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REFLECTIONS OF ADULT CHILDREN RAISED IN FEMALE-HEADED FAMILIES

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The literature indicates that children growing up in female-headed families are at risk of experiencing social problems, lower academic achievement and delinquent behaviour. A qualitative exploratory-descriptive study was conducted to gain insight into the perspectives of adult children who grew up in female-headed families. Purposive and snowball sampling were utilised to recruit suitable participants. Data from 12 participants aged between 25 and 35 years revealed the strengths of these families, which are often overlooked and downplayed. The findings show that the participants developed independence and self-reliance emanating from their mothers' survival strategies, resilience and perseverance.

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INTRODUCTION

An increasing number of children are brought up in female-headed families, which have become a major element within society, locally and globally (Statistics South Africa, 2015:10; Lesetedi, 2018:194). In the USA, prior to the 1970s, almost 90% of all children lived with both their biological parents until they reached adulthood, but this number has declined, resulting in a dramatic increase in the number of female-headed families (McLanahan & Schwartz, 2002:36; Cancian & Haskins, 2014:35). Approximately 50.4% of children in the USA are now growing up in female-headed families (United States Census Bureau, 2009; Tucker & Lowell, 2016:3). In Sub-Saharan Africa, although family structures differ across race and ethnicity, there has also been a substantial increase in the number of female-headed families. In 2011 46% of families in Botswana were headed by women, with more than 60% of children growing up in these families (Akinsola & Popovich, 2002:762). Subsequently, the number of children growing up in female-headed families increased to an alarming 78% (Malinga & Ntshwarang, 2011:1). South Africa has also witnessed an increase in the number of female-headed families. In 2009 31.2% were recorded, followed by 39.4% in 2011, and 41.36% 2015 (Statistics South Africa, 2009:13; 2011:6, 2015:10). However, these figures do not provide a breakdown of such families resulting from divorce, widowhood or mothers who never married.

There is a plethora of literature on these families and various factors account for their increase. One key reason for the formatio nof this family type is the escalating rate of divorce and separation in marriage (Kpoor, 2014:1960). Other reasons include cohabitation, desertion, death of a father, and women who by choice decide to be single mothers "in order to gain a sense of independence and efficacy" (Kpoor, 2014:1961).

Most previous research on female-headed families focused on negative consequences, partly because researchers were inclined to proceed from the family-deficit perspective, which views families headed by females as pathological, labelling them as "broken or disrupted" (Uchenna, 2013:112). The literature compares female-headed families with the ideal two-parent families and shows that children from female-headed families struggle on a wide range of indicators such as their economic standing, behaviour, health, academic performance and relationships with significant others (East, Jackson & O'Brien, 2007:14; McLanahan, Tach & Scheider, 2013:340; Amato, Patterson & Beattiec, 2015:191).

The wellbeing of children from female-headed families is threatened by extreme levels of poverty and economic hardships inherent in these families (Zeiders, Roosa & Tein, 2011:78). In many instances mothers have limited education and experience, and therefore find themselves working in low-paying jobs which leave them on the verge of poverty (DeFina, 2008:156). Studies report that, compared to children born in two-parent families, children in female-headed families tend to indulge in sexual relations early in their lives, which has serious implications such as unplanned pregnancy and contracting sexually transmitted infections (Simons, Burt & Tambling, 2013:460).

However, other researchers have reported contradictory results on the effects of female-headed families on children. Usakli (2013:262), for instance, conducted a study on children from female-headed families and children from two-parent families to measure their competence and self-esteem. It was evident from the study that children from female-headed families perform as competently as their two-parent peers, and in some instances outperform their counterparts. Although children who are raised in female-headed families are vulnerable, some authors contend that not all children from these households are prone to low educational grades (Hofmeyr, 2018:3). Similarly, Leung and Shek (2018:2535) challenge the hypothesis of the "pathology of matriarchy" in studying the relationship between female-headed families and educational achievement, and hold the view that female-headed families do not have any effect on educational achievement. Additionally, it is recognised and acknowledged that educated mothers are better equipped to offer skills and advice on how to cope with life events and boost their children's sense of control (Booth, Scott & King, 2010:590). It should be noted that contradictory research results show that children do not necessarily need both parents for psychological wellbeing and positive outcomes (McLanahan *et al*., 2013:418). Furthermore, children whose parents remained single were less likely to present with behavioural problems as they experienced less parental conflict than children from two-parent families.

The narrative that female-headed families lack social and economic support is rigorously disputed by Schatz, Madhavan and Williams (2011:599) as children often spend periods of time living with other families, usually the maternal grandparents, who provide social and economic support. Grandparents are regarded as the "heroic figures" of the female-headed families as they are instrumental in improving the family's financial resources with assistance in the upkeep of the family (Sun & Li, 2014:1443). Grandparents also assist in the physical care of children (Sun & Li, 2014:1443). Boys rely on their maternal uncles who are father figures in their lives (Richardson, 2009:1042). Their role represents a valuable strategy in preventing delinquency and violent behaviour among young males.

The study by Golombok and Badger (2009:154) revealed that single mothers often have an intense level of emotional involvement with their children and maintain a stricter role within the home. In addition, single mothers and children negotiate and share close and exclusive relationships, including the maintenance of a clear distinction between parent-child roles (Nixon, Greene & Hogan, 2012:146).

Much attention has been paid to the negative outcomes usually associated with living in female-headed families, but the experience of growing up in a female-headed family from the perspective of the adult child has not been thoroughly explored (Nixon, Greene & Hogan, 2015:1046). Hence, this study was conducted to fill this gap in the literature. Considering the prevalence of female-headed families, it is crucial for social workers to understand the perspectives of adult children from female-headed families in order to provide services and assistance that will improve their psychosocial wellbeing (Walsh, 2012:3).

THEORETICAL FRAMEWORK

Social work practice emphasises tapping into the strengths and resources of people and their environment in realising its goal of helping to address the social and economic needs and injustices they face (Guo & Tsui, 2010:234). The strengths perspective discourages the use of a deficit-based approach that assigns disempowering labels to individuals, categorising them in terms of pathology (Saleebey, 2006:197). Therefore, this approach turns the focus from personal defects, deficits and disease to the discovery of strengths and the identification of risk and protective factors. Inherent in the strengths perspective are

various elements that can be applied to families. The family strengths perspective aims to identify factors that contribute to the family's wellbeing across diverse cultural settings (Raffaelli & Wiley, 2012:350). Families are defined as unique, possessing traits, talents and resources that translate into strengths (DeFrain & Asay, 2007:449). The strengths of families render them resilient in periods of adversity; therefore, social workers must cultivate and enhance the strengths of their service users (Smith, 2006:16). Furthermore, the strengths perspective helps social workers learn a new critical language of strengths and positive human qualities that are often unrecognised, unnamed and unacknowledged in the helping process (Guo & Tsui, 2010:235). Therefore, the assessment of female-headed families from a strengths perspective offers family members an opportunity to discover their inner strengths and enhance their potential and abilities to recover from adversity.

The comparison between the traditional two-parent and the female-headed families led some scholars to underestimate the strengths inherent in the latter (Harris, 2013:387). This belief was entrenched by the fact that previous research conducted on female-headed families proceeded from the pathological view. Hence, images of teenage pregnancy, matriarchal households, absent fathers, identity crises and poverty were combined to construct female-headed families as damaged and dysfunctional. It is on this basis that the strengths perspective was adopted as appropriate for the study as it transforms the professional relationship of social workers and service users from an unequal dyad to an equal, collaborative partnership for problem solving.

RESEARCH QUESTION AND GOAL

The research was guided by the following question: What are the experiences of adult children who grew up in female-headed families? The research goal was to explore and describe the experiences of adult children who grew up in female-headed families.

RESEARCH METHODOLOGY

A qualitative explorative-descriptive research facilitated a deeper understanding of the participants' experiences. Purposive sampling was used to recruit 12 participants who met the criteria for inclusion. Adults aged between 25 and 35 years who grew up in female-headed families in Pretoria (Gauteng) and were willing to take part in the study were recruited. Semi-structured interviews were conducted, audio-recorded, transcribed verbatim and analysed following Tesch's eight steps (outlined in Creswell, 2009:186). The researcher and the independent coder analysed data independently and reached similar conclusions regarding the themes and subthemes that emerged.

Biographical profiles of the participants

Twelve adults from Pretoria participated in the study. Their profiles are presented in Table 1 below.

TABLE 1
DEMOGRAPHIC DETAILS OF THE PARTICIPANTS

P	Gender	Age	Marital status and children	Qualification	Employed
K	Male	34	Married for 11 years, 1 child	BA Degree	Yes
L	Female	34	Divorced for 4 years, 2 children	BA Degree	Yes
M	Female	33	Single	BA Degree	Yes
N	Male	33	Single	Diploma	Yes
O	Female	32	Single, 2 children	BA Degree	Yes
P	Female	32	Single, 1 child	Diploma	Yes
Q	Female	32	Single, 1 child	Certificate	Yes
R	Female	30	Married for 6 years, 2 children	Diploma	No
S	Female	28	Single, 1 child	Grade 10	Yes
T	Female	26	Single	BA Degree	Yes
U	Male	26	Single	Grade 12	No
V	Female	25	Single, 2 children	Grade 12	No

Nine females and three males aged between 25 and 35 years, with an average age of 30 years, participated in the study. Their psychosocial development fits Erik Erickson's sixth stage of intimacy versus isolation in which young adults (18 to 35 years) begin blending their identities with those of friends (Corey, 2014:65). When individuals lack a strong sense of identity at this stage, they are likely to have difficulty in forming and maintaining lasting relationships. Nine participants were single at the time of the interviews, which may be attributable to the delay in marriage in order to advance careers and become financially secure (Hewitt & Baxter, 2011:45). Two participants were married and one was divorced. A total of eight participants had children; five women participants had children outside marriage. This picture seems to validate the notion that women who grew up in female-headed families were also more likely to raise their children without partners (Pougnet, Serbin, Stack, Ledingham & Schwartzman, 2012:550).

Despite the generally held belief that children in female-headed families perform poorly academically and are likely to drop out of school (Harcourt, Adler-Baeder, Erath & Pettit, 2013:2), this assertion was disproved as five participants had Bachelor's degrees, three had diplomas, one had a college certificate, two were students both in their final year at university, and only one had not passed matric (Grade 12). Of the 12 participants, nine were employed and only one was looking for employment. This finding refutes the view that children from female-headed families have trouble finding and keeping a job due to the lack of a father figure in their lives (McLanahan & Schwartz, 2002:37). Instead, they have proved to be self-reliant.

Presentation of themes and subthemes

Three themes and six subthemes (Table 2) emerged from data analysis on the perceptions and experiences of adult children who grew up in female-headed families.

TABLE 2
THEMES, SUBTHEMES, AND CATEGORIES

Themes	Subthemes
Theme 1: The participants' descriptions of their childhood experiences	
Theme 2: The participants' specific experiences related to being raised in a female-headed family	2.1: Absence of the father in participants' lives 2.2: Resilience of the mother in a female-headed family 2.3: Strengths of growing up in a female-headed family 2.4: Challenges of growing up in a female-headed family
Theme 3: Support system in female-headed families	3.1: Spiritual support 3.2: Extended family support

Theme 1: The participants' descriptions of their childhood backgrounds

The fluidity and diversity that marked the participants' views in their interpretation of a family reveal complex and dynamic experiences of the roles of mothers and other family members. Such perspectives are contrary to those which purport that family life revolves around a mother and a father, who are married to each other, and their biological or legally adopted children. The participants' family backgrounds shed light on their family composition, living arrangements, upbringing, as well as their general wellbeing while growing up.

While eight participants lived predominantly with their mothers in townships, only four lived with their grandmothers in rural areas. Nine participants were living with extended family members. The participants outlined a wide variety of family types when describing their family composition and living arrangements.

Female-headed families have different demographic characteristics and their composition varies significantly from one family to another (Amoateng & Kalule-Sabiti, 2008:98). This is attributable to

the social process affecting the formation of female-headed families. Studies conducted in Iowa (USA) found that many children were living with extended families/relatives and only a few were living in exclusively female-headed families (Taylor, Larsen-Rife, Conger, Widaman & Cutrona, 2010:469). Often a woman is likely to seek shelter at her parental home until she can practically and emotionally afford to establish her own. Another study shows the vital role played by grandmothers in the upbringing of young African women (Makofane, 2015). This is consistent with the fact that members of female-headed families spend periods of time living with other families, usually the parental home of the mother (Kelch-Oliver, 2011:77). However, urbanisation and industrialisation have led to a reduction in the occurrence of extended families in African rural communities due to the migration of women, and their children who remain with them, to towns and cities where they seek employment.

Theme 2: The participants' specific experiences of being raised in female-headed families

Female-headed families have been, and in some instances still are, associated with a negative impact on children, who by all accounts experience an array of problems on a wide range of indicators such as health, education and economic status. The participants' understanding of their families and how they experienced their world as members of these families are discussed below.

Subtheme 2.1: Absence of the father in the participants' lives

Five participants who knew their fathers articulated their need to understand the circumstances around their fathers' lack of involvement in their lives. They needed to fully comprehend the reasons and contexts of their absence and had many unanswered questions. Although the participants expressed the need to communicate with their fathers, they did not show an interest in initiating and maintaining a relationship with them.

> *"As I grew up I wanted to know and gain an understanding of my father's whereabouts. I was told by my grandmother that he had problems with my mom when she was pregnant with me and he then left her."* (Female, 32 years)

> *"I think if I were to meet him, one question that I would ask would be: why did you leave me?"* (Female, 28 years)

> *"I am not sure if I still want to go back there and start and maintain a relationship with him. I think just knowing him will be good enough and maybe just to ask him a few questions…why didn't you come back? What happened? What did I do wrong?"* (Female, 26 years)

The findings are consistent with those of Makofane's (2015:34) study in which participants showed no interest in forming relationships with their absent fathers. For instance, one participant considered her father "as dead" by saying: *"I feel that he is such a coward and irresponsible father. So, he is dead and buried to me."* However, this narrative is in contrast to other findings in which adult children hoped to meet their fathers and establish meaningful relationships with them (East *et al*., 2007:17).

Even though some (five) participants needed an explanation as to the reasons their fathers were not involved in their lives, they accepted explanations from their mothers who had told them the reasons that led to the break-up with their fathers.

> *"Mama told us that daddy has moved on with another woman and that we would not see him anymore. I felt shattered and ended up looking down on myself."* (Female, 32 years)

The same sentiments were expressed by a participant in another study who associated her low self-esteem with being abandoned by her father (Makofane, 2015:33). There is a strong view that a father's presence or absence shapes the way daughters think about themselves, their relationships and the world as a whole (Freeks, 2017:93). As a result of the close relationship that is characterised by pure trust, the participants accepted their mothers' explanations and were able to move on with their lives.

Subtheme 2.2: Resilience of the mother in a female-headed family

Resilience denotes the capacity to overcome adversity or to thrive despite challenges (Power, Goodyear, Maybery, Reupert, O'Hanlon, Cuff & Perlesz, 2015:2). It is often associated with factors such as personality characteristics, or access to resources and support. These factors include, among others, positive self-esteem, strong coping skills, optimism, strong social resources, adaptability, perseverance and a high tolerance of uncertainty (Ledesma, 2014:1). There is evidence of the resilience of mothers in female-headed families and their ability to demonstrate positive responses to adverse situations.

Despite many challenges encountered in their journey of growing up in female-headed families, the majority (10) of the participants reported a sense of pride in their mothers for being able to overcome and endure hardship. They acknowledged that they did not grow up in the best of situations, but appreciate their mothers for providing for them and ensuring that they could thrive, even in dire situations.

> *"The resilience and persistence that my mother and grandmother were blessed with as well as the strength and discipline that they had always surprised me…there was always a plan. I always say when things are not okay, my grandmother would have worked out a plan right there and there, my mother would have done something…you know…I always draw strength from that even when I feel things are not going the way they are supposed to. I'm like, come on…I've seen my mother, grandmother hustling basically, so that is one thing I always draw strength from and say you know what?…those women were very strong…for me. The way they did things has really benefitted me greatly."* (Male, 33 years)

> *"My mother has a sense of responsibility. I think my mother would have been bitter if she was somebody else, having to raise a child alone when the other parent is alive and healthy. My mom was not bitter at all, she never really complained about her situation. So for me…that is why I am not the kind of guy to whine a lot because I was exposed to that environment where you need to find an alternative where there is none. There were always means of doing something in that house, you know…so I think if I can have half of the courage she had, I will go far in life."* (Male, 34 years)

The findings show the strengths that young male participants drew from their mothers' and grandmother's upbringing, which will have a lasting impact on their lives. Although some authors stated that many mothers heading families were in low-paying jobs, they were nonetheless able to stretch available resources to make the best of a dire situation (Elliot, Powell & Brenton, 2015:353). Similarly, it was found that mothers heading families were experienced in developing strategies for survival and meeting their families' needs under difficult circumstances (Orthner, Jones-Sanpei & Williamson, 2004:165). The view of mothers fulfilling the roles of both mother and father is a strength that suggests an awareness of the duality of a mother's parenting responsibilities.

Because they were working in low-paying jobs, the mothers of the participants found it difficult to meet the material needs of their children, but that did not deter them from bringing out the best in their children. The following narratives are based on the participants' reflections on how they lacked basic necessities and the lengths their mothers would go to in order to provide for them.

> *"We [the participant and her siblings] would wake up in the morning without having breakfast, go to school and have nothing during lunch…We'll just drink water and go back to class. Back home in the afternoon, we would find that mama made a plan to put something on the table for us to eat."* (Female, 32 years)

> *"I remember at some point when my mom was laid off from work, with seven children, it was not easy; we had to live on what she could bring home each day. She made sure that we never went to bed on an empty stomach."* (Female, 26 years)

These experiences support an African (Sepedi) adage that says, *Mma o tswara thipa ka bogaleng*: "a mother holds the sharpest part (blade) of a knife." A figurative translation means that mothers will do everything within their power and go to great lengths to protect and provide for their children. These experiences resonate with the finding that single mothers work twice as hard as a two-parent family to put food on the table and to ensure a safe environment for their children (Meier, Musick, Flood & Dunifon, 2016:669). Mothers' hard work provides financial and emotional security in uncertain economic times, but can nonetheless be satisfying and rewarding.

While it has been widely reported that the mother's next of kin usually help by taking care of the children (Kpoor, 2014:1967; Sun & Li, 2014:1443), one participant related how her mother single-handedly met the financial needs of the entire extended family.

> *"I grew up in a family where my mother was the breadwinner for the whole family. My aunt was not working and my mother was working as a domestic worker."* (Female, 33 years)

Researchers report that financial deprivation in female-headed families is prevalent and it is a common explanation for children's poor cognitive development and consequently poor academic achievement in school (Sun & Li, 2014:1441). However, the outcome of this study does not support this view because, despite the lack of resources, participants clearly performed relatively well academically (cf. Table 1). The participants' experiences are similar to those expressed by women raising their children alone, that their maternal capabilities bring them pride and positively reinforce the sense that they are good mothers (Darychuk & Jackson, 2015:453).

Subtheme 2.3: Strengths of growing up in a female-headed family

The participants shared the strengths inherent in their families as well as valuable lessons they had learned growing up in female-headed families in the face of adversity. Furthermore, the narratives illustrate how participants capitalised on these lessons and strengths.

A sense of independence and self-reliance was experienced by five participants after seeing their mothers succeed in raising them single-handedly.

> *"The realisation that as a woman I am capable of doing anything I want and not to rely on any man, but just as me standing alone…I don't need to draw anybody in my equation. If I need help I can ask but personally, I am capable of doing anything I want and also the fact that I am the driver of my destiny."* (Female, 32 years)

> *"I think I have become one young lady who is strong emotionally and otherwise. I feel it was a motivation for me to grow up without a father because maybe if I had a father I would be spoilt and would not have taken my education seriously...If I did not get educated, I would be expanding a circle of growing up without a father and that of destitution. So for me, his absence was a motivation for me to really work hard and get out of this circle of destitution."* (Female, 26 years)

> *"What I have realised with me and what I have seen on my horoscope is that I love to be independent. Very independent…but…as I was growing up, I told myself to focus on my career, buy a house and build on my wealth. I did not count on marriage because I wanted to rely on myself. I came alone on this planet and I wanted to have the necessary means to raise my children. You understand…I love to be independent...As I am sitting with you now, I knew that one day I must go and find my own place to stay. So…yeah! I do not want to depend on anyone."* (Female, 32 years)

> *"I have learned to stand up for myself and not wait for somebody to come and do things for me because there are situations in life that require one to stand and do something. Coming from a female-headed family, I just grew up seeing my mom and grandma working so hard to ensure our wellbeing, so I grew up with the same ethic that they had. My situation has taught me to work for myself, though it is not bad for other people to say I can marry a rich man who*

would do things for me, but for me it has taught me that I don't have to marry a rich man, I can be a rich woman myself and it has taught me to be a hard worker, more than anything else." (Female, 34 years)

"I look at how well my mother has raised all her children, for me the influence on me is that I can make it in life…when you grow up without a dad who would stand up for you any moment when you are bullied, you learn to stand up for yourself the whole time. You know that if you do not stand up for yourself, no one would." (Male, 34 years)

The participants drew strength from their challenges as they turned adversity into opportunity, and took advantage of these opportunities to determine their own destiny. The participants' accounts resemble the lived personal stories of single mothers who described how their children negotiated greater independence and self-sufficiency (Clark, Stedmon & Margison, 2008:576). Similarly, the autonomy and self-reliance of the children in female-headed families were found to be useful to get ahead in society, mothers encouraged their children to become independent and self-sufficient (Keller, Borke, Yovsi, Lohaus & Jensen, 2005:34). The participants' accounts differ from the finding in the literature that children in female-headed families are likely to drop out of school, be expelled or suspended, or to repeat a grade (Mudyan & Lee, 2010:445). Instead, the participants in this study viewed their family situation as a source of inspiration to remain focused on achieving their life goals, regardless of any challenges.

Seven participants also shared how the difficulties that they had to contend with turned into opportunities for personal growth and development, as they felt comfort and pride in their mothers' caregiving abilities. Inspiration and motivation also dominated their descriptions of the strong points they acquired throughout this journey.

