumatic and frightening experience for any young child. It seems that Mona had some idea that her mother was distressed but appears that she was not aware of the intense severity of her mother's colossal suffering (Owens et al., 2011).
- Her older sister bullied her from an early age and continues to do so and by all accounts, Mona is relieved that she has limited contact with her.
- Her mother neglected her and the reader is once again reminded that Mona's mother was cold and reportedly detached from Mona and her siblings. Mona divulged that her mother didn't demonstrate much love and affection.

- She grew up with not only one, but a number of family members who could have had mental problems. I have inferred the following possible psycho-pathologies from Mona's narrative that (a) her mother was suicidal and Mona shared that she was manic-depressive; (b) her grandfather was chronically abusive (was he a psycho- or sociopath who took what he wanted and when he wanted?); and (c) the older of her step-sisters was taking drugs and drinking alcohol (indications of substance use disorder) and owned a brothel house. She introduced Mona to drugs and alcohol when Mona was young. Mona claims that she seldom drinks alcohol but she has a long history of drug use.

- **Observation of Mona's BPD symptoms**

The following BPD symptoms were observed in Mona and recorded in Table 4.4 below. She scores 9 out of 9 symptoms and a minimum of five symptoms are required for an identification/diagnosis of BPD (American Psychiatric Association, 2013). Table 4.5 provides an illustration of the symptomology of BPD in relation to Mona's presenting problems.

- **Interpretation of Mona's symptoms**

Mona felt that her husband abandoned her (feelings of rejection) when he suddenly passed away following a heart attack (tick 1). As far as her relationships with others are concerned, to begin with, she gets on fairly well with people. However, after time though, she becomes irritated with them and then most of her relationships deteriorated. During the period we spent together, she spoke about a number of boyfriends that she had or was currently with. To begin with, she idolised each one of

them but before long, she lost faith in them (devalued) (tick 2) and subsequently ended the relationship.

In addition, item 3 warrants a tick as Mona’s sense of self was damaged to the extent where she had little faith in herself. She was disappointed in herself but felt trapped with no way out. As regards suicide, Mona disclosed that she did try and commit suicide once. As far as I am aware and based on what she disclosed, she did not present with “regular” suicide ideation—certainly not on my watch. However, she did engage in self-mutilation as evidenced by her admission of the scars on her front, lower arms. This observation warrants a positive tick.

Mona’s emotions tend to be volatile resembling the ups and downs of a roller coaster. The feedback from other occupants of the Centre stands

Table 4.5 Mona’s BPD symptoms

BPD symptoms	Tick
(1) Real or imagined abandonment	✓
(2) Unstable and intense interpersonal relationships	✓
(3) Insecure self-image or sense of self	✓
(4) Impulsivity in at least two potentially self-damaging areas	✓
(5) Regular suicidal behavior or self-mutilating behavior	✓
(6) Emotional instability noticeable by mood reactions	✓
(7) Chronic feelings of emptiness	✓
(8) Untimely, intense anger or difficulty controlling anger	✓
(9) Strong suspicion that others are out to get to her	✓

testimony to her histrionics (tick criteria 8). As far as criteria 9 is concerned, she sometimes thought that other people were out to get her, had something against her or were not fond of her. If she was reassured, she would sometimes settle down. In my view, it seems that when Mona

goes into “nobody loves me” mode, she distances herself from others (dissociates) and disappears. During these times drugs become attractive as a way of self-soothing.

4.5.4.3 *Substance Use Disorder (SUD)*

Picking up on Mona’s story and from the disclosure of her drug history, she could be identified/diagnosed with Substance Use Disorder as defined in the DSM-5 (American Psychiatric Association, 2013). This identification was made by the Centre and myself prior to her going to the hospital where it was confirmed and subsequently treated with medication.

4.5.4.4 *Comorbidity*

The concept of comorbidity in the realm of addiction is also referred to as dual diagnosis (Rethink, n.d.). Since Mona presents with a number of psychological dilemmas and to streamline her identifications/diagnoses, her condition can be regarded as comorbid (NIDA, 2010).

In Mona’s case, the 2 diagnoses/identifications under scrutiny could be a traumatic- and stressor related disorder (primarily, childhood sexual abuse and probably posttraumatic-stress disorder or PTSD) with a comorbid substance use disorder (mainly heroin). On the other hand, it could also be a substance use disorder with a co-occurrence of a traumatic- and stressor related disorder. It is not as simple as one disorder causes the other (causality), irrespective of which one came first. Whichever way one looks at the diagnosis/identification, such analysis tends to be somewhat complicated and challenging for both client and practitioner. The problem here lies in the persistence and severity of the related symptoms as well as their resistance to treatment (NIDA, 2010).

NIDA (2010) explains this chicken-or-the-egg wonder in terms of how the comorbidity of substance abuse and mental illness or vice-versa could possibly play out:

- Substance abuse can lead users to experience some symptoms of another illness—for instance, marijuana use can cause psychosis;
- Mental illness, whether mild or severe, may lead to drug abuse. In such cases, the use of drugs is a way of self-medicating (for instance, smoking tobacco sometimes helps people with schizophrenia); and
- Corresponding influences that seem to lead to drug abuse and mental illness include fundamental brain deficits, genetic susceptibilities and/or experience or experiences of stress and trauma.

- **Heroin and psychopathology**

Psychological problems associated with heroin use tends to present with other psychopathology. The comorbid diagnoses/identifications could include mood disorders, anxiety disorders such as posttraumatic stress disorder and personality disorders, particularly anti-social and borderline personality disorder (NIDA, 2010).

4.5.5 A classic case of trauma and addiction

Mona has a saying which, when I reflect on it, says a lot about her life and its connection to opioid drugs. This is what she said: “Cocaine blows your mind—heroin takes what’s mine away.” In my view, her childhood experiences and later life escapades puts her squarely in the ranks of trauma and addiction (Foundations Recovery Network, 2015; Johnson, Cohen, Brown, Smailes & Bernstein, 1999; Zanarini, 2000). Mona’s relationships with her family could possibly have played a

significant role in the way her life unfolded. She has been doing drugs and sex work for many years and has only recently “retired” from the industry and given up heroin twice. Currently, she is still clean and says that heroin actually disgusts her. Her history of drug use and traumatic experiences spans some 24 years. What follows is an attempt to unpack the impact of Mona’s life experiences during these years. This interpretation resonates with her view of how heroin can douse traumatic memories.

4.5.5.1 *Traumatic childhood experiences*

It hardly seems surprising that Mona chose drugs to numb out the pain of her childhood sexual and physical abuse (Daniulaityte & Carlson, 2011; Foundations Recovery Network, 2015; Hazelden Betty Ford Foundation, n.d.; Zanarini, 2000). Given the way her life panned out working on the streets, heroin as her choice of drug to survive also comes as no surprise. This powerful opiate has the propensity to produce a fake sense of understanding. It also tends to solve life’s problems through anxiety-less eyes. Once lured into its powerful yet damaging embrace, users struggle to break free from its false sense of security.

Mona’s family provides the backdrop of her traumatic childhood experiences. It created the breeding ground for her life of prostitution and drug use. The sad thing is that when there are indications of childhood traumatic experiences, many people are likely to turn to alcohol and/or drugs to escape from the pain of the memories. In the long term, they will need effective treatment to help them to cope with the cooccurring issues (Hazelden Betty Ford Foundation, n.d.).

4.5.6 *Mona’s prognosis*

Mona’s life presents with a classic case of the influence of trauma in the world of addiction. Despite the blatant evidence of the elements to

support trauma and addiction, it would appear that Mona is caught up in the trap of drugs to numb out and sex work as a matter of survival. She is currently in treatment for recovery from her addiction and working on the Narcotics Anonymous 12-step programme (The Narcotics Anonymous Step Working Guides, 1998). She still has to get her mind round going to NA meetings on a weekly basis. She believes that the time has come to hang up the towel from sex work.

Her chronic lack of any support system is potentially one of the major problems of her drug abuse. While enablers can often derail the recovery process, my view is that it is better to have a nagging enabler than no enabler at all. One of Mona's challenges (and my concern) is that she currently has no fixed place of abode and roams between shelters and places like the Centre where we met. Now and again, she stays with her niece but only for a short while. Wherever she lays her hat is her home and how she gets there is squarely determined by her own actions. She is resilient but she is also vulnerable. Mona believes that she really should have died a long time ago—but she is still alive. She believes that God must have a reason for her to be on this earth.

4.6 RANDY

4.6.1 Background

Randy is a young man in his twenties who has been living on the streets for quite some time. He had no fixed place of abode and stays in hostels for a minimum price for board and lodge. To earn money to pay for his “accommodation”, he sold chocolates on the street. Often the police would confiscate his goods which meant that Randy had to make alternative arrangements. In the long run, living on the streets was not an option and ultimately he found his way to the Centre where we met.

Here he was fed and in return helped with a number of chores, particularly cooking meals.

4.6.2 *So much for family*

Randy is the second eldest of five children. His mother passed away when he was about 16-years old and his father died in a car accident at the end of 2013. He attended his father's funeral and it was the first time he had set eyes on his family in 12 years. He gets on well with his sister who is now married and although he knows she would like him to come and live with them, he is fiercely vehement that he does not like his brother-in-law. He also has an aunt who is fond of him as he is of her. For some undisclosed reason, he does not want to stay with her. He is estranged from his oldest brother and his two younger brothers.

4.6.2.1 Randy and his father

Randy and his father did not see eye-to-eye and by all accounts, they had an acrimonious relationship. His father used to physically, emotionally and psychologically abuse him. Randy was very close to his mother and when she died of cancer, his relationship with his father deteriorated irrevocably. One of the many catalysts was the distribution of his mother's provident fund following her death. Her fund was apparently for the education of the children which did not materialise. Instead the money was used to support their father's drinking habits.

Randy and his father fought physically and verbally on a regular basis. Following the death of his mother, his father brandished him from the family home. Home was on the streets until a neighbour rescued him. The community was aware of Randy's plight and rallied to his needs.

His father interfered with his safe-keeping with a community member and had him sent to a children's home. Eventually, his situation came to the attention of the school he attended. The school offered boarding facilities for Randy at no cost and in lieu of payment, he looked after the school gardens. This is where and when he started smoking dagga. He stayed in the school until he finished matric but all the while, he was concerned about his two younger brothers. But there was very little he could do about it. The family drifted further and further apart and Randy continued with his life without them.