"When I look at her [mother], she is a perfect example of a go-getter. She might not have been able to achieve her goals as quickly as she wanted, but she stayed in the game and she would say its fine, this is the goal that I want to achieve, at the end I will get there although it might take time but I will push and succeed. So that is what I have drawn from my situation." (Female, 32 years)

"When you lack certain things in life that serve as an encouragement for you to work hard because you know that if you do not, you might end up having nothing." (Male, 34 years)

"It has just taught me that as women, we have so much strength within us….you know….my grandmother raising us, and she was there for all of us…and I look at my mother as well, providing for all her children. For me the influence that they had on me is that I can make it in life as a woman. Yes, there are many challenges in life but I can succeed." (Female, 33 years)

Through their efforts to coach and create supportive family environments, mothers in female-headed families displayed a variety of coping strategies that their children could emulate. The messages that the participants received from their life situations came in the form of concrete examples, as described by a participant in another study who stated that *"she* [her mother] *showed me what it was to be a strong African-American woman, you know, and not relying on the resources of what the world offers"* (Everet, Marks & Clarke-Mitchell, 2016:344). Furthermore, mothers recognised the importance of teaching their children to be comfortable within themselves, to acknowledge their inner strengths, and to draw from such strengths to persevere and survive.

Family cohesion emerged very strongly from the participants' accounts as they shared how their mothers endeavoured to create loving relationships and interaction among all family members.

"Although we were struggling financially, we grew up well because our mom taught us to look out for one another as siblings. When I am sick, I know for sure that my sisters and

> *brothers are there for me. So there was that cohesion amongst us, that emotional bond within us…regardless of our circumstances."* (Female, 26 years)
>
> *"Cohesiveness and unity that was in the family were amazing. My mom would say as she was a religious person, she would tell us that it is not about what you have or can do, it is about the unity that we have. We might not have everything in the family but because of this unity, the neighbours in the community would never point at us and say these people do not have much. But the unity that we had was strong and kept us going*." (Male, 26 years)

It is reported that mothers in female-headed families engage in routines of spending more time with their children as a family to facilitate an ongoing process of enhancing cohesion and instilling values to foster family growth and evolution (Moriarty & Wagner, 2004:203). In a study by Lashley (2014:3), mothers alluded to the importance of family cohesion by participating in their children's activities so that they were not disadvantaged in any way. Furthermore, the mothers mentioned that providing time and activities guaranteed their children's connectedness to the family unit.

Resilience emerged as a strong element that enabled the participants to overcome challenges in their lives. Resilience is the capacity to change, adapt and grow in spite of ongoing stress or adversity (Brown, Howcroft & Muthen, 2010:339). It is the ability to successfully cope with stress and recover from difficult situations. In a study by Hong and Welch (2013:54), a mother raising her children alone described resilience figuratively as follows: "*It is better to be like a blade of grass, its roots are strong and although the leaf bends with the wind it does not break."* Some participants developed a strong character from their experiences which helps them resist external pressure.

> *"I am not easily influenced and that is because of the circumstances that I have been through at home. I grew up in a family where our mom was always trying to instil a positive outlook on life and to be content with what we had. We learned to accept our family situation and not try to be like others. So when I have friends I am not easily influenced because I was taught to accept myself and my situation from a young age."* (Female, 32 years)
>
> *"My circumstances have made me a responsible person, to be firm and to stand up for myself. In 2013 I learned that I am HIV-positive, so when I found out, I did not cry like other people when they find out that they are HIV-positive. I told myself that I know the circumstances where I come from. I am not going to succumb to this status. I grew up struggling and I am not going to let it add to my struggles. I will put HIV aside and live my life the way I want to."* (Female, 25 years)

The findings showed the participants' ability to regain a state of equilibrium in the face of adversity in order to sustain and enhance their day-to-day functioning. The resilience in children from female-headed families is attributed to the elasticity of spirit that their mothers have demonstrated in confronting hardships in their lives, and their ability to recover from adverse situations (Nikolova, Small & Mengo, 2015:488). Children from even the most dysfunctional or resource-deprived families manage not only to survive but also forge decent lives for themselves (Goodman, Lloyd, Selwyn, Morgan, Mwongera, Gitari & Keiser, 2015:15). The participant who articulated how she dealt with her HIV-positive status indicates the strong character she has developed through her positive emotions. Thus, resilience within female-headed families can be utilised by social workers to help them realise their strengths and to view difficulties as stepping stones to achieve optimal family functioning.

The participants are committed and dedicated to making a positive impact on their children's lives.

> *"My relationship with my child is very strong because I do not want my child to grow in my absence in whatever way. So my background has really contributed positively and has made me to love and appreciate a family."* (Male, 34 years)

> *"When I had my first child, I started looking at life through a different lens and was more focussed on completing my university qualification so that I could give him a better future."* (Female, 32 years)

The participants' experiences cultivated a determination to develop a healthy relationship with and to provide the best for their own children. Similarly, participants in another study revealed that they want what is best for their children and would protect them from growing up the way they did (Makofane, 2015:33). The first excerpt challenges the most publicised notion that men who grew up in absent-father homes are unlikely to get involved in the upbringing of their own children (Pougnet *et al*., 2012:552).

Upon reflecting on how the family situation has affected their relationships with other people, participants shared that:

> *"Coming from that family has taught me to adapt to different situations, so it was easier for me to relate and cope with people of different characters."* (Female, 26 years)

> *"I don't have issues meeting new people. When I get into a room full of people I don't shy away and sit alone in a corner or something."* (Female, 34 years)

These experiences challenge previous findings that children growing up in female-headed families have lower self-esteem and struggle to form and maintain relationships (Harper & McLanahan, 2004:395). On the contrary, the findings show that participants are assertive, confident and ready to confront work-related challenges.

Single mothers teach their children about self-worth and value while growing up (Everet *et al*., 2016:343).

> *"I was raised in a manner that when I don't like certain things in a relationship, I speak out about them and if there is no change, I simply move on with my life."* (Female, 33 years)

The independence that some adult children who were raised in female-headed families have enabled them to move away from unfulfilling intimate relationships (Keller *et al*., 2005:34). This finding resonates with that by Lashley (2014:6), that single mothers impart a sense of pride in their children irrespective of their family background in order to negotiate and maintain fruitful relationships. The independence and self-determination exercised by individuals who grew up in female-headed families is a strength that would enable them to determine and foster healthy, intimate relationships.

Subtheme 2.4: Challenges of growing up in female-headed families

The strengths perspective emphasises individuals' assets rather than their deficits or problems (Peacock, Forbes, Markle-Reid, Hawranik, Morgan, Jansen, Leipert & Henderson, 2010:642). However, negative experiences or challenges are not ignored; they are acknowledged as part of the individual's personal experiences and are used to focus on the individual's strengths (Black, 2003:341). The participants' challenges are highlighted in this section focusing on the current day-to-day challenges as a result of growing up in female-headed families.

Regardless of the successes and opportunities mentioned by the participants, they nonetheless seem to feel deserted by their fathers. Eleven participants expressed pain and discontentment as they are of the view that their fathers deliberately chose not to form part in their lives.

> *"My father has caused me a lot of pain because he would have been there for me if he wanted to."* (Female, 26 years)

> *"It is somewhat painful. I am always wondering whether my life would have been different if he was there for me."* (Female, 28 years)

> *"I remember a time when we were still renting a flat with my husband, he did something that I thought was terrible to me and I felt extremely…extremely angry. The first time he*

> *disappointed me, I was crashed…I pushed our son over the balcony and he was injured. My son was removed from my care and I was admitted to a psychiatric clinic for about four months, and through counselling I discovered that I had a lot of unresolved issues from my childhood and they were creeping into my adult life and influencing how I handle situations around me."* (Female, 30 years)

The same was true of participants in another study; their narratives were replete with descriptions of abandonment, hurt, resentment, anger, pain and feelings of being unloved (East *et al*., 2007:16). Another study also revealed that a father's absence left some participants emotionally wounded as they felt lost, unloved, rejected and betrayed by their unreliable fathers (Makofane, 2015:31). Such feelings can have adverse effects on the emotional wellbeing of children growing up in the absence of their fathers. McLanahan *et al*. (2013:411) contend that fathers who abandon their children may leave them with emotional wounds that may result in fear of rejection and betrayal. Such fears could, however, develop a strong character that can act as a defence mechanism and a shield against disappointment.

THEME 3: SUPPORT SYSTEMS FOR FEMALE-HEADED FAMILIES

This theme outlines the support system from which female-headed families gain strength and courage. The spiritual and social functions are brought about by the social networks in which the family participates (Kebede & Butterfield, 2004:358). Richardson, Johnson and St Vil (2014:493) posit that support systems are effective in diminishing or countering stress, reducing isolation, supporting life changes, and providing role models, information and resources.

Subtheme 3.1: Spiritual support

Nine participants found solace and strength in God (Supreme Being), the fundamental teachings of the Bible and role models in church. Their belief in God was a source of meaning and inner peace that brought feelings of comfort and optimism.

> *"Look, from my mother's side it was difficult to get support from her family. She was the first born of five girls, we have no uncles and her mother was the second wife, so it was also tough for our grandmother. The thing that supported me was the church because at the time when I was doing Grade 7, I had started going to church and I feel that it really played an important role in my upbringing. It also relieved her from stress because that meant I spent less time on the streets with friends, and my younger brother also followed me. We completed matric and life started to change for the better."* (Male, 34 years)

> *"Teachings from the Bible, teachings that I got from the church and the relationships I developed with the children of God. When you look at the people who have a close relationship with God and are successful, it motivates you in such a way that you want to be closer to God so that you can be successful as well."* (Female, 30 years)

> *"The church played an important role because as you know within the church there are get-togethers established for women, you see…women of prayer…those were the women who were always supportive to mama through prayers and also with material things like toiletries. They would visit just to check on us. If there were church trips that we could not afford, they would pay for us and even buy us food and make sure that we are not different from the others because we do not have money."* (Female, 26 years)

It was evident from Lashley's (2014:5) study that the church was an important part of the lives of participants in that it brought meaning and engendered a sense of belonging in times of need. Similarly, a participant described her reliance on faith and the relief that came with support received from people at the church (Broussard, Joseph & Thompson, 2012:198). This form of support is connected to the philosophy of *ubuntu*. Meiring (2015:8) states that the language of *ubuntu* has a lot in common with the language of the Christian Bible. The Old Testament prophets taught about care for the widow, orphans and the poor, and the whole Bible emphasises the value of generosity. It is argued that both *ubuntu* and

Christianity stress the significance of life together and relationships between people (Nell, 2017:7). The ability for churches to form and retain strong links with family members in female-headed families is important over time and should be seen as a resource and strength for social workers to draw from during practice.

Three participants observed cultural rituals as part of their spiritual practice to find comfort and peace in the midst of challenges. Those who did not know their paternal history and had no contact with their fathers were of the view that they were disadvantaged, considering that certain rituals had to be performed to prevent misfortune and to allow them to prosper in life.

> *"When things were not going well at home, we would call upon the ancestors to intervene but there are things that require the attention of your paternal aunt. How would you know your aunt when you don't even know your father? Through consultation with traditional healers at times you learn that the ancestors want certain rituals to be performed to appease them. Only the paternal aunt can help in such matters, otherwise misfortune blocks your success in life."* (Female, 28 years)

Some Africans practise ancestral worship founded on the belief that the dead live on and are capable of influencing the existence of the living (Bogopa, 2010:1). It is believed that ancestors are capable of either blessing or cursing the living (Munthali, 2006:368). This finding concurs with Makofane's (2015:33) study in which participants shared that some of their cultures require that a special ritual ceremony should be performed by the paternal family to welcome the birth of a child and introduce him/her to the ancestors. The process of ancestral worship takes place in the form of a lifecycle, from birth to death (Mokgobi, 2014:26). There are certain ritual ceremonies that cannot be performed without a particular relative who should fulfil certain obligations (Bogopa, 2010:2) such as paternal aunts, as indicated by some participants in this study. It is believed that failure to perform certain rituals in honour of the ancestors may bring about health-related problems and general misfortune in life (Berg, 2003:196). This aspect calls for social workers' understanding, acknowledgement and appreciation of the service users' cultural needs in order to provide them with culturally congruent services.

Subtheme 3.2: Extended family support

Extended family support has been characterised by concepts such as proximity, frequency of interactions, closeness and mutual assistance (Weisz, Quinn & Williams, 2015:8). Extended families play a critical role in the context of female-headed families. For instance, mothers in female-headed families use the support of extended families in the maintenance of their children (Taylor *et al.*, 2010:469). Conversely, some extended family members may become a source of stress to these mothers rather than offer support, as the relationship may not be characterised by reciprocity (Taylor, Forsythe-Brown, Lincoln & Chatters, 2017:538).

Ten participants shared their experiences of the support they received from their extended families, and the extent to which the family were involved in helping them to cope successfully with stressors associated with female-headed families.

> *"My uncle who passed away cared so much about us, although he could not buy us things such as clothes, he tried his best. When you lacked something at school…he would give you money and also gave advice on relationships and what to look out for in a life partner, things that we could not discuss with our father as he was not there. Many times, we would call him and he would come running to help. We all relied on him."* (Female, 32 years)

> *"When mama was coming home late, my uncle and aunt would come to check whether we have already started preparing supper, when we don't have money to buy bread, they would give us the money and mama would reimburse them when she came back."* (Female, 32 years)

> *"Generally, the burden is just too much for any mother raising her children alone. In my situation, my mom had the support from her family. She would wake up very early in the morning to go to work, but she didn't worry about what's going to happen to me. My uncle would leave a bit later so he would wake me up for school. When I came back from school, there was always someone in the house to look after me, so I think to a certain extent that made her life easier, she had a support system."* (Male, 33 years)

In Michigan, USA, extended families are regarded as a viable form of support because the female-headed family does not live and function in isolation but in extended family situations (Taylor, Forsythe-Brown, Taylor & Chatters, 2014:148). African female-headed families also enjoy support from extended families in raising children. In African cultures the maternal uncle plays a critical kinship role (Madhavan & Roy, 2012:803). A mother's brother must be consulted in all matters affecting his sister's children (Richardson, 2009:1042). Furthermore, he helps with food and clothing, and acts as mediator when disputes arise within the family. He also has power when children's marriages are arranged.

DISCUSSION

The goal of this study was to explore the retrospective accounts of adult children who grew up in female-headed families. The participants shed light on the diversity inherent in the structure of female-headed families. The narratives revealed that such families have different demographic characteristics that vary significantly.

All 12 participants grew up in the absence of their fathers as a result of desertion. Some of the participants were angry because their fathers did not show an interest in them and failed to initiate and maintain relationships with their children. They nonetheless articulated the desire to understand their fathers' reasons for not being involved in their lives, although they accepted their mothers' explanations that led to the dissolution of parental relationships. However, others are still harbouring a sense of abandonment and desertion by their fathers well into adulthood.

Despite the many challenges the participants encountered while growing up in female-headed families, they view their family situations positively. Participants were in awe of their mothers' resilience and they were of the view that the lessons they have learned will enable them to overcome life's challenges. Experiencing difficulties culminated in opportunities for personal growth and development for the majority of the participants as they are comfortable and proud of their mothers' caregiving abilities. Female-headed families enjoy substantial support from various systems from which they garner strength and courage. The participants' connection with God also gave them a sense of direction and guidance. For some participants, not knowing their fathers' whereabouts and lack of contact with him were viewed as a cultural disadvantage, because they believed that certain rituals have to be performed by members of the paternal family to prevent misfortune.

IMPLICATIONS FOR PRACTICE

From a strengths perspective, the assessment of female-headed families is important in offering family members an opportunity to discover their inner strengths and enhancing their potential and abilities to recover from adversity.

Social workers should partner with non-government organisations, faith-based organisations and the community, and initiate mentoring programmes such as the buddy system where male children are mentored by social fathers to become responsible men who will take care of their children. However, such interventions should not disregard the importance of female children as they also need to engage with social fathers on certain aspects of their lives, particularly relationships with intimate partners. Social workers should market their services in schools and identify children in need for early intervention. This will help curb the anger and bitterness that children often harbour because of a difficult childhood.

CONCLUSION

Despite the challenges encountered by children from female-headed families, the multiple strengths that characterise these families have been brought to the fore by the participants. The resilience of single mothers as well as the participants' acquired independence emerged strongly from the findings. While the mothers' resilience has sustained these families, it is important to conduct narrative research to capture the personal accounts of the mothers who are heading families. In addition, extensive qualitative and quantitative research should be conducted to establish how social workers can apply the strengths approach when offering services to female-headed households.

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CULTURAL SPECIFIC ATTITUDES OF BATSWANA PEOPLE TOWARDS ADOPTION

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KEYWORDS: adoption parent, alternative care, attitudes, culture, Batswana, cultural specific

NTRODUCTION

Children in South Africa reside in a society in which their rights, impartiality and dignity are elevated to the highest regard by the Constitution. Article 28 of the South African Constitution (1996) unequivocally states that the protection of children against abuse, violence and exploitation is both a basic value and an obligation. The aim of child protection is therefore to ensure the care, wellbeing and safety of children by means of a holistic and integrated approach. In the face of the best efforts of the South African government and civil society, many children still remain vulnerable (Lombard, 2014:1). An option for the placement of children who are found to be in need of care and protection by law is adoption. Adoption is a traditional method of alternative care in the child protection field and has been regarded for many years as the most effective and stable means of providing care for orphaned, abandoned and vulnerable children (Department of Social Development, 2015:1). It is the permanent placement of children who are no longer in the care of their biological parent(s) or permanent guardian (DSD, 2015; Loening-Voysey & Wilson, 2001:34; Hill & Hill, 2005:1). Blackie (2014:2) is of the opinion that there are large numbers of children who have been abandoned and require care, but correspondingly there are low numbers of available caregivers and adoptive parents. This, together with conflicting culturally held views on adoption, is an indicator that there is a crucial need for an understanding of adoption in African society (Mokomane & Rochat, 2011:352-353). According to Pilane (2002:72), the Batswana people strongly believe in and support their own culture, norms and values. They believe that what distinguishes them from other cultures are their cultural practices, their respect for their ancestors, their style of marriage, child rearing, ways of greeting and respect for others. The purpose of this study was to determine culture-specific attitudes of Batswana people towards adoption.

CONTEXTUALISATION AND PROBLEM STATEMENT

Children whom have been abandoned, orphaned and neglected find themselves in a strenuous and challenging situation (Akpalu, 2007:1070). Such situations are on the increase in South Africa (Rochat, Mokomane, & Mitchell, 2015:1). These children face a greater risk of being impoverished, discriminated against, having to face different types of abuse, the loss of property rights, being confronted with labour and/or sexual exploitation and neglect. These factors can threaten such children's potential to complete school and could further lead to the endorsement of practices that increase their vulnerability to social ills such as HIV/AIDS (Sigweni, 2008:32).

Blackie (2014:2) states that these children require care, but there are few available caregivers or adoptive parents. Adoption can be defined as the parental commitment to a child by someone who is

not the child's biological parent or guardian (Loening-Voysey & Wilson, 2001:34). Mokomane and Rochat, (2011:347), Gerrand and Nathane-Taulela (2015:1) as well as the Children's Act (38 of 2005) promote adoption as the best form of alternative care in cases where a child has been abandoned. Section 157(3) of the Children's Act states that, if it is in the best interest of a child, a very young child who has been orphaned or abandoned should be made available for adoption (Children's Act 38 of 2005:71). This section of the law is supported by Crossen-Tower (2004:335) and Mokomane and Rochat, (2011:347), who stated that adoption provides stability and permanence in a child's life better than other forms of alternative care such as institutional or foster care. Harber (1999:4) noted that in relation to the care of children, great emphasis is placed on communal care as opposed to institutional care for children who are deemed vulnerable. Instead of informal care arrangements, legal adoption was introduced and developed in South Africa mainly for the assistance and betterment of the Caucasian population, which in turn made adoption services practically inaccessible to the African population. As a result, the African community utilised culturally appropriate forms of family building and maintaining familial relationships.

According to the National Department of Social Development's statistics on adoption, 14 803 adoptions were registered in South Africa for the term 1 April 2004 to 31 March 2010, which is an indication that an estimated 2 400 adoptions took place per year (Van Wyk, 2011:1). Nieuwoudt (2014:14) added that this is a small number in comparison with other methods of alternative care, such as foster and residential care, as there are currently over 3 million orphaned and abandoned children in South Africa according to Statistics SA (as cited in SA NEWS, 2011:1). Examining statistics of the Registry of Adoptable Children and Parents (RACAP) (2013, as cited in Blackie, 2014:2), there are 297 unmatched parents. There are only 14 black adoptive parents with 398 black adoptable children, 190 white adoptive parents with 3 white children available for adoption, 43 Indian adoptive parents with no Indian children available and 9 children termed "mixed race" (Blackie, 2014:2). This status clearly indicates a disparity in the cultural demographics regarding adoption. Barbara and Heston (2006:5) reported that 61 to 68% of orphaned African children are cared for by their grandparent or great grandparents, and almost all others are in the care of another relative. Based on these findings, it does appear adoption has a culturally specific connotation, one that may not hold the same meaning in African cultural groups as in Caucasian cultures.

The African Child Policy Forum (ACPF) (2012:1) states that in many African societies, the legalised disruption of blood ties is either unfamiliar or forbidden. This means that the placement of children with people other than their parents – albeit a friend, relative or orphanage – is not recognised as a final act that determines the child's future relationships. The author continues to say that in a large number of African communities, "full" formalised adoption continues to be a foreign concept and is therefore scarcely utilised. Mokomane and Rochat, (2011:352) confirm this argument by stating that, psychologically and spiritually, most black citizens in South Africa do not agree with the legal adoption process (as currently practised in South Africa) and are of the belief that this practice does not coincide with their cultural and ancestral belief system. One of the barriers to adoption can be linked to the belief in ancestors, which results in communities believing that it is difficult to raise a child whose ancestry is unknown (EveryChild, 2012:10). Pakati (as cited in Gerrand, 1997:11) explains that in traditional societies strangers were excluded because cultural norms and values placed a strong emphasis on the aspect of belonging in a family, and therefore family boundaries were rigidly defined. In addition, blood ties in this group were stressed and the entire community participated in and was responsible for socializing its children. The issue of childlessness was, in turn, culturally defined. Gerrand (1997:12) highlighted that as a result of this, a child of different blood entering into family other than their own was not an act that was provided for. This belief can be clearly explained by a comment by Mphala, the KZN Commissioner for Traditional Leadership Disputes and Crimes: "It would take years before there was a flexibility of mind about adoption among most South Africans. We would have to have a big indaba [meeting] before it could be accepted. Ancestral spirits look after their relatives and no-one else. In our religion, in our culture, this thing is ring-fenced". In Africa,

specifically also in South Africa, fertility and parenthood are held in high esteem and thus voluntary childlessness is not common (Ombelet, Cooke, Dyer, Serour & Devroey., as cited in Gerrand & Nathane-Taulela, 2015:57). This, in turn, places great pressure on black women to fulfil their clan requirements by proving their fertility and giving birth to a child of their own (Gerrand, 1997:12). Infertility thus results in negative social consequences such as stigmatisation and ostracism (Dyer, Abrahams, Hoffman & Van Der Spuy, 2002:1657).

Mokomane and Rochat, (2011:352-353) pointed out that many black South African civilians view the adoption of a child as hindering the child's relationship with their family of origin and clan roots (i.e. a closely-knit system of relatives). This has serious consequences for the adopted child's bio-psychosocial wellbeing. A widely used bio-psychosocial definition of health reads: "Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity" World Health Organization (WHO, 2006:1). A strength of this definition is that it presents a holistic view of the individual by acknowledging that good health is more than just good physical health. It also encompasses mental, emotional and social wellbeing. The bio-psychological perspective is conceptually attractive to social workers and other professional healthcare workers, because it resonates strongly with holistic perspectives such as "person-in-environment" and "psychosocial" approaches (Chui & Wilson, 2006:131).

The Batswana, along with many other African cultures, have experienced rapid Westernisation since the nineteenth century (Pilane, 2002:1). Traditionally, the adoption of children did not take into account the best interests of the child; the focus was more on the interests of the adoptive parent. Adoption was principally associated with the production of heirs to a family, which is an important factor in the Batswana family. Each family required an heir who would protect the name of the family, their property and heritage from extinction (Sigweni, 2008:15). Again, Christianity has spread rapidly and has had an influence on most people, including the Batswana community. Today the Batswana people are caught between their traditional culture and Western civilisation. Because of the pressure of Western civilization civilisation, many Batswana have abandoned their traditional practices, beliefs and attitudes so that they can fit into the new dispensation and be able to face the changes that have occurred so drastically in their country (Pilane, 2002:1; Sigweni, 2008:13), including the changes in African family structures (Bigombe & Khadiagala, 2003:1). The researcher was not able to find recent evidence of research done specifically focusing on Westernisation and its influence on the Batswana's beliefs and attitudes regarding adoption.

Yet the levels of children who have been abandoned are extremely high in contrast with low levels of adoption (Blackie, 2014:2). This, together with conflicting culturally held views on adoption, is an indicator that there is a crucial need for an understanding of adoption amongst the different cultures within black society. Mokomane and Rochat, (2011:352) further strengthened this argument by stating that most black citizens in South Africa do not agree with the legal adoption process (as currently practised in South Africa) and are of the belief that this practice does not coincide with their cultural and ancestral belief systems. An example of this is the reasoning that it is difficult to adopt a child whose origins they are not familiar with, and then change the child's name when the legal adoption process is finalised (Gerrand & Nathane-Taulela, 2015:58). Although much has been written on the views and perceptions of the African community in general by authors such as Gerrand (1997), Mokomane and Rochat, (2011) and Blackie (2014), the researcher found no evidence of research done amongst the Batswana community regarding adoption. The researcher therefore identified a need to determine the specific attitudes of the Batswana people towards adoption practices in an African community context. This study therefore aims to generate culture-specific and relevant knowledge to create an understanding of indigenous, cultural perspectives regarding the attitude of the Batswana people, and, in addition, to encourage social workers to deal with adoption-related matters in a culturally sensitive manner. The rationale is that if a better understanding of the culture-specific attitudes of Batswana people towards adoption is cultivated, agencies will be better equipped to explain adoption in a culturally appropriate manner, thus developing appropriate indigenised techniques.

The research question is therefore: What are the culture-specific attitudes of Batswana people towards adoption?

THE AIM OF THE STUDY

The aim of the study was to establish and describe the culturally specific attitudes of Batswana people towards adoption.

RESEARCH METHODOLOGY

Research design

The study adopted a cross-sectional research design within a quantitative paradigm. The reason for this is that the population was a geographical community with a specific cultural description/identity (Creswell & Clark 2011b:53; Grinnell (2011:231). The study focused on a cross-section of the population. Delport and Fouchè (2011b:434) were of the view that quantitative research is utilised to answer questions concerning relationships between two variables for the purpose of explaining or describing the phenomena that those observations reflect. The study is descriptive in nature as it described the culture-specific attitudes of Batswana people towards adoption. Fouché and Delport (2011:63) added that by making use of this approach, the researcher objectively measures the variable(s) of interest and does not actively work with the respondents so that unbiased conclusions may be drawn. The researcher wanted to describe the findings relevant to this specific community as an example of a particular cultural group.

Participants

The participants were selected on the basis of their relevance to the subject under study (Babbie, 2007: 308; Greeff, 2011:366). Consistent with the aim of this study, only two population groups have been included, namely adults of the Batswana cultural group in Ikageng, Potchefstroom, who formally or informally care or have cared for children, and those members of the community who have an opinion about adoption.

Sampling strategies

This study utilised a two-fold strategy for sampling. As far as demarcating the population is concerned, a purposive strategy was followed in that the Ikageng community in Potchefstroom was selected as demarcated community. Purposive sampling consists of elements that include the most relevant characteristic, representation or common attributes of the population that serve the purpose of the study (Strydom, 2011b:232). The researcher purposively selected four welfare organisations, referred to in this article as organisations A, B, C and D, to be included in the study as all of them are involved with formal care arrangements and their client base includes, amongst others, the Batswana population. Secondly, the researcher made use of availability sampling as a non-probability sampling technique by including carers and/or members from the target community who responded to the general advertisement and were available at the time of the research study. A convenient sampling technique can be understood as a sampling technique in which respondents are selected based on convenience and/or they are easy to find (Bachman & Schutt, 2014:15).

Data-collection method

The researcher used a multi-item questionnaire with closed-ended questions, developed by Gerrand (1997:101-105), to measure the attitude of an African community towards adoption. Delport and Roestenburg (2011:186) pointed out that the basic objective of a questionnaire is to elicit facts and opinions about a topic from a particular group of people. The questionnaire is not a standardised tool. However, it was constructed, validated and pilot tested by the author (Gerrand, 1997). In addition, the questionnaire was constructed in terms of a Likert scale and the respondents were required to indicate whether they agree, strongly agree, disagree, strongly disagree or were neutral regarding the statement given. The researcher expanded the questionnaire to include specific demographic items allowing

respondents to indicate whether they are currently in a care arrangement and the nature of that care arrangement. This enabled the researcher, in addition to addressing the main questions, to determine if the respondents' specific care arrangement had an influence on their opinions about adoption.

Data collection

The study was conducted in Ikageng, Potchefstroom. Posters were distributed and placed at the different welfare organisations. No participant was forced to participate in the study; respondents' participation was voluntary at all times (Strydom, 2011a:116). Anybody responding to the advertisements who considered themselves 'carers' or 'having an opinion' about care arrangements such as adoption was included in the study. The fieldworkers (social workers from the different welfare organisations) explained the reason as well as the aims of the research and the potential risks and benefits of participation. Respondents were required to sign an informed consent form (Creswell, 2014:96). After obtaining informed consent from the participants, the questionnaire was administered individually either at their respective homes or in the privacy of the various organisations' offices. The field workers assisted those respondents who are illiterate with the interpretation and completion of the questionnaires. The areas where the questionnaires were distributed were the social workers' specific focus area, for example, organizations A - D that renders foster care services. After completion, respondents were requested to deposit the questionnaire in sealed boxes placed at the different welfare organisations' offices.

Data analysis

For the purpose of this study, the quantitative data were collected through a questionnaire that was analysed through IBM SPSS Statistics Version 23, Release 22.0 (SPSS) (Fielding & Gilbert, 2006:22-23) done by the North-West University's Statistical Services. This enabled the researcher to calculate Cronbach Alpha values and descriptive statistics to represent the data in figures and tables. Specifically, the analyses utilised descriptive statistics and mean score analysis at item-descriptive level. The statistician made use of the following tools: frequencies and descriptive statistics, Cronbach's Alpha, Independent T-tests, analysis of variance test (Anovas), Mann-Whitney and Spearmans rho. Such analysis enabled the researcher to determine the distribution for variables, or the proportions of males and females on an item regarding adoption. Doubell (2014:16) noted that this will allow the researcher to understand and interpret the data and identify relevant trends in the data.

Ethical aspects

Ethics refers to a system of moral principles governing an individual or group's behaviour. The system is adopted by a group or individual, and accepted as the norm (Strydom, 2011a:115). Mabusela (2013:10) and Maleka (2010:6) added that ethical principles offer rules and behavioural expectations concerning the most appropriate conduct when working with respondents as data should not be collected at the expense of other human beings. This study was approved by the Ethics Committee of the NWU with the following ethics approval number: NWU-00028-16-A1; permission from the respective organisations was also obtained. The following key ethical principles were considered and maintained throughout the process of the study, namely written informed consent and the use of a consent form; confidentiality; autonomy; protection of vulnerable respondents. The storage of data collected was organised and managed in a way that prevented loss, and only authorised access was allowed.

Validity AND reliability

Validity "is concerned with the integrity of the conclusions that are generated from a piece of research" (Bryman, 2012:171). Simply put, it indicates whether a measurement tool measures what it is supposed to measure (Bryman, 2012:171). Questions to test validity include the following: "What does this instrument actually measure?" "How accurate and consistent is this measure?" (Bless, Higson-Smith & Sithole, 2013:229). This study concentrated on face validity, which is interested in the way in which the measuring instrument appears to the participants (Bless *et al*., 2013:234; Delport & Roestenburg, 2011:173). The researcher, the supervisor, the science committee, the statistical consultant as well as the ethics committee agreed that the questions asked in the questionnaire should fit the focus of the study.

On the other hand, reliability is interested with how consistent a measure is (Bless *et al*., 2013:222) and whether the findings of a study can be duplicated (Bryman, 2012:46). For the purposes of this study the researcher examined the reliability of the instrument quantitatively by means of Cronbach's Alpha. As a further means of ensuring reliability, the researcher included the questionnaire in an appendix, so that it is available to other researchers who wish to repeat this study in future (Doubell, 2014:14).

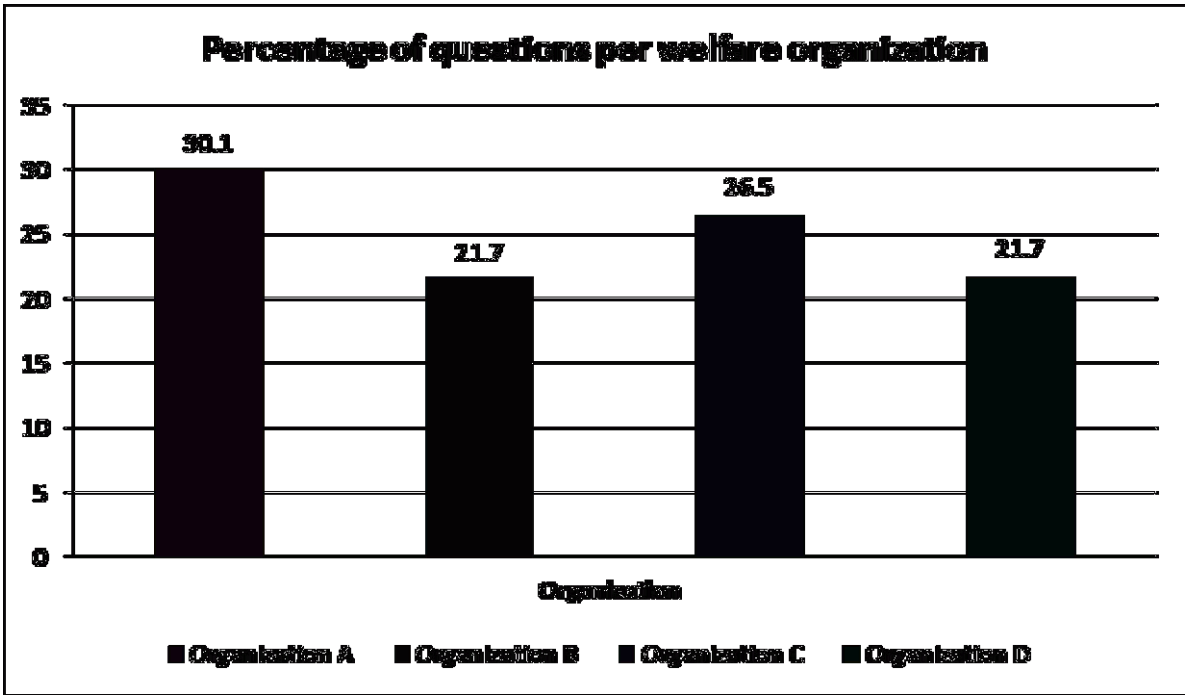
FINDINGS

A detailed discussion of the findings resulting from the questionnaire follows. Additional references are included where verification or controls of the quantitative findings are deemed necessary. The data collected were analysed using Statistical Package for Social Sciences (2016). A convenience sample (n=83) was taken of the Batswana people residing in Ikageng, Potchefstroom, North-West Province in South Africa. Descriptive statistics in this study provide a summary of data, for example, the mean for the group as a whole (Pallant, 2013:6), thus the general opinions regarding different aspects of adoption of the group as a whole. Anovas were used to compare gender, age, employment status, educational levels and status as a carer on a single quantitative measure or score focusing on the opinions regarding adoption (Maree, Ebersohn & Vermaak 2008:56). Both focus on the general opinion regarding adoption, but the descriptive statistics focus on the group as a whole (all the respondents simultaneously), whereas the Anova was used to establish whether gender, age, employment status, educational levels and status as a carer has an effect on people's opinions and therefore provides the general opinion per group, for example, testing for differences in opinions between the groups. The effect sizes relating to the Anovas were used to determine the practical significance of the differences; however, they do not indicate what the differences are; therefore the comments explaining the differences in opinion were added too.

Profile of the welfare organisations

The following bar graph gives an overview of the total population referring to the four organisations that were requested to distribute the questionnaires. The graph furthermore gives an overview of the percentages of the respondents who took part in the study as per organisation.

FIGURE 1
GRAPHIC PRESENTATION
PROFILE OF THE WELFARE ORGANISATIONS



The questionnaires were distributed between organizations A - D in Potchefstroom. The mentioned organisations render child protection services to people of the Batswana culture in Ikageng, Potchefstroom as one of their focus areas and were thus requested to distribute the questionnaires. The table above indicates that 30.1% of the data collected comes from organization A, 26.5% was collected from organization C, and 21.7% from organizations D and B each. It seems that the majority of the respondents who took part in the study formed part of these organisations' client base, many of whom were exposed to alternative care.

Demographical information

The following demographical information was requested from the respondents: 1) culture denomination, 2) employment status, 3) educational qualification, 4) their position as a carer/non-carer and 5) gender. The researcher requested this information in order to get an understanding of the respondents' demographical profile. Only respondents who indicated that they are of the Batswana culture were included in this study.

The sample of the study consisted of 28% males and 72% females. The employment status of the respondents presented as follows: the majority of the respondents were employed full-time (38.0%), other respondents were employed part-time (36.7%), indicating that they were contracted employees. Unemployed respondents made up 25.3% of the total number of respondents who took part in the study. Information on the educational qualification of the respondents revealed that 21.7% completed their schooling career below Grade 9; 30.1% of the respondents indicated that they had completed their schooling career between Grade 10-12, and 47.0% of the respondents hold qualifications higher than Grade 12; these could include a training certificate, technikon diploma, technical diploma, university degree, postgraduate degree etc. In terms of age, the average age of the respondents is 41.16 (Std. deviation = 13.637) with the youngest person being 18 and the oldest person being 71. The respondents who took part in the study consisted of a younger generation who were 45 years and younger (68.4%) and an older generation (31.6%). The respondents who took part in the study as a result of exposure to some form of alternative care totalled 63.9%, whilst those who had an opinion regarding adoption consisted of 36.1% of the population.

TABLE 1
DEMOGRAPHICAL PROFILE OF THE RESPONDENTS

STATUS	N	PERCENTAGE
Gender		
Male	23	28%
Female	60	72%
Employment status		
Full-time	32	38.0%
Part-time	30	36%
Unemployed	21	25.3%
Educational qualification		
Below Grade 9	19	21.7%
Grade 10-12	25	30.1%
Post-school qualification	39	47.0%
Age		
Younger generation	57	68.4%
Older generation	26	31.6%
Carer		
Expressing opinion	30	36.1%
Alternative care	52	63.9%

Position as carer

The question on respondents' position as a carer was asked to determine whether the respondents had been exposed to a form of alternative care, and to distinguish between respondents who took part in the study because they held an opinion regarding adoption.

TABLE 2
POSITION AS CARER

Position as carer	Number	Percentage
Non-carer (with opinion)	30	36.1%
Past carer	12	15.7%
Informal carer	13	16.9%
Formal carer (i.e. foster care)	32	39.8%
Adoption	8	10.8%

It should be noted that the respondents did not choose only the most appropriate answer, but all options that applied. Therefore, the percentages in the above table will not add up to 100%, since they reflect the percentage of respondents choosing each option. In terms of the respondents' position as a carer: 36.1% indicated that they were not taking care of someone else's child nor had they done so in the past; therefore, their participation is based on their opinion regarding adoption. For the rest, 10.8% of the respondents have adopted the child that they are currently taking care of; 15.7% of the respondents indicated that they have taken care of someone else's child in the past but are currently not doing so; 16.9% of the respondents stated that they are currently taking care of someone else's child through an informal care arrangement (i.e. kinship care); and 39.8% of the respondents are currently taking care of someone else's child through a formal foster care arrangement.

Reliability and descriptive statistics

The birthparent, the adopter and the adoptee are key role players in the adoption process. These three members are vulnerable to the attitudes of the general community (Gerrand, 1997:25). The questionnaire was also divided into these three sections, namely the parent giving their child up for adoption (the birthparent), people who adopt a child (adopter), and a child who is being adopted (adoptee). Cronbach Alpha values and descriptive statistics of the three constructs resulting from the individual sections of the questionnaire are represented in Table 4.

TABLE 3
RELIABILITY AND DESCRIPTIVE STATISTICS

Section	Cronbach Alpha	Mean	Std deviation
Birthparent	0.60	3.96	0.65
Adopter	0.61	4.12	0.58
Adoptee	0.57	1.80	0.69

The reported Cronbach Alphas were 0.566 and higher, thus the constructs could be deemed as moderately reliable. Field (2013: 708-709) confirm that an Alpha coefficient of between 0.5 and 0.7 shows moderate reliability.

Frequencies and descriptive statistics

In terms of understanding the respondents' attitude towards adoption, the researcher collected information regarding the birthparent, the adopter as well as the adoptee. Frequencies and descriptive statistics enabled the researcher to determine the distribution for variables. Doubell (2014:16) adds that this will allow the researcher to understand and interpret the data and identify relevant trends in the data.

The respondents' attitude towards the birthparents

The birthparent is a key role player in the adoption process. This section was given to determine the respondents' attitudes towards the birthparent and his/her role in the adoption process.

TABLE 4
ANALYSES OF THE RESPONDENTS' ATTITUDE TOWARDS THE BIRTHPARENT

BIRTHPARENT							
Statement	**Strongly agree**	**Agree**	**Neither agree/ disagree**	**Dis-agree**	**Strongly disagree**	**Mean**	**Std. de-viation**
1. A person should have the right to give their child up for adoption.	56.1%	30.5%	8.5%	2.4%	2.4%	1.65	0.921
2. A person's decision to give their child up for adoption should be respected.	53.1%	32.1%	6.2%	3.7%	4.9%	1.75	1.067
3. The community should reject a person who gives up their child for adoption.	4.9%	6.2%	8.6%	32.1%	48.1%	4.12	1.122
4. A person who gives their child up for adoption shows disrespect for his ancestors.	6.3%	22.5%	8.8%	35.0%	27.5%	3.55	1.282
5. Understanding should be shown to a person who gives their child up for adoption.	43.9%	35.4%	6.1%	9.8%	4.9%	1.96	1.159
6. A person should only give permission for their child to be adopted if blood ties exist between the person adopting the child and the child.	7.3%	19.5%	17.1%	30.5%	25.6%	3.48	1.269

The mean scores of items 1, 2 and 5 ranged between 1.65 and 1.96, indicating that the respondents agreed with the statements made. The mean scores of the negatively phrased items, i.e. items 3, 4 and 6, ranged between 3.48 and 4.12. This indicated that the respondents disagreed with these statements. Therefore, the finding is that the respondents generally feel positive regarding the birth parent. This is contrary to a study in the USA by Miall and March (2005: 538), who found that birthparents are often viewed as irresponsible and uncaring.

The respondents' attitude towards the adopter

The person who adopts a child plays a vital role in the adoption process. The goal of the statements given in this section was to determine the respondents' attitudes towards the person(s) who adopt a child.

TABLE 5
ANALYSIS OF THE RESPONDENTS' ATTITUDES TOWARDS THE ADOPTER

Statement	**Strongly agree**	**Agree**	**Neither agree/ disagree**	**Disagree**	**Strongly disagree**	**Mean**	**Std. deviation**
B. ADOPTER							
7. People who adopt a child should be rejected by the community.	7.5%	7.5%	6.3%	3.0.%	48.8%	4.05	1.242
8. People who adopt a child show disrespect for their ancestors.	5.1%	6.3%	15.2%	36.7%	36.7%	3.94	1.113
9. People who adopt a child should be accepted by the community.	65.8%	26.6%	2.5%	-	5.1%	1.52	0.959

10. Understanding should be shown to people who adopt a child.	55.6%	43.1%	-	1.4%	-	1.47	0.581
11. People should have the right to decide to adopt a child.	47.9%	43.8%	1.4%	2.7%	4.1%	1.71	0.950
12. People should only adopt a child if blood ties exist between them and the child they are adopting.	10.1%	15.2%	12.7%	39.2%	22.8%	3.49	1.280
13. Respect should be shown for people who adopt a child.	62.7%	32.2%	1.7%	3.4%	-	1.46	0.703
14. People who adopt a child who is unrelated to them show disrespect for their family.	10.8%	12.3%	12.3%	29.2	35.4%	3.66	1.361

The mean scores of items 9, 10, 11 and 13 ranged between 1.46 and 1.71, indicating that the respondents agreed with the statements made. The mean scores of the negatively phrased items, i.e. items 7,8,12 and 14 ranged between 3.49 and 4.05. This indicated that the respondents disagreed with these statements. Therefore the finding is that the respondents generally feel positive regarding the adopter. The findings is different from the findings by Mokomane and Rochat, (2011: 352), who argue that most black citizens in South Africa are not positive towards those who adopts children as they believe that this practice does not coincide with their cultural and ancestral belief systems. One of the barriers to adoption can be linked with a belief in ancestors, which results in communities believing that it is difficult to raise a child whose ancestry is unknown (EveryChild, 2012: 10).

Respondents' attitude towards the adoptee

The child who is being adopted (adoptee) is an important factor in the adoption process. The respondents' attitudes toward the adoptee may influence their behaviour towards the child. The statements given were used to determine the respondents' attitude towards the child who is being adopted.