4.6.2.2 Post-matric

Randy started working in a bakery after he left school. He was still smoking cannabis ("zol" as he calls it) but was not interested in any other drugs at this stage. The owner of the bakery took a liking to him and believed that he had potential. Randy didn't agree with his boss and at the time we met, he still felt that he has no potential. His self-confidence and self-esteem seemed to be deeply bruised and dented. This is hardly surprising considering the barrage of insults his father lavished at him.

Randy's boss believed in him and offered to send him to England to work in a friend's bakery. Despite Randy's negativity about his potentiality for anything, he capitulated and decided to take him up on the generous offer. This was just the break he needed. Or was it?

4.6.3 England oh England

Randy left the borders of South Africa for the first time and started working in his new job in a bakery somewhere in England. He seemed to have settled down relatively quickly and even managed to acquire a

slight English accent. As a pastry chef, he threw his energies wholeheartedly into his new job far away from home. He stayed in this job for quite some time but became restless. Randy wanted to explore England and to try something new. It was at this time that he decided he would like to work in an English pub. He wanted to get some other work experience other than working with dough. He ultimately left the bakery for what he thought would be greener pastures.

4.6.3.1 From bakery to pub

The British term “pub” is short for public house which, in its original form, meant any building that is open to the public. Such establishments later included the sale of food and was licensed to sell beer, wine and spirits (Differ.com, n.d.). When Randy got to his new destination and started working in a pub, he realised that it wasn’t all it was cracked up to be. In a short space of time, he realised that he had made a poor decision but he was stuck. He thought working in an English pub would be something novel and different.

4.6.3.2 Welcome to cocaine

Returning to Randy’s spell in England, he also visited other pubs where he met loads of people and also made some friends. It was also at this time that he started using crack cocaine. This form of cocaine differs in some significant ways from hydrochloride or powder cocaine. Perhaps the comparison provided by Cocaine.Org (n.d) might serve to shed some light on how these two forms of cocaine differ as illustrated in Table 4.6.

4.6.3.3

A comparison of cocaine powder and crack cocaine

A study by Hatsukami and Fischman (1996) focused on the differences and similarities between crack cocaine and cocaine hydrochloride (powder cocaine). The purpose of their research was to determine how their findings might influence policies on imprisonment and treatment programmes for individuals who use cocaine in any form. The conclusion of the research is based on the following:

- The effects of the drug are similar whether the individual is using cocaine hydrochloride or crack cocaine. I mentioned some of the effects of cocaine in Brad's story but now find it necessary to add a few more.
- There is a strong likelihood for abuse, dependence and severe consequences when crack cocaine is smoked. As for cocaine hydrochloride, similar consequences results when cocaine is injected intravenously but less when it is snorted or sniffed.
- The reasons for abuse, dependence and the severe consequences of cocaine use seems to be related to the immediacy, duration and the degree of the effects of cocaine. The frequency and amount of cocaine used also contributes to the damaging side effects but not necessarily on which type of cocaine is used.
- Finally, when cocaine hydrochloride is snorted (i.e., used intranasally) this may lead to the use of crack cocaine (i.e., it becomes a gateway drug).

4.6.3.4 Psychological and physiological effects of cocaine

According to the Drugs and Human Performance Fact Sheets (n.d.), the psychological and physiological effects of cocaine hydrochloride occurs in

two phases—the early phase and the late phase. There are a host of dangerous side effects but I believe that these two phases adequately serves the purpose in terms of this research.

- Early phase effects

- (i) Psychological effects include euphoria; excitation; feelings of wellbeing; general arousal; increased sexual excitement; dizziness; selfabsorption; increased focus and alertness; mental clarity; increased talkativeness; motor restlessness; stabilised fatigue; improved performance in some tasks; and loss of appetite. When higher doses are taken the uses experiences psychosis with confused and
- (ii) disoriented behaviour; delusions; hallucinations; irritability; fear; paranoia; antisocial behaviour; and aggressiveness.
- (iii) Physiological effects become apparent in an increase in heart rate and blood pressure; increased body temperature; dilated pupils; increased light sensitivity; constriction of peripheral blood vessels; rapid speech; dyskinesia (e.g., twitches, jerking and so forth); nausea; and vomiting.

- Late phase effects

- (iv) Psychological effects include dysphoria (for instance—dissatisfaction, anxiety, restlessness or fidgeting); depression; agitation; nervousness; drug craving; general central nervous system depression; fatigue; and insomnia.
- (v) Physiological effects can be seen in itching/picking/scratching; and normal heart rate.

Table 4.6 The difference between powder cocaine and crack cocaine

Powder cocaine	Crack cocaine
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Cocaine/coke	A form of cocaine base
White powdery substance	White/cream/pale yellow crystals/rocks (mixture of powder cocaine, water and baking soda)
Snorted/sniffed/dissolved in water and injected	Smoked/snorted/dissolved in vinegar or other acids and injected
Snorted/sniffed intra-nasally: 20 minutes to reach the brain Effects up to 60 minutes	Smoked: 20 seconds to reach the brain Effects up to 30 minutes Quicker, stronger but short-lasting high
More expensive than crack cocaine	Less expensive than powder cocaine
Less addictive than crack cocaine	More addictive than powder cocaine
Less risk of dependence when snorted	Greater risk of dependence when smoked
Generally not associated with violent behaviour	Associated with violent behaviour

4.6.4 *Deportation*

On one occasion, when Randy was high and in a pub, he heard some people talking and he didn't like what he was hearing. He snapped and went ballistic and a physical fight ensued. His behaviour in this instance correlates with violent behaviour that is associated with crack cocaine (Cocaine.Org, n.d.; NIDA, 2013.) To make matters worse, when the cops came, he punched one of the officers. He was summarily arrested and subsequently ended up in prison. He then spent some time in a detention centre until his deportation orders came through and he was eventually extradited to South Africa.

4.6.5 **Returning to South Africa**

On his return to South Africa, Randy became more involved in using drugs. He was also homeless, penniless and eventually ended up living on the streets. He was so desperate that when he was approached to smuggle drugs into South Africa from other countries he agreed to the deal. Randy was involved in three drug smuggling operations and from three different countries.

4.6.5.1 Drug “mule”

To be a drug “mule” essentially means to smuggle drugs from one country to another. Drug “mules” are also known as body packers (for example, Koehler et al., 2005; Mandava et al., 2011). Body packers may be required by dealers or exporters to swallow packets of illegal drugs to smuggle them into countries. The ingestion of cocaine (or other drugs) is a dangerous method of drug smuggling. If a drug-filled packet bursts in the “mule’s” gastrointestinal tract, death is highly likely (Mandava et al., 2011). Randy muled drugs from South America using this method of smuggling. By all accounts it was a traumatic experience for him and he vowed he would never do this again.

On his second and third drug muling experiences, Randy was mandated to smuggle powder cocaine in the panels of his suitcase. This was a particularly harrowing experience for him as he was convinced that he was going to get caught and arrested. The customs officials strip searched him from top to bottom and bombarded him with questions but failed to find any drugs on him.

Randy was fed, clothed, accommodated and handsomely paid when he was overseas. Despite all the frills, if you ask him if he would do it again, I predict his response to be somewhere along the lines of: “Definitely not”. The possible reason for this predicted categorical response is that Randy was extremely anxious during the smuggling process particularly on arrival at airports.

4.6.6 *Randy’s trauma and anger*

The anger that Randy harbours is akin to a firelighter that ignites an already blazing, subconscious furnace. At the slightest provocation, he can

lose his cool. If someone chastises him about something, he would get very defensive and as a consequence, he would leave the Centre. He returned months later and after someone criticised him yet again, he left the premises and has not been seen since. During our initial sessions, he shared with me how angry he got about an incident that occurred at the Centre. Perhaps if he had stayed on, we could have explored the origins of his anger outbursts. We could also have looked at how to unpack and manage his anger.

4.6.6.1 Anger and children

In defining anger, Golden (2003) posits that anger is a multi-faceted, natural human reaction. In much the same way, the National Association of School Psychologists (2012) propose that anger is a natural reaction. Given these very similar definitions of anger, it seems that Randy's reactions and emotions are hardly surprising. This is in light of the manner in which his father treated him. His story reveals that as a child and adolescent, he was repeatedly traumatised by his father. It sounds quite likely that his childhood trauma was punctuated by disruptions of his sense of safety and security. It also sounds as if he was living in an unstable home environment spurred on by an alcoholic parent (Zwolinski & Zwolinski, 2012).

- [Support from significant others](#)

Children find it particularly hard not only to understand their feelings but also talking about them. All children need genuine guidance and support from significant people in their lives (parents, teachers, etc.). If they get this kind of support, they are more likely to try and work through their thoughts before reacting to events in a negative way. It is the

responsibility of caring adults to be vigilant that children do not express their anger in unsuitable ways. Anger and other strong emotions need to be appropriately channelled in socially and psychologically acceptable ways (National Association of School Psychologists, 2012).

- *Trapped emotions*

“When a child is traumatised, subsequent events, which may or may not be perceived as inherently traumatic by the average person, are experienced as traumatic” (Zwolinski & Zwolinski, 2012, no page number). As an adult, Randy openly talked about the verbal, emotional and physical abuse his father metered out on him. He clearly remembered what happened to him during his adolescence. Chances are that both him and his siblings were abused and neglected from an early age. It is also quite possible that they may not have any recollection of their childhood traumas.

What were these young children supposed to do? They were vulnerable, had no autonomy to speak of and had no option but to depend and rely on significant others to guide them (i.e., parents, teachers or others). Some of them could very well have been their abusers. The upshot of their precarious childhood positions is that their frustrated emotions may get bogged down in their traumatic responses. These trapped emotions may then manifest in adulthood in socially and psychologically unacceptable ways (Zwolinski & Zwolinski, 2012). Such was Randy’s inheritance from his childhood days which could have given rise to his present-day anger outbursts.

4.6.7 Creators of our own destinies

I’ll say this for Randy, when he hits rock bottom, he has the doggedness to pick himself up and find ways to improve his life. He actually has

no alternative as he can only rely on himself. Regarding his immediate family, perhaps he has become accustomed to the silence. One wonders if somewhere at the back of his mind, he longs to hear from them. Perhaps his luck has turned as recently an aunt has offered to help find him a job. She's not his real aunt but at least someone has extended a helping hand. Randy can be quite stubborn and it was reassuring to hear that he had apparently capitulated and taken her up on the offer. I believe that he is fit to survive but it's up to him how he goes about it. We are, after all, creators of our own destinies—with or without our traumas and mishaps.

4.7 JANE

4.7.1 [Background](#)

Jane presented with blackouts as a consequence of excessive alcohol consumption. Apparently when she is under the influence, she says and does things that she has no recollection of. This tends to happen mostly when she is out socially but not when she has a drink at home with family or close friends. She finds her alcohol-infused behaviour somewhat perplexing, not to mention strange.

Jane is far from a plain Jane kind of woman and at the time we met, she was about to turn 42. She has the trimmings of a model and is a talented artist with a rather alluring and unusual style of painting. She had recently cut her long hair which people close to her found rather strange. In the past, they complimented her on her crowning glory and Jane has no idea what drove her to rid herself of her locks.

4.7.2 [Jane's artwork](#)

Jane appreciates that she is gifted as far as her painting is concerned. At the time of the interview, she was not boosted by her artistic value

and, as a consequence, she lacked the motivation to complete any of her work. She finds numerous flaws in what she puts on canvass and tends to leave most of her paintings unfinished. At one time, she offered painting classes but stopped as she felt that her students drained her of the very thing she thought she was passionate about. She felt that painting was supposed to be therapeutic but instead, she realised that her students were using the lessons to air their personal problems.

It was during this time that her childhood feelings of her child sexual abuse and father-daughter incest fervently snaked its way into her heart and head. She capitulated and, at the insistence of her family and close friends, agreed to counselling to air her life of trauma. Jane disclosed that she lacked the motivation to do anything and had started to avoid people. She was reluctant to communicate with others and had no desire to see anyone save her immediate family.

In an extensive study conducted by Brown and Finkelhor (1986, p. 70), the researchers indicated that “sexual abuse victims continue to feel isolated and stigmatised.” In a study by Briere (in Brown & Finkelhor, 1986), it was found that 64% of sexually victimised abused women felt isolated compared with those who did not experience the same emotion (49%). Herman (in Brown & Finkelhor, p. 70 1986) wrote that all survivors of father-daughter incest felt like they were “branded, marked and stigmatised.”

It would appear that when the going gets tough, Jane goes into hiding and isolates herself as a way of protecting herself from further humiliation. In other words, she engages in avoidance rather than approach behaviour (Elliot, 2006). She directs her behaviour away from negative stimuli which,

in her situation, could perhaps be due to the demands and criticisms of her art students. Their behaviour, for Jane could have been reminiscent of her father's behaviour to some degree.

At one stage Jane mentioned that she thought she had a "split personality" (bipolar personality). Jane further disclosed that her older sister had been diagnosed with bipolar disorder and wondered if she could also be afflicted with the same disorder.

4.7.3 Jane's family of origin

Jane is the middle of three siblings. She has an older sister who is married and who has one child. She also has a younger brother who is married with two children. Her father is late and her mother is still alive and remarried after her husband passed away. Jane's father emigrated from Italy to work in South Africa where he met and married Jane's mother. Jane's father was one of several siblings, all of whom were degreed professionals apart from her father. He chose to go into agriculture and eventually into the restaurant business. Jane was terrified of her father who she described as "bombastic" with a "big ego and very domineering." Jane made scant reference to her mother's family background save only that she was Afrikaans-speaking.

4.7.3.1 The pecking order

Throughout her life Jane felt that her father put her sister on a pedestal. She was also aware that her brother idolised their father and the admiration was reciprocated. Her brother spent many hours with their father fishing and has become, and continues to be a professional angler. Jane's father used to tell Jane that his daughter-in-law was more of a daughter to him than she was. Given the sibling pecking order, Jane

felt like the odd one out. Perhaps Alfred Adler's middle child syndrome theory can shed some light on her perceptions.

4.7.3.2 *Middle child syndrome*

Jane's position in her family of origin is what Alfred Allan termed as the middle child syndrome (Whitbourne, 2013). According to Stewart (in Whitbourne, 2013), our individual characteristics, values, achievements and life successes are determined by our birth positions within our families of origin. Theories such as Stewart's 2012 birth order theory (in Whitbourne, 2013) is perhaps worthy of note.

- [Stewart's 2012 birth order theory](#)

Stewart based his theory on Alfred Adler's original view of birth order. Like Adler, he also distinguished between actual birth order (ABO—numerical order of birth) and psychological birth order (PBO—self-perceived position in the family). This theory appears to boil down to the realisation that one's actual birth order is not necessarily the same as one's perceived order in the family of origin. The middle child according to Stewart generally tends to be ignored. Nonetheless and because of this (being ignored), middle children may sometimes find ways to garnish attention from their parents and peers. Jane by all accounts was sadly not one of these children.

Griffin in her blog post (2012, October 18) reports on the book by coauthor Katrin Schumann and the book entitled "The Secret Power of Middle Children". In this book, the authors Salmon and Schumann believe that despite the fact that a number of middle child children may harbour feelings of not belonging, there are many who have found a niche for themselves in society. According to these authors, middle child children

tend to be motivated towards social causes and justice. If they are in traditional business, they are innovators and team leaders.

As far as Jane is concerned, her actual birth order and her psychological birth order are one and the same—she is the middle child and, by all accounts, she felt that she was the odd one out. Throughout her childhood and into early adulthood she felt that she was ignored by her parents and believed that she was not worthy of their attention. Try as she might, she could not find ways to be heard by her family and only managed to get through to her family much later on in her life. At this time, far too much water and resentment had gone under the bridge. Jane's negative perception of her family in relation to herself will become clearer as her story unfolds.

4.7.4 *Jane's nuclear family*

Jane has been married for a number of years and they have one daughter. Her husband comes from an Afrikaans-speaking background and is fluent in both English and his mother tongue. From what I observed during the session, he seems to be a caring and supportive husband who is sensitive to Jane's needs and she of his. Jane is also fluent in the same languages as her husband but does not speak Italian despite her paternal heritage. Her husband is not only part of her nuclear family as in her eyes and heart, he is her only family together with their daughter.

4.7.5 *Jane's life of trauma*

4.7.5.1 Introduction

Jane's life was irrevocably surrounded by trauma and her life experiences are storied commencing from the age at which her ordeals began. Following the narratives, a number of the psychological effects of her

traumas are unpacked. As she is religious, she turned to faith-based resources for trauma counselling after the loss of her daughter. It would appear that she chose not to seek counselling for her childhood sexual abuse (CSA) and her father-daughter incest (FDI).

Jane's husband only found out about her molestation by the gardener and her father's incest after their daughter passed away. Her choice not to reveal her child sexual abuse and incest appears to be a common occurrence. Herman (1981/2000, p. 129) writes that "most incest victims both long and fear to reveal their secret." Although Jane offered no reason for not disclosing, Herman (1981) offers two possible reasons for her decision not to reveal her father-daughter incest. In the first instance, perhaps Jane believed that there was no source of help available to her and; secondly, that her disclosure would cause no end of problems particularly within her family context.

According to SgROI, Blick and Porter (1982, p. 16), there are a number of reasons for Jane keeping her secrets of childhood sexual abuse and father-daughter incest throughout her childhood and into adulthood. These reasons could have been the motivating forces that eventually lead her to disclosure many years later (that is—following the death of her young daughter). Keeping her secret could have been motivated by the offering of rewards by her father or perhaps even the gardener; that she enjoyed the activity and wanted it to continue; that her father was the "valued perpetrator" and in her mind, may have left her feeling good about herself in many ways (for instance—her self-esteem, feeling important); she may have been threatened (such as physical threats or how angry her mother would be if she disclosed).

It was just as well her father was late at the time Jane revealed her sexual abuse to her husband. In Jane's words, "If I had told him while my father was alive, things would have been quite different."

4.7.5.2 [Child sexual abuse \(CSA\)](#)

What is child sexual abuse? Sgori, Blick & Porter (1982, p. 9) succinctly define CSA "as a sexual act imposed on a child who lacks emotional, maturational, and cognitive development."

When Jane was growing up her parents worked away from home for most of the time. Together with her siblings, they were left at home and were looked after by the staff. They walked to school and back every day and their parents were scarcely involved in their school activities.

The gardener used to molest her most afternoons on her return home from school. Jane told her mother what was happening but the response she got was most certainly not what she expected. Instead of listening to Jane and protecting and comforting her, her mother accused her of lying and looking for attention. Perhaps her mother had a tendency to be "psychologically absent" (Sgori & Dann, 1982, p. 193) when it came to listening to Jane and her sexual abuse. Adopting to be "psychologically absent" is an effective defense mechanism and also a way of escaping responsibility. Jane's mother could well have chosen not to listen to Jane as it was a convenient way out.

Jane had no idea what her father thought of what the gardener was doing to her. In fact, she is not sure if he even knew what was happening. She lost track of how long the gardener molested her but

she was relieved when they moved away. In Jane's words, "You are young and you forget all about it." Or so she thought.

- Initial and long-term effects of child sexual abuse (CSA)

A review of the studies of CSA by Browne and Finkelhor (1986) in some measure summaries Jane's initial and long-term effects of CSA. According to their research, initial reactions include fear; anxiety; depression; anger and hostility; aggression as well as sexually inappropriate behaviour. Long-term effects include depression and self-destructive behaviour; anxiety; feelings of isolation and stigma; poor self-esteem; difficulty in trusting others; a tendency towards revictimisation; substance abuse and sexual maladjustment.

To this list of the abhorrent effects, Porter, Blick and Sgroi (1982) add a host of impact issues that affect children of sexual abuse. These include

- the "damaged goods" syndrome (physical injury or fear of physical damage and societal response);
- guilt (feels responsible for the sexual behaviour, for disclosure and the disruption of the disclosure);
- fear (consequences of the sexual abuse, the physical damage, future interpersonal or sexual relationships, retaliation from the perpetrator upon disclosure);
- depression (before or even after disclosure of the sexual abuse);
- poor social skills (parents limit outside relationships following intrafamily child sexual abuse) and low self-esteem (fear of physical

damage, societal response, guilt and blame for taking part in the sexual behaviour);

- repressed anger and hostility (angry at the perpetrator, parents, family members, friends, teachers, neighbours, etc.) for lack of protection;
- inability to trust (as a consequence of broken promises by the perpetrator or significant others);
- blurred role boundaries and role confusion (between the perpetrator and the child and more so when the perpetrator is a family member);
- pseudomaturity and failure to complete development tasks (role confusion as age-appropriate developmental tasks have been tampered with—the child prematurely adopts an adult-like role); and
- self-mastery and control (the child has been violated and therefore is not able to master and control his or her own life).