TABLE 6
ANALYSES ON THE RESPONDENTS' ATTITUDE TOWARDS THE ADOPTEE

Statement	**Strongly agree**	**Agree**	**Neither agree/ disagree**	**Dis-agree**	**Strongly disagree**	**Mean**	**Std. de-viation**
C. ADOPTEE							
15. Kindness should be shown to a child who has been adopted.	75.6%	15.9%	2.4%	3.7%	2.4%	1.41	0.902
16. A child who has been adopted should be accepted by the community.	74.1%	21.0%	-	1.2%	3.7%	1.40	0.876
17. A child who has been adopted should have the same rights as other children.	72.8%	22.2%	1.2%	1.2%	2.5%	1.38	0.799
18. People should avoid adopting children because they grow up to be criminals.	7.4%	7.4%	12.3%	30.9%	42.0%	3.93	1.233
19. The ancestors of the family who has adopted a child will not accept an adopted child.	21.0%	12.3%	11.1%	25.9%	29.6%	3.31	1.530

The mean scores of items 15, 16 and 17 ranged between 1.38 and 1.41, indicating that the respondents agreed with the statements made. The mean scores of the negatively phrased items, i.e. items 18 and 19, ranged between 3.31 and 3.93. This indicated that the respondents disagreed with these statements. Therefore, the finding is that the respondents generally feel positive regarding the adoptee. This is opposite to the findings of a study in Botswana which indicated that the Batswana community are of the belief that adopting a child where no blood ties exist hinders the child's relationship with their family of origin and clan roots (i.e. closely knit relatives). This would increase the child's possibility of suffering from depression and sense of isolation, which are a consequence of separation from birth parents; in addition, it weakens a child's sense of identity and self-esteem, which stems from knowing his/her familial and communal culture (Malinga & Ntshwareng, 2011: 1).

Inferential statistics

The next section of the findings focuses on whether there was a difference in opinion between the groups indicated by the following biographical information of the respondents: gender, educational qualification, family composition or their position as a carer. Independent T-tests, Mann-Whitney tests and Anovas were used to test these differences. In addition, the effect sizes were used to explain the data from the respondents. A statistical hypothesis test (T-test) was conducted in order to test this difference. A T-test can be understood as a test that is used when there are two experimental connections and different participants allocated to each condition (Field, 2013:364). An Anova test was conducted in order to test for differences in opinion with regards to the different biographical groups based on a comparison of the ratio of systematic variance to unsystematic variance (Field, 2013:430). A Mann-Whitney test works by observing the differences in the ranked positions of scores in different groups (Field, 2013:224). The effect size is said to be a measure of practical significance (Ellis & Steyn, 2003:51). The same authors further state that the practical significance of results is important for two reasons: when the results of population data are reported as well as to comment on the practical significance of a statistically significant result (Ellis & Steyn, 2003:53).

Gender

An independent T-Test was done in order to determine whether there is a difference in attitude towards adoption between the two groups (male and female). This test was important, because it allowed the researcher to interpret whether a difference existed between the respondents' gender and their attitude towards adoption.

TABLE 7
INDEPENDENT T-TEST WITH REGARDS TO THE RESPONDENTS' ATTITUDE TOWARDS GENDER

Gender	N	Mean	Std. Deviation	p-value*	Effect size
A_Birthparent					
Male	23	4.10	0.62	0.22	0.29
Female	58	3.90	0.66		
B_Adopter					
Male	23	4.02	0.66	0.37	0.22
Female	56	4.17	0.55		
C_Adoptee					
Male	23	1.71	0.77	0.57	0.14
Female	58	1.81	0.65		

* p-values are reported for completeness sake, but won't be interpreted, since a convenience sample instead of a random sample was used.

The effect sizes (0.14 – 0.29) indicated practical non-significant differences in attitude between the two gender groups towards the birthparent, the adopter and the adoptee. This means that the respondents strongly disagreed with the negatively phrased statements; therefore the finding is that both males and females have a positive attitude towards adoption. Gerrand (1997: 81) also found that there is a very small positive correlation between gender and attitude. According to the researcher, this correlation is not significant.

Age

The researcher inquired about the respondents' age in order to determine whether their age had an influence on their attitude towards adoption. An independent T-test was done in order to test whether there is a difference between the younger and older generation towards adoption.

TABLE 8
INDEPENDENT T-TEST WITH REGARDS TO THE RESPONDENTS' ATTITUDE TOWARDS AGE

AGE		N	Mean	Std. deviation	P-Value	Effect size
A_BIRTHPARENT						
Younger generation	<46	54	4.10	0.61		
Older generation	46+	24	3.63	0.68	0.006	0.69
B_ Adopter						
Younger generation	<46	53	4.27	0.49		
Older generation	46+	24	3.86	0.62	0.007	0.66
C_ Adoptee						
Younger generation	<46	54	1.58	0.57		
Older generation	46+	24	2.16	0.60	>0.01	0.97

* p-values are reported for completeness sake, but won't be interpreted, since a convenience sample instead of a random sample was used

The effect sizes (0.66-0.97) indicated practically visible to practically significant differences between the opinions of the younger and the older generation. The younger respondents tended to strongly disagree with negative statements and strongly agree with positive statements regarding the members of the adoption triad (i.e. the birthparent, the adopter and the adoptee), whereas the older generation leaned a bit more towards neither agree/disagree. The finding is that the younger generation tends to have a more positive attitude towards adoption compared to that of the older generation. This is in agreement with the findings by Bigombe & Khadiagala, 2003:1 and Sigwenie (2008), who stated that due to the pressure of civilisation, the younger generation of Batswana's have abandoned their traditional practices, beliefs and attitudes, and therefore changed their attitude towards adoption to fit the new dispensation and be able to face the drastic changes that have taken place in the country as well as the changes in African family structures.

TABLE 9
ANOVA TESTING FOR DIFFERENCE IN ATTITUDES WITH REGARDS TO EDUCATIONAL QUALIFICATION

Status	No	Mean	Std deviation	p-value Anova*	p-value Welch	Effect size	
						1 with	2 with
A_Birthparent				0.092	0.127		
Below Grade 9	18	3.67	0.70				
Grade 10-12	25	4.09	0.61			0.60	
Post-school	38	4.01	0.63			0.48	0.14
B_Adopter				0.029	0.016		
Below Grade 9	17	3.94	0.38				
Grade 10-12	24	4.37	0.56			0.78	
Post-school	38	4.04	0.63			0.16	0.53
C_Adoptee				0.067	0.086		
Below Grade 9	18	1.78	0.53				
Grade 10-12	25	1.57	0.67			0.31	
Post-school	38	1.98	0.74			0.27	0.56

* p-values are reported for completeness sake, but won't be interpreted, since a convenience sample instead of a random sample was used.

Educational qualification

An Anova test was used to determine whether there is a difference in respondents' attitude towards adoption when considering educational qualification.

In terms of a birthparent, two medium or practically visible differences in effect size (0.60 – 0.48) were reported. These differences were between the group who stopped their school career below Grade 9 and both the other two groups, respectively. The below Grade 9 group disagreed (leaning a bit towards neutral) with the negatively phrased questions, therefore indicating that they have a positive attitude towards a birthparent giving their child up for adoption. The groups with Grade 12 and post-school qualifications both disagreed with the negatively phrased questions, therefore indicating that they have a slightly more positive attitude towards birthparents who give their child up for adoption.

The group of respondents with an educational qualification below Grade 9 disagreed with the negatively phrased questions, indicating that they have a positive attitude towards the adopter. There is a large difference (effect size = 0.78) between this group's attitude and the attitude of the group with a Grade 12 qualification. The Grade 12 group disagreed, tending towards strongly disagreed. There is also a practical visible difference (effect size = 0.53) between the attitudes of the Grade 12 and the post-school qualification groups. Again¸ the Grade 12 group disagreed, tending towards strongly disagreed. The post-school qualification group disagreed with the negatively phrased statements, indicating that they have a positive attitude towards the adopter.

In terms of the attitude towards the child who is being adopted, there was a practically visible difference (effect size= 0.56) in responses to the questions by the Grade 12 and the post-school qualification groups. Both groups agreed with the statements. However, the finding is that the Grade 12 group leaned a bit towards strongly agree and therefore are a bit more positive towards the adoptee. Kingsbury (2008); also found that people who tend to adopt are wealthier and more educated. In the case of American adoptions, more than 95% of adoptive families have a high school education, and more than 90% have a bachelor's degree.

Family composition

An Anova test was used to determine whether there is a difference in respondents' attitude towards adoption when considering family composition.

TABLE 10
ANOVA TESTING FOR DIFFERENCE IN ATTITUDES WITH REGARDS TO FAMILY COMPOSITION

Status	Number	Mean	Std devia-tion	p-value Anova*	p-value Welch*	Effect size	
						Single with	Married with
A_Birthparent Single	35	3.9781	0.69249	0.984	0.984		
Married	21	3.9524	0.70935			0.04	
Other	24	3.9500	0.58285			0.04	0.00
Total	80	4.2289	0.65792				
B_Adopter Single	33	4.2289	0.52526	0.348	0.372		
Married	21	4.0990	0.56005			0.23	
Other	24	4.0030	0.67276			0.34	0.14
Total	78	4.1244	0.58376				
C_Adoptee Single	35	1.6857	0.58869	0.354	0.382		
Married	21	1.7643	0.73742			0.11	
Other	24	1.9472	0.76417			0.34	0.24
Total	80	1.7848	0.68506				

* p-values are reported for completeness sake, but won't be interpreted, since a convenience sample instead of a random sample was used

The table above indicates the responses of different family compositions towards adoption. This analysis focuses on single, married and other (in a relationship, divorced and widowed). No practically visible or practically significant difference were reported (effect sizes <= 0.34). This means that there were no visible differences between the groups that were in a relationship, married, divorced or widowed. The finding is that the respondents in these groups have a positive attitude towards the birthparent, the adopter and the adoptee, and that their relationship status had little to no influence on their attitude towards adoption. Van Laningham (2012: 21) supports the findings in a statement that resource-related variables such as marital status were not found to significantly predict consideration of adoption or adoption-seeking behaviours.

The next section of the study aimed to determine whether the respondents' position as carers has an influence on their attitude towards adoption. T-tests and Mann-Whitney tests were used to test the difference between the respondents' position (in a caring position or holding an opinion regarding adoption) and their attitude towards adoption. T-tests as well as Mann-Whitney tests were conducted with smaller groups, whereas only T-tests were conducted with groups large enough to get the effect size.

The attitude of the carer towards adoption

The next section of the findings focuses on whether there was a difference in opinion regarding the respondents' position as a carer, for example, a non-carer, past carer, informal carer or adoptive parent and their attitude towards adoption. Independent T-tests (Field, 2013: 364) and Mann-Whitney tests (Field, 2013: 224) were used to test these differences In addition, the effect sizes were used to explain the data from the respondents. Each of these constructs will be discussed in more detail.

The position of the "non-carer" (holding an opinion)

An independent T-test was conducted in order to assess respondents who are not caring and have not previously cared for someone else's child's attitude towards adoption.

TABLE 11
INDEPENDENT T-TEST OF THE NON-CARER (HOLDING AN OPINION) TOWARDS ADOPTION

NON-CARER (WITH OPINION)	N	Mean	Std deviation	P-value	Effect size
Birthparent					
Yes	29	4.04	0.74	0.14	0.17
No	53	3.92	0.60	0.08	
Adopter					
Yes	29	4.19	0.53	0.10	0.19
No	51	4.07	0.61	0.086	
Adoptee					
Yes	29	1.64	0.55	0.10	0.34
No	53	1.89	0.74	0.10	

* p-values are reported for completeness sake, but won't be interpreted, since a convenience sample instead of a random sample was used

The table above indicates that the respondents who are currently not taking care of someone else's child and have not done so in the past (but hold an opinion) had practically non-significant differences (effect size <= 0.34). This means that there were small differences in their opinions regarding the birthparent, the adopter and the adoptee. This group of respondents strongly agreed, leaning to agree, with the positive statements regarding the birthparent, the adopter and the adoptee. In addition, they strongly disagreed with the negatively phrased questions regarding the birthparent, the adopter and the adoptee. The finding is that respondents' who are not caring and have not previously cared for someone else's child's have an overall positive attitude towards the birthparent, the adopter and the adoptee.

The position of the past carer

A Mann-Whitney test was used in addition to an independent T-test to test whether the respondents' role as someone who has been exposed to alternative care has had an influence on their attitude towards adoption.

TABLE 12
INDEPENDENT T-TEST AND MANN-WHITNEY TEST OF PAST CARERS TOWARDS ADOPTION

				T-test		Mann-Whitney test	
PAST CARER	N	Mean	Std deviation	p-value	Effect size	P-value	Effect size
Birthparent							
Yes	13	4.38	0.50				
No	69	3.88	0.65	0.005	0.78	0.010	0.29
Adopter							
Yes	12	4.35	0.50				
No	68	4.07	0.55	0.98	0.48	0.116	0.18
Adoptee							
Yes	13	1.65	0.55				
No	69	1.83	0.71	0.308	0.26	0.409	0.09

There is a practically significant difference between the respondents who cared for someone else's child in the past and the other respondents' opinions regarding the birth parent (effect size = 0.78). There was a practically visible difference between the two groups' opinions regarding the adopter (effect size = 0.48). The Mann-Whitney tests supported these findings. This means that the group of respondents who have an opinion regarding adoption differed in their attitude towards the birthparent in comparison to those who have cared for someone else's child in the past. The finding is that both groups of respondents had a positive attitude towards the birthparent; however, past carers were more positive than the other respondents. Furthermore, there was a small difference in the attitudes of past carers towards the adopter and the adoptee, albeit they were compared to those who have an opinion regarding adoption.

The position of the informal carer

An independent T-test and Mann-Whitney test were used to test whether the respondents' exposure to informal care has had an influence on their attitude towards adoption.

TABLE 13
INDEPENDENT T-TEST AND MANN-WHITNEY TEST OF INFORMAL CARERS TOWARDS ADOPTION

				T-test		Mann-Whitney test	
INFORMAL CARER	N	Mean	Std deviation	P-value	Effect size	P-value	Effect size
Birthparent							
Yes	14	4.10	0.76	0.20			
No	68	3.93	0.63	0.08	0.23	0.429	0.09
Adopter							
Yes	14	4.49	0.40	0.11			
No	66	4.04	0.58	0.07	0.78	0.002	0.29
Adoptee							
Yes	14	1.32	0.37	0.10			
No	68	1.90	0.70	0.08	0.84	0.000	0.35

Practically significant differences effect size (0.78 - 0.84) were indicated between the respondents who are currently taking care of somebody's child through an informal arrangement and the other respondents' opinions regarding the adopter and the adoptee, respectively. The finding is that those respondents who have been exposed to informal care were more positive than the other members of the adoption triad (the birthparent, the adopter and the adoptee) .

The position of the formal carer

Formal care in this case referred to foster care and kinship care. A T-test was utilised to assess whether being part of a formal arrangement affects respondents' opinions regarding adoption.

TABLE 14
INDEPENDENT T-TEST OF FORMAL CARERS TOWARDS ADOPTION

FORMAL CARER	N	Mean	Std deviation	P-value	Effect size
Birthparent					
Yes	33	3.89	0.70		
No	49	4.01	0.62	0.420	0.420
Adopter					
Yes	32	3.99	0.69		
No	48	4.20	0.48	0.133	0.133
Adoptee					
Yes	33	2.09	0.80		
No	49	1.61	0.53	0.004	0.004

The effect sizes assessing the difference in opinions of the group taking formal care of somebody's child and the other respondents all indicated practically non-significant differences (effect size <= 0.42). The finding is that there is a small difference in formal carer's attitude towards the birthparent, the adopter and the adoptee. The findings indicate that this group of formal carers has a positive attitude towards all three members of the adoption triad.

The position of the adoptive parent

This group of respondents had already been exposed to adoption. The researcher did not exclude this group of respondents, as it was important to describe their attitude towards this form of alternative care. An independent T-test and a Mann-Whitney test were conducted in order to assess whether the respondents' own experience in the adoption system, as an adoptive parent, has had an influence on their attitude towards adoption.

TABLE 15
INDEPENDENT T-TEST AND MANN-WHITNEY TEST OF THE ADOPTIVE PARENT TOWARDS ADOPTION

				T-test		Mann-Whitney test	
ADOPTIVE PARENT	N	Mean	Std deviation	P-value	Effect size	P-value	Effect size
Birthparent							
Yes	9	3.80	0.79				
No	73	3.98	0.63	0.511	0.24	0.283	0.12
Adopter							
Yes	9	4.24	0.49				
No	71	4.10	0.59	0.438	0.24	0.703	0.04
Adoptee							
Yes	9	1.56	0.38				
No	73	1.82	0.71	0.092	0.38	0.415	0.09

There were small differences (effect size < 0.4) in the attitude of respondents who are currently caring for an adopted child compared to the other respondents regarding the birthparent and the adopter and adoptee. This was confirmed by the Mann-Whitney tests performed. The finding is that group of respondents who had been personally exposed to adoption as an adoptive parent had a positive attitude towards the members of the adoption triad. The findings correspond with the findings by Gerrand (1997:79), who focused on the attitude of the African community in Soweto towards adoption. The researcher also found no indication of significant differences in attitude from one member of the adoption triad to another.

DISCUSSION

The orientation and the problem statement were discussed in the first phase of this study, along with the research methodology, limitations and ethical aspects of conducting the study.

The researcher wanted to understand the culture-specific attitudes of Batswana people towards adoption. This was done by focusing on three groups in the adoption triad, namely the birthparent, the adopter and the adoptee. In addition, the research tested the respondents' demographic information against each constraint in order to assess whether it had an influence on their attitude towards adoption.

The research results of this study produced a number of findings. The demographical information allowed the researcher to acquire a clear indication of the respondents who participated in the study. In addition, the demographic information allowed the researcher to exclude the respondents who did not fit the focus of the study. The researcher then determined the attitude that the respondents had towards the birthparent, the adopter and the adoptee. The respondents who took part in the study had a positive attitude towards the birthparent, the adopter and the adoptee.

Independent T-tests, Anova and Mann-Whitney tests were performed in order to establish whether there was a difference in the respondents' demographic information and their attitude towards adoption. For example, the researcher tested whether the respondents' gender, age, educational qualification and family composition has had an influence on their attitude towards the birthparent, the adopter and the adoptee. The results of these tests also indicated that the respondents have a positive attitude towards adoption regardless of their age, gender, educational qualification, family composition.

The independent T-tests, Anova and Mann-Whitney tests performed determined whether the respondents' exposure to alternative care has had an influence on their attitude towards adoption. The researcher divided the "position of carer" into four categories, namely someone who is currently taking care of someone else's child, someone who has taken care of a child, someone who is taking care of someone else's child formally/informally, and someone who is taking care of an adopted child. These variables were tested against the birthparent, the adopter and the adoptee. The results of these findings indicated that regardless of the respondent's position as a carer, they had a positive attitude towards the birthparent, the adopter and the adoptee.

The respondents of the Ikageng community who took part in the study had a positive attitude towards all three members of the adoption triad, and there was no visible indication of a difference in attitude towards the birthparent, the adopter and the adoptee. The respondents' demographical information as well as their position as a carer had little to no influence on their attitude towards adoption, which remained positive.

The findings reported in this study are similar to those of recent studies that were conducted on adoption in African families. Authors such as Chanyandura and Rungani (2017) and Runjani (2017) mention that adoption is no longer treated as taboo in many black families and that traditional rituals are performed, in some cases, to fully integrate the adopted children into the family.

CONCLUSION AND RECOMMENDATIONS

Child neglect and abandonment may be caused by a number of social ills in South Africa. This results in children in dire need of care and protection. The focus of alternative care should not be placed

exclusively on short-term care but it should afford destitute children the stable and permanent care that adoption can provide. In this article the researcher presented, analysed and interpreted research findings based on the responses given by 83 respondents from the Ikageng community in the North-West province. The questionnaire was divided into three sections focusing on understanding the attitude of the respondents towards the person who gives their child up for adoption (birthparent), the person(s) who adopt a child (adopter), and the child who is adopted (adoptee). The purpose was to determine the culture-specific attitude of members of this particular cultural group towards adoption and whether their demographic profile (i.e. their gender, age, educational qualification, family composition and position as carer) has had an effect on their attitude towards adoption. The result of the data analysis indicated that respondents had a positive attitude towards the birthparent, the adopter and the adoptee. The findings of this study demonstrated that this particular cultural group is more receptive towards adoption. This could be as a result of Westernisation, acculturation and/or their exposure or experience in the alternative care field. Studies conducted by Mokomane and Rochat, (2011), Blackie (2014) and Gerrand (1997) support the findings but highlighted the reluctance of people in African communities to make use of adoption as a form of alternative care. Furthermore, the literature on adoption in the African community does not distinguish between the different cultural groups within it. Therefore, studies may indicate the general opinion/attitude of a particular cultural group found within the specific area of study. In-depth knowledge and understanding with regard to adoption could lead to the development of an effective culturally relevant adoption model in the future.

Limitations

- Ikageng is a fairly big township in the North-West Province in South Africa. A small sample was drawn from four institutions using convenience sampling, which is a non-probability sampling method. As a result, generalisation of the findings to the rest of the community is not possible.
- The majority of the respondents who took part in the study were in a position of formal or informal care arrangement; therefore, the results may be positively skewed to respondents in a position of caring.

Recommendations for service providers

Service providers, rendering services in adoption, should consider the following points.

- Community education can play an important role in gaining public support and increasing the knowledge and understanding of the necessity for adequate resources, finances, maintenance of adoption programmes that are of a good quality and effective legislation (Weyers, 2011:251). Welfare agencies need to respond accordingly to the following: the community's attitude towards adoption and criticism of the adoption agencies' procedures and policies so that any misconceptions about the agency practice can be clarified and/or corrected.
- More awareness needs to be created in welfare organisations and departments regarding their role and influence on knowledge of adoption and ethical adoption procedures.

Recommendations for future research

Future research could be considered on the following aspects.

- This study could be replicated qualitatively, using focus groups, in other communities where the Batswana culture is prominent to test whether findings are accurate.
- Future studies could also focus on different cultures (e.g. Zulu, Xhosa, Venda, etc.) and observe whether attitudes towards adoption differ according to the respective cultures.