A considerable number of these effects are reflected in the ultimate form of sexual abuse—father-daughter incest.

4.7.5.3 Father-daughter incest (FDI)

- [Introduction](#)

In 1955, Weinberg, a then obscure sociologist (in Devlin, 2005), found that FDI was the most common form of incest in the United States of America. Further literature indicates that FDI is by far the most damaging kind of sexual abuse (Browne & Finkelhor, 1986). In the South African context, research by Vogelmann (1990) indicates that sexual abuse occurs at a rate of 70 to 80 percent within the family home by a family

member. His research resonates with American research in that FDI is one of the most common forms of family sexual abuse. South African born Russell (1997) has undertaken research both internationally and in her country of origin. Her South African research details the stories of five women who were survivors of various forms of step- and biological FDI.

- Jane's father-daughter incest (FDI)

A sexual relationship between a parent and a child is the most commonly known type of incest. Groth (1982, p. 215) defines incest as "overt sexual activity between persons whose kinship pattern prohibits marriage." According to Jane, her biological father rarely supported her and she felt that her older sister and younger brother meant more to him than she was. She has no idea why he felt this way about her and as a consequence, she felt that she was not wanted. Jane ultimately came to the sinister conclusion that this was the reason for the sexual abuse he meted out on her from puberty through adolescence and into early adulthood. While she was at home, boyfriends come to visit but her father did not approve and sent them packing. The sexual molestation continued until she left home when she was about 20 years old and at the time when she could no longer live "under his domain and hold."

It comes as no surprise that Jane was wary of her parents. She felt like she was trapped in her own fear to such an extent that she closed herself off. Sadly, she disclosed that she was reluctant to talk to anyone and firmly believed that no-one would believe her in any event. Her father used to tell everyone that whatever she said they must not believe her. She disclosed that he incessantly picked on her for no reason and

repeatedly told her how useless she was. To this day, she can still hear his voice even though he has long since passed away.

As for her mother, Jane feels that she either ignored or refused to acknowledge what was happening to her daughter. It would appear that her mother adopted a somewhat indifferent attitude towards Jane. Herman (1981, p. 89) writes that even if Jane's mother was aware of the family incest, she could have been "unwilling or unable" to help her daughter. As Herman suggests, perhaps she was also too "frightened or too dependent" to confront her husband Herman (1981, p. 89).

The irony of Jane's abuse is that many years later she went to see a psychologist (an uncle) who revealed that he suspected that his relative was sexually abusing her. Jane went to see him after she lost her daughter but was not comfortable going into detail about her abuse as he was a family member.

- *Psychological effects of taboo incest*

In an incest situation such as Jane's and umpteen others, power and dominance exists within the family. Jane described her father as "domineering and bombastic" and her opinion of him could be characterised as a dominant husband (SgROI & Dana, 1982). In Jane's recount of her family it becomes clear that her father was all-powerful and to gain his acceptance she succumbed to his insidious behaviour of sexual exploitation.

Below are some of the psychological effects that Jane appeared to demonstrate.

- *Feelings of being set apart*

Jane shared that she felt that she was different from other women. She is not alone as most women who have been sexually exploited by their

fathers describe themselves as being “different.” They also tend to feel that they are not “normal” and that they are damaged goods (Porter, Blick & Sgroi, 1982). Jane felt that she was useless and unworthy (Herman, 1981; Russell, 1999).

- *Identity damage*

After Jane left the family home she disclosed that her sexual encounters were mostly with older men. It would appear that her modus operandi here was to exploit them—turning the tables so to speak. Her behaviour could possibly be ascribed to her adult feelings that the core of her identity was rooted in her experiences of her incest. It can also be attributed to sexual maladjustment as a consequence of her incest (Browne & Finkelhor, 1986; Herman, 1981; Porter, Blick & Sgroi; Russell, 1999).

Neuman (2012), points out that the primary long-term effects of childhood sexual abuse is on self-esteem and not necessarily on how individuals adjust to sexual relationships later on in life. Most female survivors of incest grow up feeling somewhat guilty despite being told repeatedly that they are not responsible for what happened. Nonetheless, deep down they continue to feel complicit (Neuman, 2012).

Akin to most survivors of the stigmatisation of incest, Jane felt that she had to internalise her secret to maintain the family’s status quo and dignity (Herman, 1981). This left her feeling unworthy and that she had nothing to offer the world. As time went by, and with the support and nurturing of her husband, she was able to find some sense of her own identity and self-worth.

Sadly, from time-to-time, her past comes back to haunt her. During these moments she finds solace in alcohol to help her block out and numb her

painful memories. Daniulaityte & Carlson (2011) confirms Jane's reactions to her traumatic life experiences and her alcohol consumption to cope with her psychological stress.

- *Betrayal*

Jane's deepest betrayal emanated from her father who, instead of treating her as the child and early adult that she was, used her for his sexual deviation. As a child, Jane traded her trust and need for her father's love and attention, a bargain she was to regret for the rest of her life. During our session, Jane mentioned that she had ambivalent feelings about her father particularly when he was diagnosed with cancer. She disclosed that she pitied him yet on his dying day she had still not forgiven him. Her profound sense of betrayal resulted in difficulties with most intimate relationships until she met her husband.

Jane disclosed that her intimate relationships with the opposite sex were far from healthy. She admitted that she responded to her incestuous abuse by becoming promiscuous in her early adulthood. Briere (in Russell, 1997, p. 34) explains Jane's promiscuous sexual behaviour as (a) her way of being of value to someone; (b) a way to initiate or continue an intimate relationship; (c) being able to receive caring attention, albeit it superficial; and/or (d) to gain interpersonal power. In Russell's book—"The Secret Trauma" (1999, p. 278), one of her subjects describes her intimate relationships as "having a hard time determining where my sexuality is and being free with myself". Perhaps the explanation offered by Briere (in Russell, 1997) sheds some light on Jane's promiscuous sexual behaviour.

What was equally damaging for Jane was that her mother was not there for her during her ordeal. Despite Jane telling her what was happening to her, her mother ignored her, saying that she was lying. The research by Faller (1984, no page number) indicates that Jane's mother may have had a lot to lose if she acknowledged the father-daughter incest in her home. For instance, if she did acknowledge that the incest existed she may regard this as an "indictment of herself as a mother and a spouse"—in other words—that she was a bad mother and a spouse within the context of the family. Moreover and according to Faller (1984, no page number), in an attempt to make life easier for herself she opted for "putting on blinders" and turned the other way rather than address the issue.

Nevertheless this left Jane with a sense of unresolved feelings towards her mother who did not protect her and who, by all accounts, turned a blind eye to her abuse. The failure of her mother to nurture and protect her signalled the epitome of betrayal—a betrayal she had great difficulty forgetting and forgiving. As a consequence, she harboured considerable anger and a strong sense of abandonment towards her mother (Herman, 1981; Russell, 1997; Russell, 1999).

- *Detachment*

When Jane spoke about her childhood sexual abuse and particularly her FDI, her face and voice were expressionless and palpably devoid of emotion. Her speech was like a distant monologue that sounded as if she was talking about someone else in an echoing vacuum. It comes as no surprise that it was preferable to detach herself from her agonising emotions and experiences. The detachment that characterises Jane is

partially defined by Reber, Allen and Reber (2009, p. 209) as “a sense of emotional freedom; the lack of emotional involvement in a problem, in a situation, with another person, etc.”

A psychological interpretation of her matter-of-fact recount of her ordeal leans towards an identification of elements of post-traumatic stress disorder (American Psychiatric Association, 2013). Jane was exposed to actual experiences of trauma in the form of not only CSA, but more insidiously, to child and adolescent paternal sexual abuse. There was nothing she wanted more than to banish the hideous trauma from her thoughts. Thus she appeared to have achieved through psychologically dissociating or disowning her experiences.

- *Substance abuse*

In Jane’s words: “The way we think about what happened in the past reflects the way we behave.” At the time we met, Jane explains that apparently when she drinks wine, her behaviour is out of control—in other words—her thoughts become her actions. She is informed by all and sundry that she uses foul language and behaves inappropriately. Jane has no recollection of any of her actions or what she says and relies on her husband and friends to fill in the blanks. She believes that alcohol is a necessary evil and when she is under the influence she talks about her sexual abuse to anyone who will listen to her. Ostensibly, during these alcohol-infused moments, she also opens up about the tragic loss of her daughter. Perhaps it is during these moments that she “allows” her true feelings to surface.

Whilst alcohol or any other mind-alternating substance for that matter may numb or block out painful emotions and experiences (Daniulaityte &

Carlson, 2011), in moderate quantities, it may have the propensity to release the pressure. On the downside and in larger quantities however, individuals tend to have little or no recollection of what they said or did. As a consequence, Jane's expression of her negative emotions are negated by her loss of memory. In essence, Jane was not able to reap the benefits of airing her emotions (positive or negative) as she cannot remember what she revealed due to her alcohol-induced blackouts and memory lapses. According to the National Institute on Alcohol Abuse and Alcoholism (2004), when men and women drink large amounts of alcohol quickly and on an empty stomach, they can produce a blackout. This means that they are unable to remember what they did or said prior to drinking. Women tend to be more vulnerable to this phenomenon.

4.7.5.4 [The tragic loss of a child](#)

Jane and her husband had two daughters and sadly, they lost their oldest daughter. The toddler lost her life in a bizarre and unexpected truck accident. Jane admits that it helps to talk about what happened to their daughter but the pain never goes away. She maintains that you simply have to live with it and she came to the conclusion that she did not need counselling for the tragic loss of her daughter. Although she was prescribed anti-depressants, she only began taking them some time after the incident. She admits that she hardly cried and remained strong while she mourned the death of her daughter while caring for her surviving child. Jane felt that she had to be strong for her family despite the warning signs of her meltdown.

- **“Demon attacks”**

In spite of her efforts to remain calm in the conundrum of traumatic loss, the seams started to come apart when Jane began having what she called “demon attacks”. In a way, one can interpret these attacks as nightmares which are typical of the traumatic fallout of the loss of a loved one (American Psychiatric Association, 2013). She had two such spirit attacks—one prior to her daughter’s funeral and the other a short while thereafter. From the recollection of her episodes, it would appear that her dreams centered predominantly on her deceased daughter.