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UNDERSTANDING THE SEXUALITY OF PERSONS WITH INTELLECTUAL DISABILITY IN RESIDENTIAL FACILITIES: PERCEPTIONS OF SERVICE PROVIDERS AND PEOPLE WITH DISABILITIES

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BACKGROUND AND MOTIVATION

The broad definition of disability as applicable to the study on which this article is based is "loss or elimination of opportunities to take part in the life of the community equitably with others that is encountered by persons having physical, sensory, psychological, developmental, learning, neurological or other impairments, which may be permanent, temporary or episodic in nature, thereby causing activity limitations and participation restriction with the mainstream society" (The Disability Rights Policy of the Gauteng Provincial Government, 2010:8).

Shutterworth and Mona (2002) focus on disability as it relates to sexuality, the focus of this study. They discuss physical impairments and mobility issues that serve as constraints when it comes to meeting partners. They also open the debate on whether persons with disability should have an intimate relationship with a non-disabled person, as well as discussing to what extent they are considered as 'equal' to any other member of society. In the light of anti-oppressive theory, this inequality results in some people tending to take advantage of or dominating a 'weaker' partner.

Furthermore, people with disabilities are more vulnerable to sexual assault than the general public. Reasons for vulnerability also include poor understanding of the nature of the disability and the limitations presented by it, difficulty negotiating equality in relationships and difficulty reporting abuse (O'Hara & Martin, 2001; Valenti-Hein, 2000). Also, persons with the disability may themselves not feel that they have a right to make their own decisions about sex because of their upbringing, or they may be manipulated into an abusive relationship by means of rewards or flattery (Polusny & Follette, 1995). Shutterworth and Mona (2002) discuss the cultural persecution and widespread discrimination and exclusion of persons with disability, particularly those with intellectual disability (who may or may not experience a sensory or physical disability), from access to sexual health education and intimacy.

Persons with intellectual disability in the study experienced several of these injustices, as will be outlined in the article.

Perceptions of the sexuality of people with disabilities are primarily negative and yet sexuality is a key part of human nature. Lamentably, the sexuality of persons with disability is viewed differently from they way it is perceived for able-bodied people. Tepper (2000) and Shakespeare (2000) assert that sexuality is a form of pleasure and expression of love, yet is regarded as unacceptable for persons with disability, with prohibitive societal values preventing the provision of sexual health education and sexuality counselling for such persons. The result is that people with disabilities are deprived of, or

limited in forming, lasting, loving friendships and relationships, and/or a sexual life (Shutterworth & Mona, 2002).

To add to the problem, Servais (2006) highlights that people with disabilities seem to be perceived as ill or tragic victims, perpetuating negative attitudes concerning their sexual freedom and expression. Lack of services and programmes to address this concern has resulted in a number of crimes such as rape committed against people with disabilities (Andersson, 2010).

In refining the research focus, extensive consultation was undertaken with management staff at the selected research sites at two residential centres for persons with disability, in Gauteng, South Africa. It was established that those with intellectual disability and with cerebral palsy would suit the research purpose in that they were considered to suffer extensively from denial of sexual expression as well as being represented significantly in the numbers of people who resided at these facilities.

THEORETICAL FRAMEWORK

Anti-oppressive theory (AOP) informed this study, since oppression is often deep-rooted (in values carried down across generations) and in denial of appropriate opportunities and experiences.

According to Campbell (2003, in Turner, 2011:350), the following are some of the core values and principles embodied in anti-oppressive practice, which is pertinent to this study:

- "Shared values of equity, inclusion, empowerment and community;
- An understanding that the thoughts, feelings and behaviours of individuals are linked to material, social and political conditions;
- Recognition of the link between personal troubles and public issues;
- Recognition that unequal distribution of power and resources leads to personal and institutional relationships of oppression and domination;
- The importance of encouraging, supporting and 'centring' the knowledge and perspectives of those who have been marginalised and incorporating these perspectives into policy and practice. This applies to persons with disabilities, as decisions are made on their behalf and often not meeting their needs;
- Conceiving of social work as a social institution with the potential to either contribute to, or to transform, the oppressive social relations that govern the lives of many people;
- Having a vision of an egalitarian future…".

These values and principles seek to challenge oppressive conditions and redress social injustice (Turner, 2011). AOP addresses the need for the eradication of oppression at all stages, as it may manifest as personal, interpersonal, structural and cultural. Oppression occurs when a person acts or a policy is sanctioned unjustly contrary to an individual or group because of their connection to a specific group (Blauner, 2001). This includes depriving people of the opportunity to participate in all aspects of their lives, or imposing belief systems to experience basic freedoms and human rights (Blauner, 2001).

Furthermore, people with disabilities are commonly understood to occupy marginal positions in society (Anderson & Kitchin, 2000), hence their needs and desires are not valued or prioritised. Oppression, being exercised by influential people and decision makers, entails control over the weak (Dominelli, 2002), and in this study specifically, over marginalised and oppressed disabled persons regarding their sexual expression.

AIM AND OBJECTIVES OF THE STUDY

The aim of the study was to understand the sexuality of persons with disability living in residential care facilities. Objectives were establishing what policies there were on sexuality in the institutions;

exploring service users' and providers' perceptions about sexuality; and exploring challenges as well as possible solutions regarding sexual expression.

RESEARCH METHODOLOGY

The overall research approach was qualitative in order to obtain an in-depth understanding of the participants' perceptions and experiences. The study was exploratory and descriptive in design. The 'insider' perspective, viewing the world from the perspective of people with disabilities and service providers, was necessary to implement the descriptive and exploratory designs. The fact that the topic was an unexplored area in South Africa warranted the use of an exploratory design (Babbie, 2012).

A purposive, convenience sampling technique was used to select the samples from a 'desirable' and 'convenient' group of people (McBurney & White, 2009) to fulfil the research purpose. The samples were drawn from two residential facilities for persons with disability in Gauteng. They were easily accessible and convenient to use as the researcher had a prior professional relationship with staff from both centres, which were located close to the researcher's place of employment.

In selecting the number to be used in both samples, prior information and permission were obtained from both facilities at the planning phase of the study. In the first sample the number of four service users from each centre was determined in view of the prospect of data saturation being reached with this size; participants were between the ages of 20 to 55 (when sexual needs are usually expressed) and competent in verbal communication.

The other sample consisted of eight service providers from the same facilities, four from each facility, as they were considered to have first-hand experiences with people with disabilities. Data triangulation was thus effected using two sets of samples from the same facilities. The participants had to have had at least nine months of work experience at the facility to provide sufficiently detailed information on the topic of study.

Data collection involved the use of individual interviews with service users and focus group discussions in respect of the service provider group. In both instances, thematic content analysis helped identify and interpret themes emerging from the data.

LIMITATIONS OF THE STUDY

Two main challenges were encountered during the study.

- During the data-collection exercise, even though rapport was built between the researcher and the participants, two participants were uncomfortable and therefore unwilling to be audio recorded. The researcher took notes instead and these were analysed. This was inconsistent with the data-collection process used with the other participants. Use of supervision and extensive note taking may have limited the extent of influence of this anomaly.
- One of the service providers did not participate in the focus group but was interviewed individually. The participant's input was of great value to the research study as the person held a key position at the institution – hence data from this source were included but collected in a different way. This may have compromised data analysis. However, to ensure validity the researcher adhered strictly to the interview guide used for the group.

ETHICAL CONSIDERATIONS

Ethical clearance was secured from the University of KwaZulu-Natal as well as permission to collect data from the board members, management and participants at both residential facilities. Due to the sensitivity of the research topic, and the fact that the participants themselves (people with disabilities) are a vulnerable group, the researcher used a written informed consent form, in isiZulu and English, to ensure full comprehension and voluntary participation. In addition, the following ethical principles were observed: voluntary participation, privacy and confidentiality, respect for human dignity, and

harm reduction during the research process. These principles were easily respected in that the researcher is a social worker whose code of conduct embraces such principles.

Results and discussion

The research findings from both data sets are discussed jointly so as to present a composite picture of the topic under study. Where necessary, the different sample groups' data are presented and discussed separately. Names of service users have been changed to protect and preserve anonymity. Emerging themes as per the objectives of the study are outlined below.

Sexuality policy

Service providers exhibited limited knowledge on the existence and details of their institutions' sexuality policy. Rather, they cited prohibition of romantic relationships between staff and residents, which is commonplace in many work settings. Some of their responses were:

> *"So far I do not have a proper policy, the residents can have a relationship but not with staff. We are yet to meet as a board to discuss it."* (Home Manager 1)

> *"We have not put (these) in place, but we encourage them to have healthy friendships*." (Home Manager 2)

The lack of sexuality policies in these residential facilities is a typical indication of how service providers overlook and marginalise (in the light of AOP theory) the sexual needs of persons with disability. Sexuality policies in residential facilities are important as they ensure that people with disabilities are treated fairly and humanely, and that the institutions run effectively. The absence of sexuality policies translates into institutions not even recognising that persons with disabilities have sexual needs; a basic human right is denied to them and this needs to be addressed as an anti-oppressive issue, as outlined by Blauner (2001) and Turner (2011).

Privacy

Hollomotz (2009) highlights that people with intellectual disabilities are denied their sexual rights and privacy as they are perceived as children, which can be very frustrating (Cuskelly & Gilmore, 2007). To confirm this, service users had this to say:

> *"Yes I have my own privacy but we share bathrooms with men, it is not that comfortable."* (Busi)

> *"It is there, but sometimes you are disturbed by caregivers or the cleaner, who knock at your door (and enter without permission)"* (Gugu)

From these comments we note that service users' privacy is not taken seriously, and despite caregivers knocking before entering a room, they will usually not wait for permission to enter. Kempton and Kahn (1991) confirm this finding, stating that it is impossible to secure a private space for sexual intercourse for institutionalised persons with disability.

Sex education

The majority of service providers had limited knowledge on what sex education means, as reflected in the following responses:

"I have not explored that area but I think it is important to protect them from diseases and bad relationships" (Home Manager 1)

"Sex education, what does it mean though? It's a bit difficult. They can have sex, you cannot deny them that, but they should be taught all the basics because as you know some of them are not ok mentally" (Caregiver)

Sex education is vital in preventing undesirable consequences, such as sexual abuse. Interestingly and sadly, all the female participants in the study indicated that they had been abused in their childhood, a finding also noted by Andersson (2010).

The following comments authenticate this concern, where persons with disabilities were asked if they had been approached by someone for sexual favours.

> *"Yes when I was young I almost got raped. I reported the person to my aunt."* (Busi)

> *"Yes someone did ask for sex from me, he did rape me…haaa he never got arrested."* (Gugu)

> *"Yes since I was like 15, but I really do not want to get into detail …"* (Amy)

> *"Yea it was a long time ago before I came here, I was young, he actually forced me but I never reported him ..."* (Sue)

Perhaps it is because persons with intellectual disability are considered unable to comprehend sex education that they are denied it, with disastrous consequences. Furthermore, access to sexual health education is limited for people with disabilities (Shutterworth & Mona, 2002), as most of them do not have the opportunity to go to school as a result of their disabilities.

Women rather than men with disabilities appear to be more vulnerable to abuse than their non-disabled counterparts (Gomez, 2012), presumably because their disability makes them easy targets. This study could not confirm this claim owing to the small sample size, but did find that all the female participants had been raped/abused.

Attitudes and beliefs about disability and sexuality

People with disabilities are subjected to negative attitudes and prejudices around their sexuality, most damning of which is that they are 'over-sexual'. Eastgate (2011) argues this could be as a result of the lack of sex education, as they may not know when to express their sexual urges or differentiate between appropriate behaviour in public and in private places.

Service providers confirmed this assertion.

> *"You know what, their feelings are too much!"* (Caregiver)

> *"They crave for it every day that's the truth! Even when bathing them some always have erections…"* (Caregiver)

Such responses clearly suggest that service providers thought that people with disabilities are over-sexed. This was borne out by non-disabled community/staff shunning them, evident of the oppressive practices (Blauner, 2001) to which persons with disabilities are subjected. The erection of the service user cited in the above comment could well have been purely physiological, because of the sensation of bathing.

Life-long children and infantilisation

Assumptions are that persons with disability are incapable of living their lives without full-time care from their carers and this has resulted in their being infantilised. Furthermore, policies related to sexuality are restrictive in that they are based on people with disabilities being viewed as vulnerable and tragic (cf. Servais, 2006) and as children. Hence, opportunities to form intimate relationships are close to none. In the study the service providers who were interviewed referred to their service users as their children, even though the residents were all adults. The following extracts validate this finding:

> *"…we have a good relationship. You know I treat them just like my own kids. I love them … shame."* (Caregiver)

> *"They can behave like children sometimes.* [Name of resident] *when she is angry she does not want to be bathed, she can even take off her clothes. But we are used to them so we understand them."* (Caregiver)

Being viewed as children is related to the residents' mental age not corresponding with their chronological age as a result of their intellectual or developmental disabilities. Hence the finding that persons with disability are life-long children is logical, albeit alienating and marginalising them, and entrenches their dependency. The relevant dimensions of AOP theory are discussed by Blauner (2001) and Turner (2011).

Relationships and intimacy

The study found that masturbation or self-pleasure was more common among people with disabilities than was having a partner. In accord with AOP, this is also an indication of how influential people (in this case policy makers and service providers) limit and oppress residents at such facilities, as healthy adult relationships are not encouraged. One of the participants had this to say:

> *"I'm a grown woman I have needs* (suggesting sexual needs) *... I have a chair* (laughs)*(for my physical comfort) ... I have said too much already."* (Amy)

Disadvantaged groups, such as people with disabilities, feel that their pleasure is of little concern compared to that of 'normal' people. Amy's response suggests an inability to freely express her needs for sexual expression as they are not endorsed or recognised at the facility.

People with disabilities are stereotyped as not having healthy sexual outlets, and also not being capable of having intimate relationships with non-disabled people (Esmail, Darry, Walter & Knupp, 2010) and that in such a relationship, the non-disabled partner has to inevitably assume the role of care-giving. The other societal assumption is that people with disabilities should partner with people who also have a disability (Sakellariou & Algado, 2006) as indicated in the comment below.

> *"Some people do not actually love them, they just want to use them, which is why I prefer they date their own* (kind)*."* (Home Manager 2)

Such attitudes marginalise persons with disability (cf. AOP theory) and do not allow a life of normalcy or integration of persons with disability into society.

Reproduction

Although attitudes towards people with disabilities have historically been negative, there has been some change with regard to marriage and procreation (Cuskelly & Bryde, 2004). However, the finding in the study is that there is no change or progress with regard to disabled persons being in a healthy marriage or having any children. Service users, on the other hand, desired intimate relationships and children. The following comments exemplify this sentiment:

> "*I wish I could find a man and have kids. I also want to go to school so that I can have a bright future."* (Busi)

> "*I want to have someone who can love me the way I am. I wish to have children and take care of them*." (Gugu)

Hinsburger and Tough (2002) attribute the denial of prospects for intimacy and reproduction as being related to their being viewed as asexual or over-sexual, strongly indicating the need for sex education.

Follow-up questions pertaining to users' understanding of sexual health, reproduction and contraception were asked. Examples of their responses were:

> *"It is prevention against pregnancy. I get injection at the clinic even though it makes me fat ... it assist me because I do not menstruate because I used to have period pains."* (Busi)

> *"I use the injection, it helps reduce my feelings. If you do not want injection, there are pills and condoms to prevent STIs."* (Gugu)

Busi's response indicates both that people in residential facilities were required to use contraceptives that they did not have knowledge about, as she stated that the contraceptive was administered to ease period pains. This removes 'choice' and independence (as discussed by O' Hara & Martin, 2001), again

marginalising this group of persons (cf. AOP theory). Gugu, on the other hand, was more aware of why she was having the injection, indicating that it reduced her sexual urges. One wonders what such a realisation does to an individual, where removal of feelings becomes a pharmaceutical matter.

CONCLUSIONS AND RECOMMENDATIONS

The results of this study demonstrated that there are many misconceptions related to the sexuality of persons with disability that in effect infantilise them, preventing their sexual expression, or considering them asexual or over-sexual. Misconceptions also relate to such persons not needing romantic relationships and love, particularly from non-disabled persons and not being candidates for marriage and parenthood. Such marginalisation is exacerbated by a clear lack of sexuality policies at residential facilities along with inadequate sexual health education programmes and privacy concerns preventing the freedom to express oneself sexually.

It was sad to note that all the female service users interviewed were also victims of sexual abuse, a worrying trend that needs to be addressed urgently.

In the light of these findings a number of recommendations are suggested, some of which were suggested by participants in the study.

Firstly, there should be clear and specific guidelines, which must be monitored, around the sexual expression of people with disabilities. Compliance and implementation should be encouraged through training and ongoing professional development. Service providers should be empowered by this to "talk sex" more freely with persons with a disability. Furthermore, service users should be consulted to provide input into the formulation of these policies.

Sexual health education should target a variety of persons, not only those with the disability, but also their families, service providers and the public in general. This could change negative attitudes towards persons with disability having intimate relationships, as well as dealing with their reproductive issues and preventing abuse.

People with disabilities should not be infantilised, but rather given the opportunity to be treated as adults and to make adult decisions about their sexuality. Persons with disability should not be oppressed; their right to have a voice in how they wish to express themselves sexually must be respected.

Practical day-to-day changes could be introduced at facilities, such as addressing privacy with separate ablution facilities for males and females, and recruiting staff of the same sex to cater for service users. Regarding the frustration with unannounced visits in their rooms, the authors suggest that service providers should knock and wait for a response before entering a room, and there should also be clear schedules for when monitoring or care-giving has to occur.

Finally, further quantitative research is necessary to quantify the extent of the problem in order that the concerns highlighted in this study can be based on statistical evidence to support policy and service change.

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DUAL DIAGNOSIS: HOW ADULTS DIAGNOSED WITH BIPOLAR DISORDER EXPERIENCE IN-PATIENT SUBSTANCE ABUSE TREATMENT FOR STIMULANT USE DISORDER

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KEYWORDS: dual-diagnosis, bipolar disorder, stimulant use disorder, substance use disorder, adult, in-patient treatment

INTRODUCTION AND PROBLEM STATEMENT

The United Nations Office on Drugs and Crime (UNODC) (2017:9) estimated that in the year 2015 approximately 250 million adults were abusing illicit drugs globally. Illicit drugs are generally divided into four categories: opioids, stimulants, depressants and psychedelics (Nutt, 2012:38). The use of stimulant-type drugs is responsible for a significant portion of the global burden of disease ascribed to substance use, and the growing market for these types of drugs indicates higher rates of use (UNODC, 2017:9). *Stimulant drugs* are defined as drugs that "increase respiration, heart rate, motor activity, and alertness" (Fisher & Harrison, 2013:21). *Stimulant use disorder* is defined by the American Psychiatric Association (2013b) as "[a] pattern of amphetamine-type substances, cocaine, or other stimulant use leading to clinically significant impairment or distress" (APA, 2013a:561). Even though most African countries have insufficient methods of tracking and reporting the prevalence of substance use disorders (SUD), the UNODC West African Commission on Drugs (WACD) (2014:40) reports an increase in the manufacture and seizure of methamphetamines – a stimulant drug. *SUD* is defined as "a cluster of cognitive, behavioural, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems" (APA, 2013a:483).

The Republic of South Africa (RSA) is a developing country consisting of nine provinces, home to a multicultural society, with the Gauteng province earning the highest per capita income in the country (RSA, 2018). Pretoria, located in the Gauteng province, is the administrative capital of the RSA and is the location of the research population reported on in this article (RSA, 2018). The South African Community Epidemiology Network on Drug Use (SACENDU) (2017:5) reported that between January and June of 2017 a total of 3 870 individuals were admitted to seventeen treatment centres in the Gauteng province, of whom 23% reported amphetamine-type stimulants as their primary or secondary drug of choice. The use of methcathinone (CAT), which is an amphetamine-based synthetic stimulant, is increasing in all provinces, but more so in the Gauteng province, where 9% of patients admitted to treatment reported CAT as their drug of choice (SACENDU, 2017:12). In addition, SACENDU (2017:12) reports that 39% of the 10 047 patients admitted to 80 treatment centres across South Africa during the first half of 2017 reported mental health problems upon admission.

The National Institute on Drug Abuse in the United States of America (USA) (NIDA 2010:10) defines dual diagnosis (DD) as "[t]he occurrence of two disorders or illnesses in the same person, either at the same time (co-occurring comorbid conditions) or with a time difference between the initial occurrence of one and the initial occurrence of the other". In the RSA mental disorders are diagnosed according to the Diagnostic and Statistical Manual of Mental Disorders (DSM), compiled by the APA. The APA

(2013b:4) explains that bipolar disorder (BD) was previously classified as a mood disorder, but became a separate category in the fifth edition of the DSM (DSM-5) as changes in energy levels and activity are as important as mood changes (APA, 2013a:810). Whenever the authors refer to BD in this article it is with reference to all types of BD as classified in the DSM-5 (APA, 2013a).

A study conducted by Fabricius, Langa and Wilson (2007:7) aimed at establishing the prevalence of DD among individuals in a treatment centre in Johannesburg. It was found that 57% of the 419 patients had a DD. Swann (2010:278) maintains that patients diagnosed with BD are more inclined to use stimulant drugs as they want to achieve the level of mania they experience during a manic episode of BD. The higher prevalence of DD, however, is not limited to the RSA. Tiet and Mausbach (2007:513) explain that in the USA 60% of individuals who seek treatment for drug abuse are diagnosed with mental disorders, such as BD, and 56% of individuals seeking treatment for BD have a co-occurring substance use disorder.

The presence of a DD complicates treatment in both disorders as individuals with a DD are less likely to comply with treatment and less likely to maintain abstinence in general, according to the National Alliance on Mental Illness (NAMI, 2013:1). Finding effective ways to treat these patients is made more difficult as there is a significant lack of information on the co-occurrence of BD and SUD, as well as the effects each has on the other (Swann, 2010:276). Information is limited as studies focusing on the treatment of BD usually exclude individuals with substance use disorders, thus little is known about the treatment of these patients (Weiss, Griffin, Jaffee, Bender, Graff, Gallop & Fitzmaurice, 2009:212). Fabricius *et al*. (2007:3) assert that it is no surprise that there is often no consensus concerning the treatment of DD, as there is no consensus on what causes it in the first place.

The first author became aware of the complexity of treating DD patients while working at a long-term substance abuse treatment centre in Pretoria. It was noted that those patients with a DD were more prone to relapse, but very little information was available on treating these individuals more effectively. The DD of BD and stimulant substance abuse was chosen as a starting point for a dedicated study, as it was identified as a common co-occurrence among the individuals admitted to treatment. Even though most researchers as well as SACENDU (2017:27) and the Department of Social Development (DSD, 2013a:3) acknowledge the high prevalence of DD in the RSA and calls for the development of treatment focused on this phenomenon, the authors were not able to identify research (EBSCOhost and Google Scholar) focused on intervention strategies. The authors agree with Matsea (2017) that the voice of service users should be heard to ensure that they are involved in the design of treatment programmes, as this has the potential to increase adherence to treatment, it generally improves the outcomes and prevents unnecessary expenditure. Therefore, the authors of this article aimed to explore how adult service users living with a DD of stimulant use disorder and BD experience treatment in in-patient treatment centres for SUD. The authors aimed to answer the following research question: "How do adults living with stimulant use disorder and bipolar disorder experience treatment at in-patient treatment centres for SUD in the Gauteng province?"