- *Jane’s dream content*

Jane recalls her sister-in-law mentioning that she had a vision of Jane’s deceased daughter playing with a tricycle. This upset her immensely and when she went to sleep that particular night she remembers something waking her up. Jane recalled that in her dream she felt like someone was breathing icy air onto her and that the person was pulling her heart out. She felt that her heart was beating very fast and that she was unable to move and felt pinned to the bed. She was unable to call out for help and was convinced that she was having a heart attack. In her mind she was praying and eventually she managed to fall asleep. When she woke up the next morning, she found grass in her bed.

In a subsequent reported dream, she felt like someone was taking her soul and that she could see both her body and soul leaving her. Jane’s recollection of her dreams is what Freud referred to as the manifest dream content (Freud Museum London, n.d.).

For the purpose of this study, I have chosen to focus on the dream content related to Jane’s heart and soul. The deeper meaning of her manifest dream content is somehow tied up to her latent dream content.

In this respect and with reference to the dream work of Freud, the transformations of the dreams people experience represents their unconscious (Freud Museum London, n.d.).

Recall that Jane dreamt that her heart was beating very fast and that she thought she was having a heart attack. One of the possibilities of the meaning of her dream could represent her deep-rooted unconscious anxieties or fears. The unconscious repressed fears (quite likely a residual from her childhood sexual abuse) seemed to have surfaced in her dreams following the tragic loss of her daughter.

A possible interpretation of the dream Jane had about her racing heart can in some measure be elucidated by Crisp (1999-2010). In this article, dreaming of the heart relates to unconscious intentions or outer feelings (pity, sympathy, tenderness, love, affection, likes and dislikes) as well as inner feelings (desires, secret thoughts, conscience). Depending on the dream content, the heart can also stand for worries about health. This is not necessarily about physical heart problems but rather due to feeling down about certain aspects of one's life—akin to having no zest for life. Dreaming of a racing heart indicates anxieties or fears in the unconscious that could be connected to illness or death (Crisp, 1999-2010).

The latent dream content of seeing her soul leaving her body could indicate that Jane is in danger of giving herself up for a useless purpose or to a person who is not worthy of such a sacrifice (Dream eDictionary, 2015). Perhaps on an unconscious level she was trapped in the zone of her FDI resulting in her feeling unworthy and useless.

4.7.5.5 Time for family disclosure

Ironically during her grieving for her daughter, the memories of her past were put on the back burner. In spite of her grievous life-situation, they soon made a come-back a few months later when her sister came to pay her respects. It was during this time that she too disclosed her own incest at the mercy of their father. Needless to say Jane was shocked and horrified on hearing the devastating news. Over the years she was under the impression that her sister was the quintessential golden girl.

Nonetheless, the two sisters decided to call their mother to tell her what happened to them. It came as no surprise that she was reluctant to process the news. Although they may have wanted to “reveal their secret” for a number of reasons, for instance and according to Herman (1981 p. 129), (a) they could simply have been too afraid to disclose the abuse; (b) perhaps they dreaded what others will think about their incest secret; and (c) they could well have felt that nothing would be done to rescue them from the father’s sexual abuse. Given the late disclosure of their father-daughter incest, Jane and her sister appeared to have decided “to keep mum” and perhaps for the same reasons stated above—at least until they were both in their early 40s.

4.7.6 Where Jane is now?

Sadly Jane’s beloved husband unexpectedly died of a heart attack early in 2015 at the tender age of 46. Apparently Jane has taken solace in religion and counselling from her church leaders and has become a recluse. Jane keeps in touch with her sister and her mother from timeto-time.

4.8 ALLEN

4.8.1 Background

Allen is a 36-year old male who has been addicted to drugs and alcohol for a number of years. At the time of the first client interview he was drug-free for approximately six years and presented with problems related to his binge drinking.

Allen has been an on-off member of Alcoholics Anonymous (AA) in an attempt to control his drinking behaviour but with little success. He has recently rekindled his relationship with the organisation and attends meetings twice weekly at two different sites and has two sponsors. Allen takes the 12-step programme of the AA (Alcoholics Anonymous, 2001) more seriously this time round whereas in the past, he was less committed. His mother, who made the first appointment, noticed that he was actively reading the AA book as opposed to simply paging through it as he had previously. Allen confirms his mother's observation.

4.8.2 Family of origin

Allen is the older of two siblings and his parents are both alive. He has a younger brother who recently got married. He seems to be closer to his mother and describes his relationship with his father as distant. His younger brother is closer to his father and has a healthy relationship with his mother. Although he has recently disclosed his unsavoury childhood experiences to his parents, at the moment he is reluctant to share this with his younger brother. Allen did not discuss his reason for this.

Given the son-parent allegiances, Allen spoke of no sibling rivalry. He speculates that his relationship with his father became distant as a consequence of his substance abuse over the years. He is of the belief

that his adulthood drug and alcohol addiction could be related to the abuse his step-grandfather exposed him to. His step-grandfather died a long time ago.

Irrespective of the way his life has materialised, he regards his father as an icon. Whether his relationship with his father will improve now that the past has been made present, remains to be seen. Allen is hopeful and was not averse to considering family counselling.

As a consequence of his earlier drugging days and his current on-off binge drinking, he has lost most of his worldly possessions and currently lives with his parents. Given his age, Allen feels decidedly uncomfortable living with his parents. Although he is currently gainfully employed, he is seriously looking for alternative employment. Part of his treatment plan includes delaying looking for a new job until such time as his sobriety is consolidated.

4.8.3 Romantic relationship

Allen was in a fairly long-standing romantic relationship which had dissolved recently due to his drinking behaviour. During the initial interview, it was clearly apparent that he was exceedingly remorseful about the breakup. At this time, he alluded to an altercation between his partner's parents, his partner and himself. He appeared to be somewhat regretful about the consequences and planned to apologise for his behaviour. Although his intentions are admirable, Allen has no recollection of what he said nor what he did. He admits that he has to rely on others to explain his behaviour during his alcohol-induced blackouts.

At a follow-up session, Allen disclosed that he did indeed apologise to his ex-girlfriend and her parents. Unfortunately his apology was not

received as well as he had hoped it would be. Subsequently, he came to the conclusion that the relationship was bound to fail based on incompatibility. He disclosed that he was in a quandary about how to pursue a new relationship. The problem according to him is that he usually meets potential girlfriends in places where alcohol is consumed. Allen's dilemma left him with a choice of choosing sobriety over a relationship.

4.8.4. Alcohol is not anonymous

The consumption of alcohol and its intoxicating effects has been around for centuries (Keller, 1979). Most people around the world know about alcohol yet there are many who are unaware of how it can damage the human brain and body (National Council on Alcoholism and Drug Dependence, Inc., n.d.). Some individuals may consume copious amounts (heavy or binge drinking), use controlled or limited quantities or refrain entirely. The intoxicating ingredient in alcohol such as beer, wine and liquor is ethyl alcohol (ethanol) that leads to a state of becoming drunk (Centers for Control and Disease Prevention, 2014). What follows below is research on Allen's binge drinking and alcohol-induced mental blackouts.

4.8.4.1 Binge drinking

Whether one indulges in binge or heavy drinking, consumption qualifies as excessive alcohol use (Centers for Control and Disease Prevention, 2014). Allen has a history of both types of drinking but when he first presented with his addiction, he had been binge drinking. The National Institute on Alcohol Abuse and Alcoholism (n.d., no page number) defines binge drinking "as a pattern of drinking that brings blood alcohol concentration (BAC) levels to 0.08 g/dl. This typically occurs after four drinks for women and five drinks for men" consumed over a period of

approximately two hours. Blood alcohol concentration (BAC) refers to the amount of alcohol in a person's blood. In South Africa, the limit of BAC is 0.5 per 100ml of blood for ordinary drivers and 0.2 for professional drivers (Automobile Association of South Africa, n.d. & International Center for Alcohol Policies, 1995-2015).

- Alcohol-induced blackouts

Typically, the more one drinks alcohol, the less one will remember or recall events that occurred prior, during and after drinking (White, 2004). Allen is a typical case-in-point given his memory losses of what he did or said before, during and after his bouts of binge drinking. How then does alcohol, or any other drug for that matter, affect human memory? In order to give some credence in response to this question, it is helpful to begin by looking at (i) how memories are formed and stored in the human brain as depicted in Figure 5.1; (ii) blood alcohol concentrations and blackouts; and (iii) alcohol and memory impairment (White, 2014).

(i) Memory formation in the human brain

According to Atkinson and Shiffrin (in Sternberg, 2009; in White 2004) memory formation and storage occurs in stages. The process starts from sensory memory that lasts for a few seconds. This stage is followed by short-term memory that lasts from seconds to minutes if the information is rehearsed. Long-term storage memory is followed by the short-term rehearsed, incoming information.

As can be seen in Figure 5.1, alcohol hijacks the transfer of information from short-term memory to long-term storage although it can also affect most of the other stages of memory to some degree. In most severe cases, intoxicated individuals are unable to recall critical or entire events

that happened when they were under the influence. These memory collapses are known as blackouts. Goodwin (in White, 2004) posits that blackouts represent episodes of amnesia during which intoxicated individuals, when sober, have no recollection thereof. What is more compelling and according to Jellinek (in White, 2004) is that blackouts are strong indicators of alcoholism.

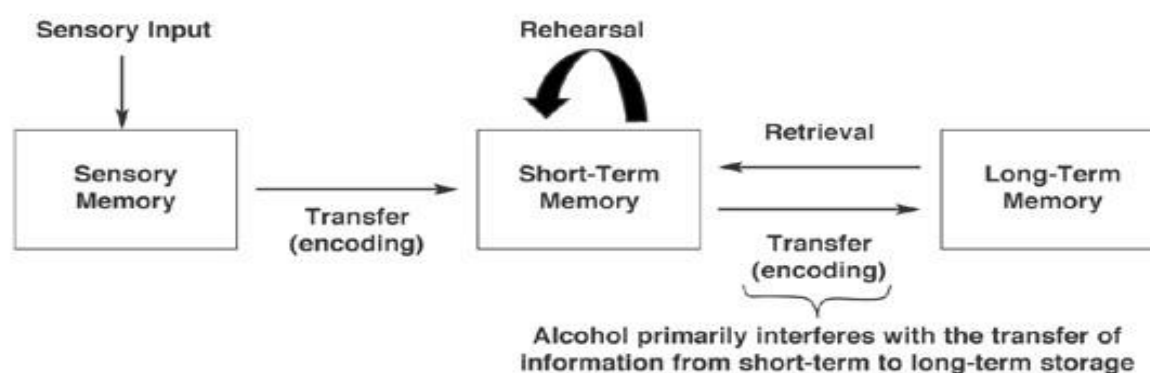


Figure 5.1.