In order to contextualise DD all literature and research findings presented will be informed by a theoretical framework, *viz.* the bio-psychosocial perspective.

BIO-PSYCHOSOCIAL PERSPECTIVE

In 1977 George Engel introduced the bio-psychosocial (BPS) perspective to the medical field, urging medical professionals to consider the biological, psychological and social components influencing the lived experiences of individuals (Hatala, 2012:52). Routledge (2005:39) explains that the perspective focuses on three components of an individual: (1) *bio*, for biology, focuses on the genetic, biochemical and physical factors of a person; (2) *psycho*, for psychological, focuses on the developmental, psychological and psychopathological aspects of an individual; (3) *social*, focuses on family systems, diversity, culture, governments and social justice, which are all incorporated into the individual's interpersonal relationships. The isolation of *culture* as a fourth component has, however, been

suggested in recent years, as culture saturates the other three components (Hatala, 2012:58); this is particularly so in countries such as the RSA where traditional healthcare forms part of many cultures and is often consulted before conventional (Western) health care (Jack, Wagner, Petersen, Thorn, Newton, Stein, Kahn, Tollman & Hofman, 2014:4).

In the RSA social workers are mainly responsible for the implementation of SUD treatment and usually focus on BPS components that 'cause' addiction and inform rehabilitation (Jack *et al*., 2014:4; Rassool, 2011:94). In addition, the BPS perspective was adopted as the theoretical framework guiding this study as both BD and stimulant use disorder have shared biological, psychological and social components that influence the cause, progression and treatment of both disorders. The BPS perspective allowed the exploration of the multivariate nature of DD as expressed by participants themselves, for example, the effects that a physical component such as lifestyle have on the psychological well-being of individuals while in treatment.

A brief overview of the causes, effects and treatment of both SUD and BD as separate disorders, as well as a DD, will be presented to shape the context of this study.

SUBSTANCE USE DISORDERS: CAUSES, EFFECTS AND TREATMENT

The causes of SUD are ascribed to various factors. The first is biological factors, such as genetics or neurochemicals, or a combination of them; the second, psychological factors such as turbulent home environments and undiagnosed mental health problems, and finally, social factors such as political turmoil, media and the school/work environment (Jack *et al.*, 2014:3; Rassool, 2011:36).

Increased levels of substance abuse inhibit educational and occupational progress as these are detrimental to the physical, cognitive and psychological health of individuals, and place stress on interpersonal relationships (Fisher & Harrison, 2013:171). In 2005 the costs related to the treatment of methamphetamine in the USA, a developed country, were US$23 billion (±R1.92 billion), including costs related to crime, environmental damage, lost productivity, infectious diseases, family disruptions, cognitive dysfunction and premature death (Brensilver, Heinzerling & Shoptaw, 2013:45). In the RSA, a developing country, the social and economic costs associated with SUDs was estimated at R105 billion in 2013, placing an immense burden on healthcare and social welfare systems (DSD, 2013a:37). SUD is associated with worsened disease outcomes for various disorders, such as HIV and TB (DSD, 2013a:37).

Stimulants increase the activity of the central nervous system, which causes high levels of energy and mental functioning with a loss of appetite, followed by a phase of extreme fatigue, paranoia, anxiety and depression known as a "crash" (Rassool, 2011:83). The use of stimulant drugs is prevalent among individuals diagnosed with mental disorders and, in some cases, the diagnosis of BD can be overlooked as stimulants counter depressive mood cycles (Swann, 2010:278). Biological effects associated with stimulant drug abuse include nausea, insomnia, paranoia, anxiety, irregular heartbeat, excessive sweating, severe headaches, pressure on the chest, myocardial infarction, arrhythmias, cardiomyopathy, acute myocardial ischemia and sudden death (Nutt, 2012:118; Rassool, 2011:225).

The treatment of SUD varies significantly, but most effective treatment interventions include and take into account the following aspects (Rassool, 2011:278):

- Services should be available and accessible;
- Treatment should change according to the needs of an individual;
- The period spent in treatment should be adjusted and adequate for every individual;
- Both counselling and behavioural therapies should be included;
- Mental disorders and substance abuse should be diagnosed and treated concurrently;
- Involuntary treatment should not be deemed ineffective;

- Detoxification should not be seen as part of treatment, but rather as the first step in preparing for treatment;
- The diagnosis and treatment of infectious diseases should be part of treatment;
- Treatment should focus on the risk reduction of all spheres of functioning.

In the Framework for Social Welfare Services, the DSD (2013b:29) encourages social welfare practitioners to provide a continuum of services, informed by the individual needs of every service user and ultimately promoting the self-reliance and social functioning of these individuals.

The following section will focus on the causes, effects, and treatment of bipolar disorder.

BIPOLAR DISORDER: CAUSES, EFFECTS, AND TREATMENT

The DSM-5 (APA, 2013a:810) points out that the focus of BD falls on changes in mood as well as changes in energy and activity involvement, and is therefore not deemed a pure mood disorder. In terms of a BD, moods are clustered into two groups, manic and depressive symptoms. *Manic symptoms* include euphoria, increased energy, increased drive to achieve goals and an increase in irritability, the need for sleep decreases, distractibility and self-confidence are heightened, and there is an increased involvement in activities despite damaging consequences (APA, 2013a:124). *Depressive symptoms* include a decrease in energy levels, an increase in feelings of hopelessness and/or worthlessness, low self-confidence, weight loss, sleep difficulty, an inability to concentrate and psychomotor retardation (APA, 2013a:125). The DSM-5 distinguishes between several types of bipolar and bipolar-related disorders which are diagnosed based on the severity of the manic and depressive symptoms and the period of time these symptoms remain present or active (APA, 2013a:123).

The causes of BD are complex and can be ascribed to numerous factors such as genetics and neurochemicals, illicit drug use, the presence of other mental disorders and/or stressful life events (Miklowitz, 2010:41). The effects of BD are well documented and impact negatively on the physical, cognitive, emotional, financial, occupational and interrelational aspects of those affected (Archambeault, 2009:108). In recent years researchers have started to notice that ethnicity can play a role in the presentation of symptoms as well, after noticing higher levels of manic symptoms among black individuals in both the RSA and the United Kingdom (Grobler, 2012:164). In a study conducted by Lachman, Nessen, Hawkridge, and Emsley (2012) with 139 adolescents in a psychiatric hospital in the Western Cape Province, the use of methamphetamine was associated with high numbers of psychotic and mood disorders.

The DSM-5 indicates that SUD among individuals living with BD is high and that more research focused on this phenomenon is necessary (APA, 2013a:144). Weiss *et al*. (2009:212) reiterate the lack of research on DD, more so on BD coupled with SUD, as most researchers deliberately exclude individuals abusing drugs from BD treatment studies. Swann (2010:278) warns that the DD of stimulant use disorder and BD are as difficult to diagnose as it is to treat, as stimulants can hide depressive moods or mimic manic symptoms; thus either diagnosis can be overlooked.

Although the treatment of BD mostly focuses on pharmacotherapy, Archambeault (2009:107) encourages practitioners responsible for the treatment of BD to focus on all the bio-psychosocial aspects causing and maintaining any psychiatric diagnosis. Swann (2010:276) warns that SUD is the rule rather than the exception among individuals diagnosed with BD and is often detrimental to the effective treatment and recovery of individuals diagnosed with BD.

DUAL DIAGNOSIS: CAUSES, EFFECTS AND TREATMENT

The causes of DD are mainly attributed to four factors: (1) SUD allows individuals to feel that they are managing psychiatric symptoms; (2) SUD triggers the onset of psychiatric symptoms; (3) the same biological and social components predispose an individual to both; and (4) a high level of co-occurrence is merely coincidental (Fabricius *et al*., 2007:2; NIDA, 2010:3). When considering these

explanations it is evident that identifying the causes of DD is complex, as it is the combination of the causes and effects of both disorders that leads to the development of the DD.

There are similar effects in both stimulant use disorder and BD. These effects seem to escalate when grouped together, as chaotic use patterns are more prominent (Rassool, 2011:36). Some of the effects associated with DD include the following: shorter periods of recovery; more visits to emergency units and hospitalisation; higher rates of suicidal thoughts and attempts; frequent displays of impulsivity and violence; higher occupational impairment and school drop-out rates; regular non-adherence to treatment; mixed mood states; higher levels of anxiety disorders; diminished quality of life; and poor treatment outcomes associated with HIV and TB (Lachman *et al*., 2012; Rassool, 2011:22).

Effective treatment outcomes greatly depend on early detection as, with time, symptoms become so intertwined that determining where one disorder ends and the other begins becomes impossible (Salloum, Pani & Cooke, 2010:354). Early detection is unfortunately not the norm, as individuals presenting with psychotic symptoms are generally not accepted into SUD treatment programmes in the RSA until symptoms have been treated (Lachman *et al*., 2012). Grobler (2012:6) acknowledges that as research on mental health care in the RSA is lacking, it is difficult to encourage people to seek treatment and provide accurate information. Even if individuals seek treatment, the primary health care system is already flooded and resources limited, thus making an accurate diagnosis and effective treatment very unlikely. The treatment gap is a major concern as most researchers agree that both disorders should be treated simultaneously and that the severity of both disorders should determine the time that treatment should continue (Fabricius *et al*., 2007:4; Rassool, 2011:218).

Pasche and Myers (2012:340) highlight that the historic separation of two sectors – the DSD heading substance abuse treatment and the Department of Health (DoH) providing mental health treatment – leaves both sectors poorly equipped to deal with DD effectively and concurrently. Despite the fact that the DSD (2013a:3) acknowledges the lack of available DD services in the RSA, available services remain inaccessible and unaffordable to the majority of the population (Lachman *et al*., 2012; Pasche & Myers, 2012:339).

Treatment specific to the RSA context is complex as most research focuses on the treatment or course of either SUD (Pasche & Myers, 2012:340) or BD (Grobler, 2012:6). Completed research that focused mostly on DD concentrated on determining its prevalence, rather than establishing specific treatment experiences of patients (Fabricius *et al*., 2007:14). Hence, the literature underscored the rationale for the study, namely to explore how adult service users living with a DD of stimulant use disorder and BD experience treatment within in-patient treatment centres for SUD.

An overview of the research methods will be offered, followed by a discussion on the findings of the study, presented as themes and sub-themes, as well as conclusions and recommendations highlighting the most important aspects of this phenomenon as it relates to treatment.

RESEARCH METHODS

Rooted in phenomenology as research paradigm (Nieuwenhuis, 2016:60-62), a qualitative research approach enabled the authors to explore how people diagnosed with both bipolar disorder and stimulant use disorder experience treatment at in-patient treatment centres in the Gauteng province (Isaacs, 2014:318). The study had an exploratory purpose to gain as much understanding of the participants' personal experiences, especially as the study was the first of its kind in the RSA. The phenomenological research design, specifically the transcendental sub-design, was used as the authors aimed to describe authentically the lived experiences of adults living with a DD while in treatment without detailed interpretations by the authors (Creswell, 2013:80).

The research population was comprised of adults who had been admitted to three treatment centres in Pretoria (Gauteng province), who had been diagnosed with both BD and stimulant use disorder. All patients diagnosed with BD were included in the study, irrespective of the subtype of the bipolar diagnosis. Purposive sampling was used in a three-phase process to identify the research sample. In

phase one purposive sampling was used to select three treatment centres in Pretoria where potential participants could be recruited. After permission was obtained from the treatment centres, inclusion criteria were provided to a social worker at each treatment centre, which aided in the identification of possible participants. Phase two of the sampling process, which was also purposive sampling, revolved around the identification of participants based on specific inclusion criteria, namely:

- Individuals who were older than 18 years;
- Individuals who had a stimulant drug addiction, which includes cocaine, CAT, khat or meth;
- Individuals who were not in the detoxification phase of treatment;
- Individuals living with the DD of stimulant use disorder and BD, which was confirmed by a medical practitioner or psychiatrist;
- Individuals could be either male or female;
- Individuals could be part of any religious and/or ethnic group;
- Individuals who could converse in Afrikaans or English.

In the third phase of the sampling process, all possible participants who met the inclusion criteria were approached by the social worker of the treatment centre and could volunteer to participate in the study. Even though the authors hoped to include a larger sample, four participants eventually participated. Nonetheless, Creswell (2013:78) states that sample sizes for phenomenological studies are often small (e.g. three participants).

The data-collection method used was a semi-structured one-on-one interview that was guided by an interview schedule. One interview, lasting up to 90 minutes, was conducted with each participant at his or her treatment site. The particular data-collection method was beneficial as it allowed enough freedom to explore the personal experiences of each participant (Isaacs, 2014:321).

All data collected were analysed through the process of thematic analysis (Clarke, Braun & Hayfield, 2015:223). Even though thematic analysis is not commonly associated with a phenomenological research design, Clarke and Braun (2013:120) explain that in recent years this form of analysis has received recognition along methodologies such as interpretative phenomenological analysis (IPA). Thematic analysis is also not confined to fixed theoretical frameworks and is seen as a basic method that is appropriate for any sample size (Clarke & Braun, 2013:120).

A number of strategies were adopted to ensure the trustworthiness of the study. *Auditability* was ensured by keeping field notes and a journal, consulting with a co-researcher and developing transcripts, which could be reviewed (Lietz & Zayas, 2010:195; Padgett, 2017:220). *Credibility*, how accurately data are presented, was maintained by discussing all themes and sub-themes with the co-author, as well as by performing member checking with one of the research participants (Lietz & Zayas, 2010:192; Padgett, 2017:219). *Confirmability* was achieved as most research findings could be confirmed by comparing research findings with literature (Lietz & Zayas, 2010:197). *Transferability* is possible when research findings could contribute to future research, theories, or practice. Transferability was ensured in this study by declaring all research processes, which could enable replication of the study (Lietz & Zayas, 2010:195).

Ensuring confidentiality, obtaining written informed consent from all participants and no harm were some of the ethical considerations that were adhered to during the study (Rubin & Babbie, 2017:85-90). The research study also received ethical clearance from the Research Ethics Committee of the university (Ref no.: GW20160523HS).

FINDINGS

Table 1 contains the biographical details of the participants.

TABLE 1
PROFILE OF PARTICIPANTS

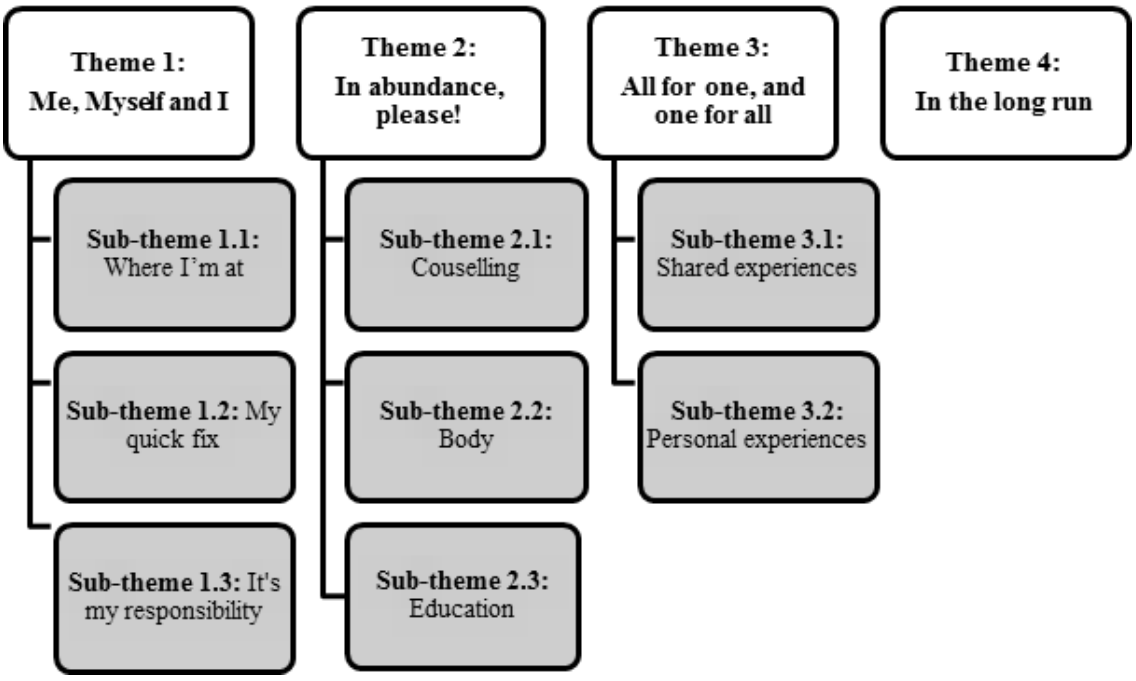
	Current age	Age when stimulant abuse started	Age when bipolar disorder was diagnosed	Gender	Number of children	Race	Level of education
Participant 1 (PAR01)	37	16	28	Male	0	White	Honours degree
Participant 2 (PAR02)	21	19	21	Male	0	White	Grade 12
Participant 3 (PAR03)	24	16	19	Male	0	White	Grade 12
Participant 4 (PAR04)	28	14	25	Female	1	White	Grade 12

Merikangas and Peters (2010:55) state that BD affects men and women equally, but women over-represent the population in psychiatric treatment centres. In addition to this NIDA (2010:9), in the USA, reports that in terms of DD men seem to access rehabilitation programmes more frequently, while women are more inclined to access psychiatric treatment.

All the participants had previously been admitted to SUD treatment programmes, three participants also mentioned prior admission to psychiatric treatment centres, a finding that correlates with Lachman *et al*. (2012), who reported re-admission rates of 41% to psychiatric treatment programmes among South African youths. It is noteworthy that all participants started using stimulants before they were diagnosed with BD.

The study's findings will be presented in the format of themes and sub-themes (Figure 1).

FIGURE 1
OVERVIEW OF THEMES AND SUB-THEMES OF STUDY



Theme 1: Me, Myself and I

The consideration of all BPS aspects influencing the development, course, and progression of both disorders should be considered throughout the treatment process to promote recovery.

Sub-theme 1.1: Where I'm at

Prior to treatment, participants used stimulants as a means of managing rapid mood changes. As all participants received pharmacological treatment, it would be assumed that their moods were stable. However, regardless of pharmacological treatment focused on biological aspects, participants still experienced unstable mood patterns on a psychological level that triggered cravings for drugs on a physical level.

> *"… my mood … in the space of one day goes … up-and-down, up-and-down, up-and-down. You can't ask me how did I feel today. Because you'd have to ask me that like every hour."* (PAR02)

> *"A lot of the times, I'm down and it makes me wish that I could get back to drugs to get like that quick fix to get happy and high again."* (PAR03)

Participants explained how their mood would fluctuate multiple times during one day; however, it is during depressive cycles that they craved stimulants most, as they longed to experience manic symptoms. As participants did not have access to substances of abuse during treatment, they resorted to other means of managing moods, as discussed in the following section.

Sub-theme 1.2: My quick fix

Generally, individuals display behaviour or use products to alleviate emotional discomfort and manage moods. As seen in the previous section most participants reverted to stimulants to manage moods; however, while in the treatment they resorted to other 'quick fixes'.

> *"I need something to be happy, all the time. Whether it is drugs, or watching a movie, or, something needs to be there to make me happy.*" (PAR02)

> *"If I'm extremely, extremely depressed and I can't do anything… Go to the bathroom. Slit. Come out. Then I'm happy. Healed."* (PAR02)

> *"Uhm psychologically this is tough hey. Like in the other rehabs, you can call your parents … you can get like tuck (tuck shop) every single day … you eat chocolate every day so you can like feed some kind of … a need or a lack or whatever, you can fill yourself with, with, with nonsense."* (PAR01)

> *"I just wanted to go and lie down and just escape the world, you know."* (PAR01)

Medication, food, sugar, contact with significant others, coffee, cigarettes, and self-mutilation are some of the 'fixes' that were mentioned by participants which offered psychological relief. As these products and behaviours can become habitual, referred to as cross-addictions, they carry their own set of risks, indicating that the root of the problem is still not being treated despite pharmacotherapy.

As a result of the continued mood instability, most participants considered discontinuation of treatment at some point. Reasons for remaining in treatment were mostly rooted in the sense of responsibility that the participants felt.

Sub-theme 1.3: It's my responsibility

Most participants believed that by remaining in treatment they took responsibility for various BPS factors.

> *"Uhm … I think that for my relationship with my parents a long-term programme is the only option I have. So, me not being here isn't actually an option."*(PAR01)

> *"So inside I'm super sad, I'm destroying myself, I'm depressed, I'm thinking about suicide, but on the outside, I'm putting up this face and trying to work the programme, and trying to advance in the programme, you know."*(PAR02)

Participants remained in treatment in an attempt to convince family members that they are committed, or because they are at an age or time in their life when they believe it is necessary to take responsibility for their actions. Other participants, however, remained in treatment to "get it over and done with" regardless of the psychological discomfort they experience during treatment. Interestingly, responsibility was expressed in terms of SUD, but not in terms of BD, a component that will be addressed in sub-theme 2.3.

The following theme will report on aspects of treatment which participants found beneficial.

Theme 2: In Abundance, Please!

In this theme, the need for physical and psychological aspects of treatment will be indicated.

Sub-theme 2.1: Counselling

The following statements indicate that counselling is one aspect of treatment that all participants esteemed:

> *"I need to speak about what's going on with me ... I don't know how to process the hurt.*" (PAR01)

> *"I live from one counselling session to the next."* (PAR01)

> *"I struggle to uhm handle my own like emotions and things that I'm not in control of and they don't teach you how to control that in the beginning."* (PAR03)

Two participants stated that they live from one counselling session to the next, as they need counselling to process what is going on in their mind. Counselling was seen as the most beneficial component in managing emotions and stress, and participants indicated that they would not recover without it. Most participants expressed a need for more counselling and most called for at least two sessions per week. One participant who received counselling twice a week, one session with a case manager and a second with a clinical psychologist, was satisfied, validating the need expressed by other participants.

Even though it appears as if counselling would be sufficient for recovery, participants valued a focus on physical aspects of treatment as well.