A general model of memory formation, storage, and retrieval based on the modal model of memory originally proposed by Atkinson and Shiffrin (1968). Alcohol seems to influence most stages of the process to some degree but its primary effect appears to be on the transfer of information from short-term to long-term storage. Intoxicated subjects are typically able to recall information immediately after it is presented and even keep it active in short-term memory for 1 minute or more if they are not distracted. Subjects also are normally able to recall long-term memories formed before they became intoxicated; however, beginning with just one or two drinks, subjects begin to show impairments in the ability to transfer information into long-term storage. Under some circumstances, alcohol can impact this process so severely that, once sober again, subjects are unable to recall critical elements of events, or even entire events that occurred while they were intoxicated. These impairments are known as blackouts (Courtesy White, 2004, no page number)

(ii) Blood alcohol concentrations and blackouts

Strange as it may seem, heavy or binge drinking is not solely responsible for blackouts. Research by Goodwin and colleagues (in White, 2004) indicates that gulping drinks and drinking on an empty stomach also

contributes to episodes of blackouts. In another study, Ryback (in White, 2004) found that blackouts occur as a consequence of a rapid rise in blood alcohol levels. This research indicates that individuals who do not experience blackouts (despite being extremely intoxicated), display slow increases in blood alcohol levels. It would appear that Allen is indicative of the former rather than the latter.

(iii) Alcohol and memory impairment

Prior to the 1950s, two theoretical hurdles hindered progress towards an understanding of the effects of alcohol on memory. During this period, there appeared to be a lack of understanding of (a) the functional neuroanatomy of memory; and (b) the mechanisms underlying the effects of alcohol on memory. In the second half of the 20th century, it became apparent that a number of brain regions are involved in the formation, storage and retrieval of different types of memory (Sternberg, 2009; White, 2004).

The initial observation of the functional neuroanatomy of memory was made by Scoville and Milner (in Neylan, 2000; in White, 2004) on an amnesic patient known as H.M. In an attempt to control the patient's intractable seizures, large sections of his medial temporal lobes and hippocampus were removed from his brain. Although H.M.'s seizures reduced greatly, he displayed a number of memory impairment symptoms. H.M. was unable to form new, long-term memories yet he was able to learn new basic motor skills. He was also able to retain information in short-term memory for a few seconds or longer if he was not distracted and he could also recall episodes of his past life that happened long ago. Recall of this nature is what Tulving (in Sternberg, 2009) termed

episodic memory. It was also found that H.M. was unable to form new long-term memories for facts and events. Tulving (in Sternberg, 2009, p. 197) referred to semantic memory as memory that “stores general world knowledge.”

In H.M.’s case, he was able to retrieve long-term memories formed approximately a year or more before his surgery but not long-term memories for a year or more after his surgery (Sternberg, 2009; White, 2004). Research such as this confirms that alcohol has a damaging impact on memory and the more alcohol is consumed, the more the memory impairments increase (White, 2004).

4.8.5 Allen’s trauma and addiction

From the onset of his first session, Allen disclosed his childhood exposure to pornography. He recalls that when he was about 6 or 7 years old his step-grandfather made him watch videos and magazines that contained explicit adult body images. Apparently the family member in question also sexually abused his female cousin.

4.8.5.1 Child pornography

Exposing a child to pornographic materials of any nature is a form of sexual abuse in South Africa. From a legal perspective, child pornography in this country amounts to exposure or causing exposure, display or causing display of child pornography or pornography to a child. Thus child pornography in any of these forms is constituted as a criminal offence and is punishable by law (Criminal Law [Sexual Offences and Related Matters] Amendment Act, 2007).

The Films and Publications Act No. 65 of 1996 (p. 3) defines “child pornography that includes any image, however created, or any description

of a person, real or simulated, who is or who is depicted, made to appear, look like, represented or described as being under the age of 18 years as (a) engaged in sexual conduct; (b) participating in, or assisting another person to participate in sexual conduct; or (c) showing or describing the body, or parts of the body, of such a person in a manner or in circumstances which, within context, amounts to sexual exploitation, or in such a manner that it is capable of being used for the purposes of sexual exploitation.”

Allen only revealed his deepest and darkest secret to his parents following our first session. It took him well-nigh 30 years to offload his lifelong burden. His mother was the first to know and, with a strong sense of trepidation, he managed to reveal his secret to his father. He has yet to inform his younger brother of what transpired during his early childhood years.

[4.9 The here-and-now](#)

Allen was not explicit about the extent and nature of his sexual abuse in the form of his childhood exposure to pornography. Nonetheless, he confessed that he turned to drugs and alcohol to block out his recurring thoughts and images of his abuse at the hands of his step-grandfather (see Daniulaityte & Carlson, 2011). By all accounts, Allen has reached a stage in his life where he is ready to face his demons. He has made up his mind to give up drinking and to attend regular Alcoholics Anonymous meetings. He has also committed to counselling on a regular basis. Working on his relationship with his father is one of his priorities.

4.10 CONCLUSION OF CHAPTER 4

Chapter 4 draws together a group of unique individuals most of whom, insofar as I am aware, have had no known reason to meet. Through the medium of their narratives, each individual presents with a sense of their own inimitable yet seemingly comparable personalities within the context of this research. Their personal renditions of their experiences, real or denied or somewhere in between have merged towards a metaphorical circle of friends.

The exceedingly personal and at times, harrowing experiences of these unique individuals, constitutes the moral fibre of this study. Their invaluable and accommodating contribution echoes the question of this research undertaking.

Chapter 5

CONCLUSION

5.1 INTRODUCTION

This chapter presents a thematic summary of the qualitative exploration of the nature of trauma and addiction. It commences with an evaluation of the study followed by the identified key and sub-themes. Supporting extracts in support of the themes are interspersed in the analyses. The chapter concludes with the strengths and limitations of the study and proposed recommendations for future research.

5.2 EVALUATION OF THE STUDY

The data collected was intended to bring to the fore the experiences of a small sample of individuals who have walked the plank of trauma and addiction. Despite the size of the sample relative to a representative target population, the narratives of the participants speak for themselves. Curry, Nembhard and Bradley (2009, no page number) informs readers that the aim of qualitative research is “to identify ‘information-rich’ participants who have certain characteristics, detailed knowledge, or direct experience relevant to the phenomenon of interest”. The rich accounts of the participants in this study are endowed with their first-hand experiences with ample or vivid recall of their trauma and addiction. As such, their narratives reflect the sinister and personal experiences of the phenomena.

ABBREVIATIONS: BP-bipolar; BPD-borderline personality disorder; CSA-childhood sexual abuse; C-PTSD-complex posttraumatic stress disorder; PTSD-posttraumatic stress disorder;
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5.3 IDENTIFIED THEMES

Trauma and addiction are the over-arching themes of the study. The sub-themes emanating from the phenomena are illustrated in the thematic map of trauma and addiction in Figure 5.2. One of the major themes is childhood trauma and there are various sub-themes of childhood trauma in some of the narratives. These include child sexual abuse, physical abuse, emotional abuse and neglect. Of the seven research participants, five have varying degrees of childhood trauma.

- **Description of the thematic map of trauma and addiction (Figure 5.1)**

In adolescence or adulthood, the repercussions of childhood trauma may see the advent of addiction and mental health issues (i.e., PTSD, BPD, etc.). Under such circumstances, support structures such as Alcoholics Anonymous and/or Narcotics Anonymous provide options for recovery. Admission into drug treatment centres might also become necessary. The family environment in which the individuals find themselves is dependent on whether the addict experiences relationships that are either toxic or enabling. The environment may be loving or devoid of rules for order and stability (i.e., disorganised and/or fragmented). Support structures such as child welfare homes or finding homes for the children could be options worth considering. Many people who are addicted have no home and resort to living on the streets. This environment may be the catalyst that drives individuals into advanced addiction (self-medication) and/or risky behaviours (thrill seeking) as coping mechanisms.

It is worthwhile noting that traumatic experiences and substance dependence often impacts on the self and identity of individuals. Damage to the identity of addicts has an effect on their self. Moreover, the self

of children growing up can lead to relapse in the adult addiction. For the bridge between trauma and addiction to be reconciled, traumatised children, as adults, need to have a sense of how they relate to themselves and how they see themselves over time—not only who they are, but who they are in the world. This will perhaps create a link between their childhood traumas and their adulthood addiction.

The consequences of childhood trauma could lead to addiction including the likelihood of mental health issues. In this study, PTSD is noticeable in a number of the participants which is a foundation for other mental health issues (e.g., BPD and BP). With CSA often, and very specifically child abuse, tends to lead to mental issues later in life. This is an observation that is worthy of attention. PTSD in terms of children is discussed in the supporting literature below. As BPD has been discussed in Chapter 4 it is not discussed in this chapter. However, a limited discussion on BP is provided below.

5.3.1. Supporting literature

The criteria for mental disorders are classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) of the American Psychiatric Association (APA, 2013). The disorders below are briefly mentioned in relation to the research participants and their experiences.

- **Posttraumatic disorder (PTSD)**

Given the narratives of the participants that revealed childhood traumatic experiences it seems fitting to approach PTSD from the viewpoint of a child. As a consequence of their young experiences, the research study takes into consideration their inherited mental health legacies and their adult acquired mental health issues. A diagnosis of PTSD (APA, 2013,

pp. 271-2) for children differs in terms of age as illustrated in Table 5.1. Thus, at the exclusion of other criteria of the disorder, the emphasis is on the age of onset of trauma. The symptoms of PTSD are discussed in sections 1.4.2.1 and 1.4.2.2 of the research.