Sub-theme 2.2: Body

Concerning the physical components of treatment, participants said the following:

> *"... there is 'gymming' equipment ... that's how I handle emotion. Because emotion handles me."* (PAR02)

> *"... exercise is good especially when you are having a difficult time…"* (PAR03)

Participants considered exercise as a valuable component of treatment in terms of managing mood and emotions. Other participants mentioned that healthy lifestyle factors, such as eating habits and sleep patterns, held great benefits and aided recovery. Education in terms of the role of a healthy lifestyle after treatment was, however, a need for one participant. The subsequent section will focus on other areas where education should take place as part of treatment.

Sub-theme 2.3: Education

Participants mentioned a need for education focused on a broad spectrum of topics:

> *"… knowledge of your addiction … and to learn to cope and a healthy lifestyle outside… what they do here is very good… there just needs to be more."* (PAR02)

> *"The drug use and the bipolar… I know they might be similar but … I would like to differentiate between the two and get to know myself better as well."* (PAR03)

Topics of interest included education on BD and addiction as diseases, developing coping skills, understanding how a healthy lifestyle promotes recovery and how BD and stimulant use influence each other. Most participants felt education should take place one-on-one with a professional as well as in groups consisting of individuals who share the same diagnosis.

It was thought-provoking to see that all participants saw education focused on both SUD and BD as a means of promoting recovery and verifying their BD diagnosis, as seen below:

> *"... like a lot of uhm psychiatrist just label uhm a lot of drug addicts as bipolar so that's why I'd like to learn more about it, and you can maybe differentiate between the two."* (PAR03)

> *"I don't think it is really treated here… we get sent to the psychiatrist but … basically just to get me on pills it's not actually to help me manage… I haven't gained any knowledge of my BD."* (PAR02)

Another participant explained that anyone going to a psychiatrist while intoxicated or withdrawing from stimulants would be diagnosed with BD. Yet another participant explained that substance use suppresses emotions and, when the use of drugs is discontinued, years of emotions rush out and create unstable moods that can be mistaken for BD. From these statements, it appears as if most participants firstly, view BD as a label or misdiagnosis, and secondly, deems knowledge on the causes, effects and management of their diagnosis as more beneficial than pharmacological treatment. In light of sub-theme 1.3, it appears that the participants found it difficult to take responsibility for managing a disorder when they question the accuracy of the diagnosis from the onset.

The following statement represents participants' belief that education should be extended to significant others as well:

> *"The people that are close to us, uhm should also be taught on uhm how to handle cravings … how to handle … us as, as addicts … because we are manipulative as well and they should be able to see past that."* (PAR03)

With this quotation, it is evident that participants desire exposure to and the inclusion of other individuals in treatment.

Theme 3: All for One and One for All

All for one and one for all is a phrase used to indicate (1) that a group can support an individual, if the individual contributes to the group, and (2) that when individuals work together they can achieve both the group's goals and their personal goals. The interplay between shared experiences, while still maintaining individualised treatment, is explained in the next two sub-themes.

Sub-theme 3.1: Shared experiences

Group therapy and support groups are common in the treatment of both SUD and mental disorders, for example, Alcoholics Anonymous (AA), and Narcotics Anonymous (NA) groups. The following statements indicate why participants found groups beneficial:

> *"… in group therapy sessions … you process so much there and you just connect with the other people…and you're like 'oh my goodness I can relate to that'… it's not just me…"* (PAR01)

> *"…the people that are here… that have been clean for long, and to see how they live and how their lives are coming right. It shows that there is hope."* (PAR04)

> *"…we should invite people from the outside to join our groups or we should travel to the outside groups, which are already set out there and hear stories from different people … what got them through it."* (PAR03)

It appears that groups can validate and normalise experiences for participants. One participant explained that having contact with other people who have recovered and are able to live 'normal' lives are a source of hope. In addition to hope, knowledge was an additional benefit derived from interaction with individuals who have maintained abstinence. Confrontation by counsellors and other individuals in recovery has long been a part of SUD treatment and was a beneficial and valued component of treatment for participants when appropriately utilised.

Sub-theme 3.2: Personal experiences

Exposure to individuals who share similar experiences appears to promote recovery; however, when experiences are generalised, individual needs are neglected and recovery demoted, as seen in the following quotations:

> *"… they must help guide you through that certain situation … because they tend to generalise it… instead of helping you through specific problems…" (PAR03)*

> *"… for them, it was like a communication thing, they were like "aw, no we understand the way you feel if you have issues" and I was like oh well that's one way of looking at it. I was just doing it because it makes me feel better. Point.* [explaining response from staff to self-harm]*."* (PAR02)

During interviews, two participants shared that they self-mutilated during treatment. The first participant saw self-mutilation as a means of communication, to show the treatment centre that he did not agree with certain aspects of treatment. The second participant experienced emotional relief when he self-mutilated; however, the treatment centre saw it as a way of communicating, instead of teaching him more effective coping mechanisms. It is evident that consideration of individual treatment needs should be taken into account as failing to do so could jeopardise long-term recovery.

Theme 4: In the Long Run

Essentially the objective of treatment is to ensure that an individual is able to achieve and maintain the highest possible personal level of functioning and not merely abstinence from substances of abuse. It appears that the most detrimental factor to long-term recovery is opposing treatment goals, as seen in the following quotes:

> *"I said to her specifically … I won't take anything that will make me pick up weight because I've got very bad body dysmorphic disorder... it's a trigger for me you know; when I used meth [methamphetamine] I was so lean it was the most beautiful feeling.*" (PAR01)

> *"...they have more addressed the issue of the substance abuse than the bipolar. No matter if, even if I come to them with my emotional problems, they rather just address religion and substance abuse."* (PAR03)

In this case it appears as if the goal of the psychiatrist was to prescribe the most effective medication to address the biological component of BD. The goal of the participants was, however, to maintain a certain image that was being threatened by the prescribed medication, regardless of the fact that this concern was mentioned, and ignored. It can be assumed that this participant is at a high risk of non-adherence and relapse, as the negative effects associated with medication triggers discomfort, a discomfort that can be addressed by a stimulant.

Other participants stated that they believe that they were in the wrong 'type' of treatment centre because the goals they had for treatment and the focus of the treatment centre were different. The following comments expand on the participants' views:

> *"…spiritually, they do a good job here…That's why there is lacking in the other things."* (PAR02)

> *"…I need to get affirmation…I seek that stuff…"* (PAR01)

> *"…I think there should be more…confrontation group [sic], where we call people out on their bad behaviour, their addictive behaviour."* (PAR03)

The quotations above highlight some opposing treatment goals, such as spirituality, confrontation and rewards.

DISCUSSION

Generally, the initial focus of treatment falls on addressing biological components, for example, the prescription of medication to stabilise mood cycles in BD (Archambeault, 2009:108), and the use of medication to manage withdrawal symptoms associated with stimulant drug abuse (Rassool, 2011:94). Despite pharmacological intervention, most participants reported unstable moods that appeared to cause psychological discomfort and triggered cravings for stimulants. On the basis of similar observations, authors such as Fisher and Harrison (2013:151) described medication as a merely complementary therapy. Unfortunately, as researchers still debate the causes of DD, there are few studies focused on its treatment, apart from pharmacological interventions (Weiss, Griffin, Kolodziej, Greenfield, Najavits, Daley, Doreau & Hennen, 2007:100). As non-adherence to BD medication is estimated at 70%, there is a dire need for alternative forms of treatment (Miklowitz, 2010:45).

As participants did not have access to stimulant drugs during treatment, they turned to other substances and behaviours, termed cross-addictions, in an attempt to manage psychological stress, a phenomenon that is common among individuals in treatment for SUD (Fisher & Harrison, 2013:40). Common cross-addictions include food, sweets, exercise, caffeine, sex, gambling, nicotine, relationships and self-mutilation (Evren & Evren, 2005:19; Fisher & Harrison, 2013:290). As cross-addiction plays a functional role, it indicates that treatment needs are not being met and that certain BPS factors are neglected (Engel, 1981:103). Empowering individuals with skills to manage psychological stressors is crucial as cross-addiction poses a risk to recovery; for example, Frye and Perugi (2010:33) report that nicotine inhibits the effectiveness of bipolar treatment and aggravates symptoms.

In addition to cross-addiction, certain internal motivators such as a sense of responsibility encouraged participants to remain in treatment. Taking responsibility for recovery appeared to be an individual process, not deliberate or guided, motivated by personal drive or the anticipation of gaining something. One participant perceived 'taking responsibility' for recovery as an opportunity to restore interpersonal relationships, where another was so focused on getting through treatment that he neglected to disclose and address psychological discomfort, thus not taking responsibility for recovery. 'Taking responsibility' should be a topic of interest during treatment and reintegration; however, treatment goals should be realistic and take place in an appropriate timeframe to promote recovery (Miklowitz, 2010:27). Social workers should ensure that service users take responsibility for their treatment and cooperate with the treatment plan, which includes disclosure of underlying disparities that caused stress (Engel, 1981:102). It is noteworthy that responsibility was only expressed concerning SUD treatment as, so we believe, all participants questioned their BD diagnosis, describing it as a label or misdiagnosis. Swann (2010:278) acknowledges that misdiagnosis is common as stimulant drugs mimic symptoms of hypomania; however, NIDA (2010:7) emphasises the need for an accurate diagnosis, as treatment goals and ultimately treatment outcomes will depend on the diagnosis made.

All participants considered counselling as the most beneficial part of treatment, as it was the most effective way of relieving psychological stressors and managing unstable moods, despite medication. In support of this view, research findings indicate that a safe environment where individuals can share perceptions and experiences has been found to be beneficial in the treatment of both SUD (Fisher & Harrison, 2013:57) and BD (Archambeault, 2009:118). Focusing on various BPS components of treatment is necessary, as focus on only one indicates possible neglect of another (Hatala, 2012:52). Most participants expressed a need for more counselling, while one participant, receiving counselling from different professionals, expressed satisfaction with counselling. Services provided by different

disciplines seem to be effective and is encouraged by Rassool (2011:228), who describes addiction and mental disorders as a multidisciplinary problem and encourages professionals to work together.

Pharmacotherapy in the treatment of both BD and SUD aids in the management of symptoms because of their effect on neurotransmitters (Miklowitz, 2010:41; Nutt, 2012:69). Zastrow (2012:359) explains that, in addition to other physiological and psychological effects, physical exercise influences these same neurotransmitters. In support of these views, participants appeared to value the psychological benefits associated with exercise more than its physiological benefits. Bordbar and Faridhosseini (2012:324) hold that knowledge regarding how lifestyle influences psychological symptoms and the effectiveness of medication, as well as knowledge regarding side effects of medication, needs to form part of treatment. Interestingly, some participants expressed a need for education in this regard.

Psycho-education that includes emotional, behavioural and cognitive therapies can ensure that individuals develop coping skills to manage psychological and social stressors as well as identifying triggers for both disorders (Miklowitz, 2010:27; Weiss *et al*., 2007:101). Acceptance of a diagnosis is important, as individuals are more likely to access services if they believe they need it and if they believe the service provider can fulfil these needs (Engel, 1981:102). Acceptance and utilisation of treatment lead to lower relapse rates, which ensures better health outcomes for individuals as well as lowered psychological and financial strain on families and healthcare systems (Fisher & Harrison, 2013:56). Some participants mentioned that psycho-education should include family members, a need supported by researchers, who indicate that lower relapse rates occur when patients and families received information on both disorders and treatment options, while fostering realistic expectations regarding recovery and treatment (Miklowitz, 2010:27; Rassool, 2011:226).

Social workers and other members of the multidisciplinary team should consider the effect of culture, because high instances of social exclusion and political turmoil, as is the case in the RSA and most developing countries, generally leads to higher rates of mental health problems and SUD (Lachman *et al*., 2012). Additionally, treatment of mental health is often insufficient in multicultural countries, ~~a~~s Western culture primarily informs treatment methods, which are not always appropriate in multicultural settings (Allott, cited in Archambeault, 2009:27). In fact, the Framework for Social Welfare Services (DSD, 2013b:29) calls on service providers to render services on a continuum ranging from prevention to aftercare and reintegration services and discourages over-reliance on treatment along.

Traditional treatment of both mental disorders and SUD includes group therapy, as it creates a platform where individuals can share experiences, achieve the common goal of recovery, and build supportive relationships while gaining knowledge and hope (Fisher & Harrison, 2013:144). Fisher and Harrison (2013:151) warn that the needs of individuals should be considered and guide treatment, as not everyone will derive the same benefits from groups. The idea that individuals should receive treatment based on their individual needs is the very essence of the BPS perspective (Engel, 1981:102). Therefore, adapting programmes to the multivariate nature of SUD and BD is essential to promote effective treatment (Merikangas & Peters, 2010:56).

In terms of the treatment of DD, most researchers agree that both disorders need to be treated simultaneously as the neglect of one disorder can cause relapse in both disorders (Camacho & Frye, 2010:190). In the USA Weiss (2004) implemented outpatient groups focused on the DD of BD and general SUD when they discovered that separate treatment groups often had opposing goals, triggering a relapse. For example, should an NA group discourage the use of any medication and a BD support group is uninformed regarding the behaviours indicating SUD, the relapse of either disorder could be overlooked thus leaving service users (i.e., participants) without appropriate support to maintain the best possible quality of life given their DD (Miklowitz, 2010:301). Salloum *et al*. (2010:354) explain that treating an acute disorder is normally successful and achieved easily, but the focus shifts to maintaining long-term stability when multiple chronic disorders such as BD and SUD need to be treated simultaneously. As recovery is a lifelong process, it is important to ensure that service users and their families are included in goal setting and that they understand and approve the treatment plan, as

this promotes treatment adherence and long-term recovery in both disorders (Fisher & Harrison, 2013:151; Miklowitz, 2010:27). Discomfort caused by opposing treatment goals was evident during interviews with participants and was caused by various aspects, such as disagreements in terms of medication, religion, a lack of rewards and the inappropriate use of confrontation in treatment. In an attempt to deliver adequate services, social workers are urged to understand the BPS aspects determining the onset, course and progression of both disorders to ensure effective treatment and allow sufficient time for recovery and reintegration (Fisher & Harrison, 2013:49).

All the findings reached in this study should ultimately inform policy development. Archambeault (2009:118) urges social workers to accept the influence they have on policies that guide the development of intervention protocols. Policies should ensure that treatment respects multicultural societies such as the RSA, where appropriate interventions should especially infiltrate the primary health care system (Jack *et al*., 2014:7). Jack *et al*. (2014:2) acknowledge that, unfortunately, discussions regarding the implementation of the national health insurance in the RSA do not focus on mental health care services as part of the primary health care system at this stage, although a lack of trained staff is another pitfall facing the RSA.

The article aimed to describe how adults living with the DD of stimulant use disorder and BD experience treatment. The authors believe this is the first study in the RSA that aimed to explore how treatment is experienced. The research sample, however, does not represent the experiences of individuals in public or psychiatric treatment programmes, or those diagnosed with different dual diagnoses. Another limitation includes the absence of all ethnic groups in the RSA, as all the participants who volunteered their participation in this study were white.

The goal of phenomenological studies is not generalisability but rather understanding the meanings assigned to experiences. The goal of the phenomenological approach coupled with steps taken to ensure the trustworthiness of the study has the potential not only to have an impact on individual lives in the RSA, but also on those in other developing countries, especially those in Southern Africa.

CONCLUSIONS

The nature of the study allowed for the gathering of rich data focusing on a diverse range of aspects moulding the experiences of participants. The authors believe that the conclusions and recommendations outlined below highlight the most important aspects of this phenomenon.

In general, DD has become a topic of interest in recent years and research focused on various types of DD is necessary for the establishment of effective treatment. A lack of epidemiological data on the prevalence of both stimulant use disorder and BD globally, and in the RSA specifically, means the prevalence and actual impact of this DD on individuals and society is unknown. In addition, the development of effective treatment will be inhibited as well, effectively delaying recovery and escalating negative effects, supporting the call of various authors for more research.

Similarities regarding the *effects* of stimulant use and BD overlap on various levels. *Biologically*, the same neurotransmitters are involved in the course and progression of both stimulant use disorder and BD. Compared to individuals with no diagnosis, those diagnosed with SUD or BD has been found to have poor *psychological* health in general. The financial and emotional strain placed on *social* systems, such as families and governments, are more severe when BD or stimulant use is diagnosed. As numerous risk factors, causes and effects associated with the development and course of BD and stimulant use overlap, it can be assumed that individuals will be prone to develop both disorders. In the absence of a DD and the holistic treatment thereof, the poor outcome of treatment is inevitable.

Concerning the *treatment*, pharmaceuticals are common in the treatment of *biological* components associated with BD and managing withdrawal associated with stimulants. Treatment of *psychological* components seems more complex as stimulants are described as more psychologically addictive than physically addictive, whereas individuals diagnosed with BD need to become comfortable with the idea

of living without the presence or anticipation of manic episodes. In general, treatment outcomes are more favourable when *social* systems are included in treatment and support recovery.

It is clear that pharmacological treatment and a formal diagnosis was not sufficient in managing symptoms or encouraging individuals to take ownership of their recovery. Rather, psycho-education and counselling were seen as the most beneficial aspects addressing the psychological needs of individuals living with this specific DD. Education in terms of lifestyle, treatment options and outcomes of treatment should be addressed. The individual needs of patients should be respected and guide treatment on a continuous basis and all physical, cognitive and interpersonal factors that can promote recovery should be included; for example, exercise, group therapy and religion/spirituality. Treatment groups seem to have the most profound impact and act as a source of education and motivation while providing hope for full recovery while addressing the lack of available social workers and other service providers in the RSA.

Social workers, service users and family members should understand and acknowledge the risks and effects of secondary problems as well; for example, nicotine can aid in managing depressive moods; however, individuals using nicotine have been found to be more resistant to BD medication, making mood relapse more probable. More in-depth and treatment-specific education for social workers in DSD and other service providers in DoH in the RSA is, however, a crucial step in developing and treating DD effectively.

The inclusion of professionals and policy developers is important, as the divide between psychiatric services headed by the DoH, and SUD services headed by the DSD has caused a treatment gap to develop where those most in need of services are lost. Echoing this recommendation, SACENDU (2017:27) expresses a need for lobbying for resources directed to understanding and addressing this growing phenomenon.

Future research should repeat this study in private and government-based treatment centres across the RSA. Results from different studies should also be compared to determine the most prominent treatment needs. Treatment programmes should be developed, implemented and evaluated to determine if treatment needs have been met.

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FACTORS THAT COULD CONTRIBUTE TO SUBSTANCE MISUSE AND CRIMINAL ACTIVITY AMONGST ADOLESCENTS: AN ECOLOGICAL PERSPECTIVE

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INTRODUCTION AND PROBLEM STATEMENT

Several scholars (Groenewald & Bhana, 2016; Korff, 2010; Mudavanhu & Schenck, 2014; Pillay & Willows, 2015) concur that there is a strong correlation between substance misuse and criminality in adolescents. A possible reason is that adolescents often engage in risky behaviour that could hamper their wellbeing without consideration of the long-term effects. A statistical look at substance misuse in juvenile offenders over the past twenty years reveals that the habit has been growing at a consistent rate in South Africa (Groenewald & Bhana, 2016). Juvenile offenders who are using substances or who have used substances previously display a higher chance of recidivism, prolonged time within the juvenile justice system and prospective correctional services in the adult correctional system (De Matteo & Marcyk, 2005; Tripodi & Bender, 2011). A study conducted in California (Denney & Connor, 2016) found that approximately 80% of adolescents who come into conflict with the juvenile justice system are either using substances, or their delinquent behaviours have led to them misusing substances. This study also found that recidivism and being involved in the adult correctional system as an adolescent with a substance use disorder problem is very common within the juvenile justice system. Other studies (Korff, 2010; Leslie, 2008; Winters, & Arria, 2011) have also indicated that imprisoned youths or juvenile offenders worldwide represent the highest number of adolescents infected with or at a high risk of contracting HIV and/or other sexually transmitted infections (STIs). This is exacerbated by regular use of illegal and harmful substances, as well as sex with multiple partners. Adolescents who are involved in substance misuse within the juvenile justice system are also at a high risk of health problems. These health problems include: distortion of senses, appetite stimulation, hyperthermia, hypertension, chest pain, dissociation, nausea and vomiting, seizures, as well as psychotic symptoms.

It is clear from the discussion above that a significant number of adolescents engage in substance misuse and criminal activity. Although several international studies (De Matteo & Marcyk, 2005; Leslie, 2008; Nalin, 2017) have been done on factors that could lead to substance misuse and criminal activity amongst adolescents, limited research specifically focusing on social service providers' perceptions of this matter has been done within the South African framework. For the purpose of this study, social service providers are practitioners who are rendering services to adolescents who misuse substances and engage in criminal activity. Social service providers usually struggle to render effective services to adolescents who misuse substances and engage in criminal activities because of a number of factors such as dysfunctional families, peer pressure and gang-related activities that have an influence on adolescent behaviour. The goal of this study was to explore factors that could contribute to adolescents misusing substances and displaying criminal behaviour as perceived by social service providers. From this goal, the following research question was derived: What factors could contribute

to adolescents misusing substances and displaying criminal activity as perceived by social service providers?

THEORETICAL FRAMEWORK

The ecological perspective (Bronfenbrenner, 1979) was chosen as a theoretical framework, as factors that could play a role in the negative behaviours by adolescents manifest on different levels. Although some authors (McCallen, 2016; Gilstrap & Ziertan, 2018) also include exo and chrono levels, for this study only the micro, meso and macro levels were utilised to analyse the data. On a micro level, adolescents' genetic and biological make-up needs to be taken into consideration, as some people are more prone to forming an addiction than others (Fisher & Harris, 2013; Winters & Arria, 2011). The use of illegal substances also has the ability to affect one's mental and emotional wellbeing, increasing the likelihood of anxiety disorders, mood disorders, post-traumatic stress disorder (PTSD) and depression. There is a significant link between the excessive usage of substances and mental disorders. With the onset age of substance misuse getting lower, youths and adolescents are putting their mental wellbeing at risk by opening the window to being diagnosed with a psychological or psychiatric disorder (Basson & Mawson, 2011; Saban, Flisher, Grimsrud, Morojele, London, Williams & Stein, 2014).

On the micro level, the family structure also plays a vital role in the development and progression of the child or adolescent. If the familial system or family members within the system have a history of substance misuse and dependency, this increases the adolescent's probability of being involved in using illegal substances as well (Mudavanhu & Schenck, 2014); they are modelling the behaviour of their parents or family members. According to Burton and Leoschut (2013), roughly 90% of juvenile offenders in South Africa have a history of ill-treatment in their family. Adolescents without parents or without parental supervision presented the highest risk for violent and criminal behaviour. These households are also likely to face financial difficulties and to be exposed to the misuse of alcohol and illegal substances.