- **Complex-posttraumatic disorder (C-PTSD)**

In her book entitled *Trauma and Recovery: The aftermath of violence—from domestic violence to political terror*—Judith Herman proposed a new diagnosis for the then PTSD. She advocated naming it “complex posttraumatic stress disorder” (1997, p. 119) to refer to “the syndrome that follows prolonged, repeated trauma.” PTSD has been refined in the current DSM-5 (APA, 2013) to which Turkus (2013, p.3) comments as follows: “[PTSD]....has been expanded to include symptoms which are a

Table 5.1 PTSD criterion for children older or younger than 6 years old (APA, 2013, pp. 271-274)

OLDER THAN 6 YEARS OLD	6 YEARS AND YOUNGER
Exposure to a trauma, e.g., sexual violence	Exposure to a trauma, e.g., sexual violence
Intrusion symptoms, e.g., repetitive playing out certain parts of the trauma	Intrusion symptoms, e.g., distressing memories, dreams of trauma, flashbacks
Avoidance of reminders of trauma, e.g., bad memories, feelings, places, people	Persistent avoidance of trauma, e.g., avoids activities, places, physical reminders, etc.—negative changes in thinking - e.g., increase in feelings—e.g., fear, guilt, shame etc.
Adverse changes in thinking and mood, e.g., unable to remember trauma or thinks “I am bad”	Changes in arousal and reactions, e.g., irritable, angry, aggressive, extreme temper tantrums, easily startled, concentration problems, sleeping difficulties
Changes in anxiety and reactions to trauma, e.g., irritable, angry, reckless	Worrying and significant distress or problems in relationships with parents, siblings, etc.

much better fit for our clinical diagnosis of Complex Trauma. They are also closer to the criteria for Complex Trauma Disorder (based on DESNOS, Disorders of Extreme Stress, Not Otherwise Specified, study done in the 1980's)." Twenty-one years down the line the proposal that Herman put forward in the late 1990s was realised.

- **Bipolar (BP)**

The Diathesis-Stress Model in some measure offers an explanation of bipolar disorder and other mental disorders. Hillman (2015) explains that this psychological model attempts to explain the reason certain people develop mental disorders such as bipolar and others do not. The elementary theory is that mental disorders are dependent on an interaction between genetics and life experience. If we take Mona into consideration, she was diagnosed with bipolar and her mother had bipolar (the genetic component). The experiences of her life up to her current status have been far from flawless as evident from her history (life experiences component).

5.3.2 Sub-themes of trauma

What is emerging with many of the participants is that childhood trauma plays an important role in what occurs later on in life—that is drug addiction and/or an inability to cope or deal with the offending trauma. Addiction and trauma may present in children and adults in PTSD including other mental disorders such as BPD and BP. According to McLean and Gallop (2003), women who have experienced severe childhood trauma (particularly sexual abuse) are more likely to manifest symptoms of BPD and/or C-PTSD. The disorders are briefly discussed

in the supporting literature in section 5.3.1.1 of this chapter. Detailed discussions of the relevant disorders can be found in the body of the study.

5.3.2.1 Childhood trauma experienced by the participants

Of the seven research participants, five experienced childhood trauma. Three were exposed to explicit childhood sexual abuse; one experienced implicit CSA in the form of child pornography; and the remaining two were survivors of childhood trauma. Of the seven participants, two were solid addicts who appeared not to present with any childhood trauma. CSA is defined by Sgroi, Blick and Porter (1982, p.9) “as a sexual act imposed on a child who lacks emotional, maturational and cognitive development.” Initially the child will react to the sexual abuse with reactions such as fear, anxiety, depression, anger and hostility, aggression and sexually inappropriate behaviour (Browne & Finkelhor, 1986). Long term effects manifest in depression and self-destructive behaviour, anxiety, feelings of isolation and stigma, poor self-esteem, difficulty in trusting others, a tendency toward revictimisation, substance abuse and sexual maladjustment.

Exposing a child to pornographic material is a form of sexual abuse in South Africa (Criminal Law [Sexual Offences and Related Matters] Amendment Act, 2007). The Act (p. 7) defines the offence as follows: “Child pornography means any image, however created, or any description or presentation of a person, real or simulated, who is, or who is depicted or described or presented as being, under the age of 18 years, of an explicit or sexual nature, whether such image or description

or presentation is intended to stimulate erotic or aesthetic feelings or not, including any such image or description of such person.....”

Research highlights that early childhood trauma such as childhood physical and sexual abuse can be associated with addiction to substances (including other difficulties) such as alcohol and illicit drugs (e.g., Browne & Finkelhor, 1986; Dayton, 2000; Dube et al., 2003; Herman, 1997).

The childhood traumas endured by the five participants are discussed below in terms of CSA and childhood trauma including neglect. The individual analyses are in no particular order and are discussed according to the time at which the interviews took place.

(i) Johnny

Johnny disclosed that when he was 12 years old he was sexually abused by a man in a public restroom (*“I can go back to my earliest memories where at 12 being sexually taken advantage of....that’s really something that’s hurt me a lot”*). At the time, his parents were not aware of this incident (*“I’ve never told my parents about it”*) and he did not reveal the reasons for non-disclosure of the assault. Moreover, he made no mention of having told them at all.

Personal dialogues and studies reveal that survivors of CSA have their own mind-set for not revealing their abuse. Herman (1981, p. 129) writes that deep down, “most incest victims both long and fear to reveal their secret.” Survivors of CSA have their own reasons for not revealing their abuse and Herman (1981) offers two possible reasons for this: (1) that there is no source of available help; and (2) that disclosure could lead to problems such as disruption and upheaval within the family context.

Sgroi, Blick and Porter (1982, p. 16) add that keeping childhood physical or sexual abuse tends to be a closely guarded secret. This could be due to rewards offered by offenders; enjoyment of the activity and wanting it to continue; that fathers or father figures are the “valued perpetrator” possibly leading to feeling good about the self (e.g., self-esteem, a sense of acknowledge and recognition—this resonates with a possible warped sense of identity and the self—a sub-theme of the study); physical threats and threats of reactions from family members and the community.

As far as Johnny is concerned he appears to take scant responsibility for his life. He lives to be on the beach with no apparent aspiration to do anything else. He also appears to be a weak character and according to Philott (n.d. no page number) he presents with “an unwillingness to work hard or show initiative.”

Self is a significant sub-theme with particular reference to childhood trauma and addiction and damage to the identity of addicts tends to have a negative effect on their identity. Moreover, the self of children growing up can lead to relapse in adult addiction. For the bridge between trauma and addiction to be reconciled, traumatised children as adults need to have a sense of how they relate to themselves and how they see themselves over time—not only who they are but who they are in the world. This will perhaps create a link between their childhood traumas and their adulthood addiction.

Johnny is fortunate as he has parents who supported him through his drug addiction. He had a solid support structure which is a sub-theme

of the study. His parents encouraged him to stay well clear from bad influences (such as his friends on the beach) despite his irritation.

(ii) Mona

Mona was very young when she became a casualty of incest (*"...my problems started when I was 7 years old...my grandfather sexually abusing me..."*). A number of the participants had distant parents (a sub-theme of childhood trauma) who demonstrated lack of love, affection and consideration. For instance, Mona had a mother who was alienated from her particularly regarding her CSA (*"....my grandfather was sexually abusing me....my mother would come home....she would ask me why am I full of black marks....I would tell her that this is what my grandfather's done to me....and she would say...that's what you wanted...."*).

Mona has been broken again and again and she had some severe childhood abuse. In all likelihood, she probably suffers from C-PTSD. Not being believed by her mother when she was abused has had a very detrimental and negative effect on her growing up. She is unable to trust and believe in others given the manner in which her mother treated her. As a consequence she believes that everything is her fault. Whether Mona will ever recover from her addiction is a mystery and perhaps she needs to fall several times before she sees the writing-on-the-wall. By getting off the streets (an environmental trigger for drug usage and a sub-theme of addiction), she stands a better chance of coming clean. Going into a treatment centre (she does not have a support structure here: a sub-theme of addiction) with detoxification is an ideal option. However, the chance of this occurring is scant to none

given the lack of support from her family both on a personal and financial level. There seems no way out for her and her prognosis is not promising.

(iii) Jane

Jane was a mere 5 years old when her traumatic life started (*"...the garden boy used to get hold of me....it happened quite a lot of times...."*). When she was approximately 13 years old, her trauma went to a whole new level (*"...when I was about in Standard 6...my dad started to molest me..."*). In a similar way to Mona, her mother was emotionally distant (sub-theme: childhood trauma) during her childhood and into adulthood. She left the children at home with the staff and it was during this time that her first trauma occurred (*"....so when I was 5 my mum left us with the kitchen girl and the garden boy...."*). It seems Jane felt as if she was being abandoned and neglected (sub-theme: childhood trauma) by her parents.

Jane uses alcohol to mask her social anxieties (*"When I drink I get flirtatious with older men....I shout and swear at my husband...."*). She believes that she becomes another person when she drinks alcohol. Based on this she believes that she has a split personality (borderline personality disorder). When people drink it is not a case of BPD but rather what is lurking in one's sub-conscious that is acting out as inhibitions are lost.

(iv) Allen

Allen was exposed to pornography when he was a young *child* (*"....when I was 6 or 7 years old my step-grandfather showed me pictures of naked people...."*). Up until his first counselling session, his parents were

not aware of his child sexual abuse. Allen has been drinking heavily for several years and at one stage, was using hard drugs and has been clean for quite some time. He appears to be despondent and currently unhappy with the way his life has turned out (*".....I have reached rock bottom.....lost everything I love.....I long to be like my old self again....."*). Allen comes across as a broken man who is struggling to get his life together. There are many things he would like to mend—to improve his relationship with his father and reconcile with his girlfriend. When he was in an inebriated condition, he ill-treated her and insulted his parents and he does not remember the incident. Similar to Jane and Brad, Allen feels that he has a “split personality” (BPD). The literature indicates that children who are sexually abused often present with this disorder (APA, 2013).

(v) Randy

Randy was treated extremely harshly by his biological father who eventually banished him from the family home. He had no option but to live on the streets which could explain his strong need to hike (*".....at one time my dad chased me....I'm walking around 1 o'clock in the morning.....12 years old.....my dad don't want me to sleep at his house anymore....."*). Eventually he was abandoned and disowned by his father (*"...so in the end my father chased me from the house...I was 15 then...my father told me that he didn't want me....."*). The treatment meted out when he was growing up appears to have an effect on a number of aspects of his adult life. He presents with low self-esteem, low self-confidence and unable to remain in one place at a time for any length of time. His adult behaviour appears to reflect the neglect

and emotional and psychological abuse meted out by his father during his childhood. He was peppered with insults and negative feedback which he seems to have inculcated into his current persona. There is evidence of domestic violence (sub-theme: childhood trauma) in the home (*"....my dad hit my mother...."*). Randy had issues with his father most of the time but particularly when he was drunk. During this time he (his father) used to physically abuse his mother (*"....he goes to all these police parties....and he used to get very drunk....and then he'd hit my mom...."*) (sub-theme: domestic violence).

As mentioned previously, Randy had a distanced, uninvolved and unloved relationship with his father. He vowed that he would not treat his future wife the way his father treated his mother. His "relationship" with his father was acrimonious and appeared to impact on his identity and his self (*"....it was horrible for me for people to tell me you're just like your dad....I don't want to be like him...he's an idiot....so a lot of times in my life I seriously focused on not being like him...."*).

5.3.3 Sub-themes of addiction

Addiction is a key theme of the study as well as a sub-theme of the consequences of childhood trauma. Primary candidates for the addiction key theme are Brad and Lilly.

(i) Brad

Brad disclosed that he was free from any childhood trauma. (In response to my enquiry about this he replied: (*"....No, that's why it's kind of difficult....I hear all these guys [about childhood trauma]....there's like a reason for it...."*). In this response he is referring to the fact that he does not have a reason (such as childhood trauma) for his addiction.

He however, understands how other people who have experienced childhood trauma can become addicts. During his avid days of addiction, he had a number of serious traumatic experiences which are described in Chapter By all accounts, he had no clear recollection of these potentially dangerous experiences as he was high at the time. Furthermore, he can only discuss these incidents based on what he has been told. Brad seems to have been brought up in a family with traditional roles where emotions are contained. He is closer to his mother than his father (*".....my mom and I are very close.....my mum and I talk about just everything.....I'm definitely a mummy's boy....."*) (sub-theme: environment and qualified by the enabling relationship between mother and son). His father was distant and aloof yet he was not abusive nor neglectful (*".....I mean my dad wasn't the most emotional but he never abused me....."*). His mother coddled him to overcome the paternal discipline. When a parent is over-compensating with a child, as an adult and on an unconscious level s/he may expect partners to treat them in the same way (i.e., an enabler). Brad appears to have been an enabler as he helped his ex-girlfriend get through her heroin addiction. This is a noble gesture under normal circumstances but certainly not in the realm of addiction—not for her and most certainly not for Brad (Drug Abuse Treatment, n.d.).

Brad was often involved with the wrong crowds or wrong, toxic relationships that he invariably became addicted to (*".....with addiction.....seems to creep in for me.....obsession with relationships.....obsessively looking for relationships all the time....."*). The relationships with his girlfriends are toxic and he enables them and they

enable his addiction. This appears to be similar to the way his mother enabled him as a child—you can take this drug because I'm there with you and there are no consequences. He is not taking ownership of his addiction.

He appears to have addictive tendencies where he substitutes one addiction for another (i.e., women, drugs, alcohol, road-running). Moreover, Brad does not take responsibility for his addiction and invariably has to get his father to bail him out of his problems. He was kidnapped by his dealers for not paying his drug bill and was held ransom until paid. Instead of finding a way to get out of this situation, he immediately contacted his father to rescue him. Granted this was a dangerous situation and most parents would rally. Alternatively, Brad could have phoned one of his friends to help him or find alternative ways to pay back his debt.

Brad suffered from social anxiety from a very young age (*".....I didn't have self-confidence to address girls...I was very nervous...when I drank, I could go up to any girl with no problem....."*) (sub-theme: identity and the self). Similar to Jane, he used substances (drugs in his case) to mask his social anxiety. A recurring theme for Brad is his fear of being abandoned and rejected (*".....to approach girls.....was very nervous...always worrying I would get rejected.....since I was a kid.....more pronounced.....the older I got....."*). His fears tended to affect his self-confidence (sub-theme: identity and the self). Somewhere along the line he has to merge his identity (who he thinks and believes he is) with his self.

(ii) Lilly

A turning point for Lilly is when her father was murdered. Although she was using drugs prior to the loss of her father, when he was shot and killed her drug use *increased* (“*My father passed away.....they shot him.....they murdered him...that’s what also escalated a lot of the drugs...*”). The loss of a loved one, particularly in tragic and/or violent circumstances impacts significantly on most individuals. Lilly is always looking for something like there’s a void she wants to fill. She is an adrenalin junkie and being a thrill-seeker is part of her personality. It appears that she is missing something in her life and she can only get that through dangerous situations. She found a substitute family with the Carnies (the carnival people in the United States) and this is what she wanted—the thrill-seeking, the drugs—everything she wanted in aid of her. The environment in the United States played a role in her addiction. When she comes back to South Africa, she steals, she drinks on the job—she has self-destructive behaviours but she does not seek help. She enjoys being engaged in very risky behaviour.

5.3 STRENGTHS AND LIMITATIONS

The strength of the research is that it highlights the immense impact that childhood trauma has on the lives of South African people. Moreover the study brings into the fold the lengths survivors of childhood trauma will stoop to douse their agonising memories. Turning to drugs and alcohol almost seems like a logical option yet it comes with damaging consequences. As far as the limitations are concerned, it is noted that there is a paucity of research on trauma and addiction in the South African context. An additional limitation of the study is that the research

participants were not a representative sample of the target population—the seven participants were from White backgrounds. Moreover, the sample for the study was limited with only seven participants involved.

5.4 RECOMMENDATIONS FOR FUTURE RESEARCH

A recommendation for future research is to draw a larger sample from a target population that is representative of different ethnic groups in South Africa.

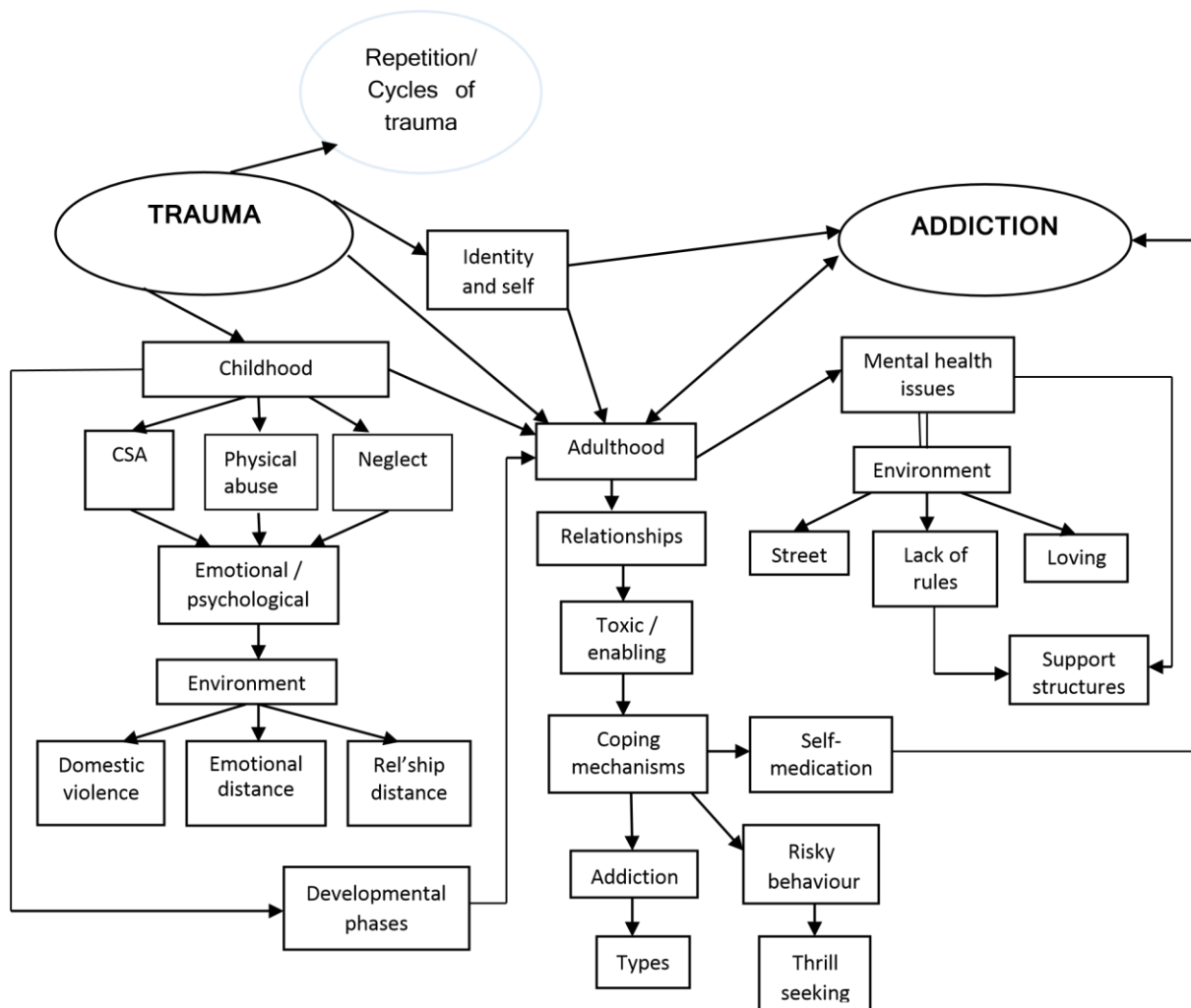


Figure 5.2 Thematic map of the two key themes and the sub-themes of trauma and addiction (courtesy of Braun and Wilkinson in Braun & Clarke, 2006). The illustration provides an overview of the various elements that are involved in the likely experience of individuals who have been traumatised in one way or another and the possibility of turning to self-medication to quell their memories and emotions. In addition, the figure illustrates the impact has on the individuals particularly on children and later on in life as adults who attempt to find mechanisms to cope.

ALCOHOLICS ANONYMOUS 12-STEP PROGRAMME

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted to it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry his message to alcoholics, and to practice these principles in all our affairs.

NARCOTICS ANONYMOUS 12 STEP-PROGRAMME

1. We admitted that we were powerless over our addiction, that our lives had become unmanageable.
2. We came to believe that a power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over to the care of God as we understood Him.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed, and became willing to make amends to them all.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take personal inventory and when we were wrong promptly admitted it.
11. We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to addicts, and to practice these principles in all our affairs.

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