Peer pressure is another factor that plays a role in adolescent's lives on the micro level. Research (Ward, Van der Merwe & Dawes, 2012) has shown that there is a strong possibility of adolescents joining a gang if they have anti-social beliefs and if they struggle to resist peer pressure towards delinquency. Deviant peer friendships and associations put adolescents at high risk of deviant behaviour that could lead to indulging in unlawful behaviour.

On a meso level, the socio-economic circumstances of adolescents play a significant role in their wellbeing. Socio-economic circumstances could also be seen as a macro-level influence. However, it is especially in a South African context where several communities struggle with poverty that socio-economic circumstances fit well on a meso level. South Africa, as a developing country, has many low socio-economic communities as well as many low-income, urbanised households. The financial stressors which many South Africans experience allow individuals to face collective forms of regular stressors, increasing feelings of negativity, substance use and delinquency (Mosavel, Ahmed, Ports & Simon, 2015).

Otwombe, Dietrich, Sikkema, Coetzee, Hopkins, Laher and Gray (2015) conducted a study on the experiences of violence among adolescents in lower socio-economic groups in Johannesburg. Through this study, it was found that violence amongst adolescents is enabled and endorsed through the misuse of substances. These substances, namely alcohol and drugs, are mainly consumed by adolescents at first because they are curious and want to experience the feeling or taste. The alarming statistics reveal that the age group for the highest illegal substance consumption rate is below 15 years. Age 17 to 20 years indicated the most murders committed related to alcohol use or being intoxicated, and most cases of violent and aggressive behaviour occur between the ages 20-21 years. It is also important to note that there is a strong correlation between poverty-stricken or low socio-economic communities and high levels of substance misuse.

The school system could also lead to various forms of violence. This includes corporal punishment, physical assault, sexual or verbal abuse, threats, bullying, theft, gender-based violence and gang-related activities. This violent behaviour at school is associated with violence perpetrated within the community (Ward *et al*., 2012). When studying substance misuse amongst adolescents in South African high schools, the frequency of use of illegal substances is higher for older adolescents in comparison to younger adolescents. Bullying is also a form of violence which takes place within the school setting. This can be categorised as problematic, aggressive behaviour which involves victimisation and perpetration of violence. It is common amongst adolescents and prevalent within schools. It is interesting to note that parallels can be drawn between school bullying and the use of illegal substances or drugs, and these are often accompanied by criminal activity (Maria & Eisner, 2015).

As discussed earlier, peer pressure could lead to gang-related activities. Gang activity and drug-dealing encourage the involvement of youths, also enabling violent and criminal behaviour. The inclusion of young people in gangs has increased in South Africa, and the average age of members is decreasing to include even pre-adolescent children. Involvement also pressures the individual to act defiantly and to disregard behaviour that is deemed socially acceptable (Edberg, Shaikh, Thurman & Rimal, 2015). The increase in homicides, sexual offences, assaults and violence among adolescents is strongly associated with gang activity and involvement (Basson & Mawson, 2011).

On a macro level, the implementation of legislation and policies that address the effect of substance misuse on adolescents involved with criminal activity could play a role. Groenewald and Bhana (2016) have stated that the South African policies which address the effect of substance abuse do not effectively address the needs of family members affected by substance misuse in terms of rendering supportive services. This is an important factor, as the implementation and practicality of these policies will have an influence on all the levels of the ecosystem of the substance-dependent adolescent. Service rendering to adolescents who misuse substances and display criminal behaviour aims to provide emotional, psychological, informational and interpersonal assistance. As explored in a recent research study conducted by Humm, Kaminer and Hardy (2018) in South Africa, various factors – including a lack of social support and service rendering – have been identified that impact on violence and criminal behaviour, specifically in adolescents.

RESEARCH METHODOLOGY

To achieve the goal of the study and to answer the research question, a qualitative research approach was adopted in order to gain a more comprehensive and inclusive perspective on the topic (Fouché & Shurinck, 2011). An exploratory and descriptive research design was utilised in order to explore the views of different service providers and to describe their experiences (Creswell & Poth, 2018). Purposive sampling was used to obtain the sample of twenty participants, when data saturation was reached (Maree, 2016). Criteria for inclusion were that participants had to be practicing social service providers rendering services to juvenile offenders who misuse substances within the geographical area of Cape Town and surrounding areas. The participants were social workers, social auxiliary workers, youth probation officers, magistrates and prosecutors.

A semi-structured interview with interview guide was used to collect the data. Participants were interviewed by the researcher, and the interviews were transcribed utilising a denaturalised method (Oliver, Serovich & Mason, 2006). A denaturalised method allows the transcriber to remove unnecessary elements of speech such as pauses and interjections, thus focusing more on the main content of the interview. Data analysis was done by utilising Tesch's eight steps to categorise the data into three themes (Creswell & Poth, 2018). Guba's model in Krefting (1991) was used to test the trustworthiness of the data. Data verification was done to ensure that the study was verifiable and reliable. The researcher made use of member checking and reflexivity as data verification methods. Ethical clearance was obtained for this study. The NGOs approached to conduct the interviews provided written permission to interview the participants (Maree, 2016).

FINDINGS AND DISCUSSION

The findings of the study will be presented next. Ten of the participants are social workers, two social auxiliary workers, four youth probation officers, two magistrates and two prosecutors.

Three themes were identified with relevant sub-themes as indicated in Table 1.

TABLE 1
THEMES AND SUB-THEMES

THEMES	SUB-THEMES
1 Micro level	1.1 Wellbeing of adolescents 1.2 Family 1.3 Peer pressure
2 Meso level	2.1 Socio-economic circumstances 2.2 School 2.3 Gang-related activities
3 Macro level	3.1 Service rendering

THEME 1: MICRO LEVEL

Three sub-themes were identified under the micro level theme, namely wellbeing, family and peer pressure.

Sub-theme 1.1: Wellbeing of adolescents

The most serious long-term effect of misusing substances is the detrimental effect this has on the wellbeing of a person. Substance misuse in South Africa has had a damaging and negative effect on the vigour, wellbeing and conditions of the country and has led to a multitude of high-risk behaviours among adolescents, including illegal and offensive behaviour, violence, unprotected sex, health complications, as well as psychological and physical difficulties (Department of Basic Education, 2013). This is echoed by the following participants' comments:

> *"A juvenile offender, for me and from personal experience in working in this field, 80% are linked to substance abuse, which affects them psychologically, physically, financially, or emotionally because they want that sense of belonging at the end of the day."* (Social worker)

> *"When you use the drugs it affects your personality, and you become aggressive and agitated. When you don't have the drug in you, you go through withdrawals, so you become agitated, aggressive and violent."* (Social worker)

> *"Emotionally, youth suffer more. Substance abuse stunts their emotional growth and affects them for years to come, even after they no longer abuse drugs or alcohol".* (Magistrate)

Substance misuse among adolescents has a damaging and detrimental effect on their emotional, psychological and mental wellbeing. Excessive and extensive use can also stunt emotional growth and development, and, most significantly, stunt brain development (Winters & Arria, 2011). Again, the use of illegal substances and involvement in juvenile-offending behaviour can be related to the desire and need for a sense of belonging. This misuse, consequently, affects one's personality and decision-making capabilities.

Sub-theme 1.2: Family

Research in South Africa (Burton & Leoschut, 2013) has shown that an estimated 90% of juvenile offenders have had a history of ill-treatment, often in their families. The family context and environment are important to shape adolescents' behaviour and emotions (Institute of Medicine and National Research Council Committee on the Science of Adolescence, 2011). Often adolescents do not have a supportive family context. Research has shown that children who have grown up in functional and stable families have a low probability of having physical and mental health problems as an

adolescent or adult (Hsiao, Fry, Ward, Ganz, Casey, Zheng & Fang, 2018). One of the participants said the following:

> *"I think it mainly stems from dysfunctional families. You don't have that sense of belonging in a family. You don't receive that love from your parent. That attachment between you and mom is not there, so now you go out and try to seek that attachment in the wrong place; and that is where you find yourself in a jail or a secure facility. So I feel it starts at home, where the children don't have that sense of belonging. They don't have that attachment and that bond is not formed between the mother, the child and the father."* (Social worker)

As seen from this account, the parental bond and relationship usually lay the foundation for the child's perception of himself or herself, as well as healthy or unhealthy behaviours and relationships. The family structure plays a vital role in the development and progression of the child. It is important to note that research (Mudavanhu & Schenck, 2014) has also shown an increase in an adolescent's probability of being involved in illegal substances if his or her family has a past of engaging in such behaviour.

The involvement of parents in the lives of their children is essential to their growth and development. A lack of involvement and interest can result in a dysfunctional relationship between the child and parent (Bukakto & Daehler, 2011). The dysfunctionality within the family system could result in the child facing or experiencing low or no self-esteem, socialisation problems, a susceptibility to pressure by peers, a lack of self-control, and a likelihood to experiment with illegal substances (Mudavanhu & Schenck, 2014). Single-parents raising children or families with absent fathers could also negatively affect the emotional, psychological and mental development of an individual. Masemola (2017) writes that children who are raised without a father figure are more likely to exhibit aggressive behaviour, indulge in substance misuse or criminal behaviour, and form unhealthy relationships with the opposite sex. She also identifies that approximately half of South African children are being raised without their fathers or a father figure.

In the following account the participants clearly demonstrate the importance of family in the upbringing of a child:

> *"When I went out to schools here in the area to do my practice, I discovered that 80-90% of the children come from broken homes. So that is how it is when it comes to behaviour and the drug use of youth – it's because of broken homes."* (Social worker)

> *"More often than not, there is family discord, there's divorced families, there's single-parent families, there's blended families, there's slip families, and that fabric within the family has become loose, it's broken".* (Social Worker)

> *"The home environment impact on how the young person perceives the world, as his family members play a big part in shaping the young person's character, values and belief systems. Single-parenting is difficult without a support system, and at times the single parent him or herself lack basic parenting skills, which impacts the healthy development and guidance of the young person. In most cases the father figure is absent, and as a result young people turn to others as role-models."* (Social auxiliary worker)

These comments are in line with the literature (Bukakto & Daehler, 2011; Mudavanhu & Schenck, 2014) and draw attention to the strong epidemic of social issues caused in part by the absence of parental figures and by dysfunctional families. These affect the optimal development of adolescents, especially the tendency to be exposed to or become involved in substance misuse and criminal behaviour.

Sub-theme 1.3: Peer pressure

Adolescents spend proportionally more time with their peers and less time with their family during this developmental stage. Consequently, the greater amount of time spent with their friends allows for their

bonds and relationships to grow. These peer relationships and connections play a fundamental role in the development of interpersonal and communication skills (McElhaney, Antonishak, & Allen, 2008). They also allow adolescents to experience optimal social interactions and functioning. However, a desire for social acceptance and popularity amongst peers may emerge at the adolescent stage and can easily result in negative consequences. The desire for approval and acceptance by peers and friends can easily influence an individual to be pressured into doing something that he or she would not normally do. This need for acceptance from peers is related to finding a sense of commonality or common ground in order to gain the approval of peers (Costello & Hope, 2016).

The participants were asked to elaborate on their perceptions on how the need for acceptance and a sense of commonality are related to peer pressure and deviant peer affiliations. The following comments were noted:

> *"…it is also influenced with the peer groups with who they associated with. The influence of peers plays a significant role in offending behaviour of youth because of the need of acceptance."* (Youth probation officer)
>
> *"If friends are bad influences, they could encourage on pressuring you to use substances to look cool."* (Magistrate)
>
> *"Youth that do not have sound parental guidance and values often fall victim of the lure of acceptance and popularity from deceptive peers".* (Youth Probation Officer)
>
> *"I think it creates a feeling of normality, that it's okay, that everyone is doing it. And it does create a sense of commonality and a sense of belonging. So I think it plays a huge role; the influence of peers."* (Social worker)

It emerged from the participants' comments that peer pressure has a substantial influence on the decisions made by individuals and the actions or behaviours executed by them. This creates a feeling of normality and a sense of commonality-generating socially acceptable behaviour, from the perspective of the adolescent. Furthermore, the individuals who lack parental relationships and guidance fill this void by finding acceptance, love and belonging with one another (McElhaney *et al*., 2008).

Through the accounts of the participants, it can be deduced that friends and peers can influence one another in a negative manner – directly or indirectly. Being affiliated and associated with a certain group of people in order to be accepted and feel a sense of belonging can put an individual at risk of indulging in certain negative behaviours merely to fit in with the crowd (Costello & Hope, 2016).

THEME 2: MESO LEVEL

In this theme three sub-themes were identified, namely socio-economic circumstances, school and gang-related activities.

Sub-theme 2.1: Socio-economic circumstance

The cultural and social environment shapes a person's growth and, specifically, the growth and development of adolescents. This environment has the ability to influence the behaviours and emotions of an adolescent (Institute of Medicine and National Research Council Committee on the Science of Adolescence, 2011). It is important to note that the social and economic status of a person's environment can also impact on growth in terms of family functioning, available opportunities offered, service delivery and social context. This may affect the functioning of family, as discussed under subtheme 1.2. Research has also shown that adolescents who are raised in poverty-stricken communities are at a greater risk of displaying aggression, misconduct and challenging behaviour. The environmental pressures were an evident factor throughout the interview process as indicated by the following accounts:

"Substance abuse plays a very big role in what our teens do. And they are so pressured by their circumstances or by their surroundings that they tend to just leap into that – into substances." (Social worker)

"Community background – like the place you are raised. The more the crime in an area, the higher the chances of starting early in crime." (Prosecutor)

"I think in the areas I mentioned, it is poverty. They are living in dire circumstances, where it's 10 people in a one-bedroom house. So poverty is a main concern." (Social worker)

Through the comments of the participants, it is clear that many environmental stressors and pressures may influence adolescents to indulge in substance misuse or criminal activity. A community with high levels of substance misuse, poverty and crime rates also puts the individual at risk of indulging in similar behaviours. This can be seen as a means of exerting societal pressure or as a coping strategy for the individual. The findings correlate directly with the literature and research of the Institute of Medicine and National Research Council Committee on the Science of Adolescence (2011), where the importance of one's social and environmental elements for emotional wellbeing is indicated.

Individuals in South Africa are faced with many stressors, particularly those of low socio-economic circumstances, given the developing and low-income status of our country. These financial stressors can result in increasing feelings of negativity, substance use and even delinquency (Mosavel, *et al.*, 2015). Moodley, Matjila and Moosa (2012) also drew attention to the strong correlation between low socio-economic communities and substance misuse combined with criminal activity.

Sub-theme 2.2: School

There is a connection between school and peer pressure (sub-theme 1.3). The school structure is a fundamental construction in the adolescent's life. It can either be a safe haven and support system, or a place of escape to fill unmet needs. Within the school setting there are also various forms of violence and abuse. These include, but are not limited to, corporal punishment, physical assault, sexual or verbal abuse, threats, bullying, theft, gender-based violence and gang-related activities (Ward *et al*., 2012). Bullying is also regarded as a form of violence and it is experienced by many school-going adolescents. It includes problematic, aggressive and victimising behaviours. Research has shown that there is a strong relationship between school bullying and the use of illegal substances or drugs (Maria & Eisner, 2015).

Peer pressure, as discussed under sub-theme 1.3, is also prevalent in the school system. Bullying in schools also has an immensely negative effect on the development and growth of adolescents. They are also more exposed and more at risk due to the influence and advancement of technology, allowing pictures, videos and information to be distributed instantaneously. Additionally, there is an association, both in the case of victims and perpetrators, of bullying with substance dependence. This again has a negative effect on wellbeing, as was discussed under sub-theme 1.1. This is not only echoed in the literature (Hsiao *et al.*, 2018; Nalin, 2017), but also through the comments of the participants:

"I think that if there is conflict at school – this is the period of high school so there is that search for identity and role confusion – so at school, it is where they really experiment in developing those skills in relationships and communication. And if you are struggling to form relationships or at least a couple of good friends, it leaves you lonely and vulnerable and an easy target. And if you come across different, then you become the target for being bullied. Once again, all these tiny variables adding up to it." (Social worker)

"I've spoken to one of my workers this morning actually about bullying and that is a thing happening in schools, with one of our clients, but also happening outside of school; and that is also gang related. And a big part of it is also substance use and misuse by the children." (Social worker)

> *"Bullying is a big problem in schools and plays a significant role in youth involvement in offending behaviour. Often young people join themselves to a gang to find protection from bullies. They, unfortunately, enter a world of crime and offending behaviour through their gang involvement which does end up unfortunately with prison sentences and a destroyed future."* (Youth probation officer)

Through these participant accounts, it is clear that pressure and bullying are experienced by a significant number of adolescents within the school environment. Pressure and bullying can also be carried out by gangsters on school grounds, or outside of the school environment, as will be discussed under sub-theme 2.3. The instantaneous distribution of information also allows for bullying to carry on outside of the school, allowing individuals to have consistent contact with each other, even though they are not physically in the same place. There is also pressure to sell and distribute illegal substances through the schooling environment and structure, and this is perpetuated by creating a sense of belonging out of fear of being bullied. This is echoed in the literature and research, as seen in the work by Nalin (2017). One of the reasons for substance misuse and dependence is the fact that those who express bullying and negative pressuring behaviour often suffer from emotional, psychological or behavioural difficulties, thus placing them at risk of developing a dependence on substances (Nalin, 2017).

Sub-theme 2.3: Gang related activities

This sub-theme closely relates to the previous one. Research has shown that the involvement in gangsterism and drugs enables violent and criminal behaviour. This involvement is especially encouraged and directed at adolescents. Research (Basson & Mawson, 2011; Costello & Hope, 2016; Edberg *et al*., 2015) has also revealed that the average age of gang members is getting lower. This means that youths are creating affiliations with gang members at a young age (as young as the pre-adolescent stage) as can be seen in the following comments:

> *"They* [the gang leaders] *drive nice cars, they have all the access to resources, women. And you know, impressionable young people see that. They see that they have authority in the community. They have a say. They create fear. So I think it's a huge factor in terms of predisposing young people. It's certainly not fertile ground and then you place that in the context of broken families, absent moms or dads, poor role models, media- and you have a young person very bombarded."* (Social worker)

> *"Gangsters have a big impact on our youth. Especially in the impoverished communities, where you come from nothing and you want to move on to something."* (Social worker)

> *"Gangster lifestyle is martyred by our youth as it offers, especially our poorer poverty-stricken youth, an easy way or access to material and financial gain."* (Magistrate)

> *"Sometimes they will stay out of school, because the gangsterism will try and incorporate them to do their illegal activities and with that, they give them money or drugs and that's how they get* [drugs]*."* (Social worker)

In South Africa there has also been an increase in homicides, sexual offences, assaults and violence among adolescents. This has been related to gang involvement and association (Basson & Mawson, 2011). Research in South Africa has also shown that drug dealers are targeting youths as young as 12 years of age to be involved in this illegal drug industry (Dias, 2017). This puts the youth at risk and introduces them to a lifestyle of danger, criminal activity and immorality.

Gangsterism, gang involvement and drug-dealing are all interlinked and form part of a broader and more complex gang-related system. The pressures from gang involvement encourage individuals to behave defiantly. These actions and behaviours are rewarded and deemed socially acceptable through the gang-related systems (Edberg *et al*., 2015). The lifestyle of gangsters is glamorised by wealth, status, power and material items. These elements are particularly lacking in the average low socio-economic and poverty-stricken household as indicated under sub-theme 2.1. Thus, by the gang culture

being publicised and advertised, these so-called *benefits* of gangsterism become an attractive lure to vulnerable youths.

This view has also been demonstrated by various participants, as seen below:

> *"They tend to look up to others and they admire those people that is involved in gangsterism and involved in substance abuse. So they basically look up to those people as a role model. I think the environment plays a big role in terms of the influences or the factors influencing the adolescents or substance users."* (Social worker)

> *"It is how they present their gang culture to the youth to attract them and how they bribe them to come in … so they make it lucrative for the youth to join; and I have heard that people are threatened to join but I don't know if the youth has the strength to stand up against them."* (Social worker)

Through the narratives of the participants, one can deduce that some adolescents admire and respect the gangsters and the culture that accompanies gangsterism. These gangsters are seen as community leaders and role models who influence the youth and broader environment. The glamorised gang culture is displayed to the youth so that they are aware of the so-called benefits and powers (Edberg *et al*., 2015).

THEME 3: MACRO LEVEL

In this last theme the challenges of service rendering will be discussed.

Sub-theme 3.1: Services rendering

The importance of having good, readily-available social supportive services for adolescents who misuse substances and engage in criminal activities are paramount (Humm, Kaminer & Hardy, 2018). However, the lack of sufficient services is noted by several participants:

> *"To the school, they are not really open for counselling in that regard because there is a lack of social workers to do the counselling and so forth. Referrals to Safe Schools – two to three months before they come out in this area … So I feel schools is also a departmental problem lacking in that sense."* (Social worker)

> *"And I think the schools, they are so over-burdened – the teachers, with the same issue of substance abuse and other issues as well … You have one social worker doing ten to twelve schools in a district. It's not possible. And if you look at areas like* […]*, those are highly problematic areas, where I would say one social worker per school might not even be enough."* (Social worker)

> *"Having some support for learners is important. I don't think all schools are fortunate enough to have a counsellor at school or someone to talk to. But we should have that support structure – someone to talk to, a grade head – some peer support or an integrated peer support around something like that."* (Social worker)

These narratives indicate that there is a lack of supportive structures within the school environment. These support structures can be accessed through school counsellors, school social workers, more supportive services and resources from the Department of Basic Education and Safe Schools, support for teachers who are facing challenging behaviour from adolescents with substance misuse problems, as well as individual learner support. Safe Schools is a division of the Western Cape Education Department. However, the field workers at Safe Schools are spread out to render services to 10 to 12 schools, just like the school social workers at the Department of Social Development. The researcher can relate directly to this, as she is a social worker at a school. Due to the lack of services rendered, the adolescents and teachers face an imbalance in the support available within the school structure and environment. This is clearly demonstrated in the comments and expressions of the participants, who have practical experience at this level. This is also echoed in the research presented by Nel, Tlale,

Engelbrecht and Nel (2016) as well as Donohue and Bornman (2014), and Amsterdam (2010), where the lack of service rendered and inadequate support available to teachers, learners and parents are underlined.

The participants further expressed the need for supportive services within communities, not only for the adolescents, but for the whole family. Their accounts emphasise the importance of working with families holistically in order to create a steady and positive influence on the development of the individual within his or her surroundings. The lack of these services opens up the prospect of involvement in crime, illegal substances or negative behaviour:

> *"I feel, the families – they are the ones that are being overseen and they are the ones that are not getting the support that they would need".* (Social Worker)

> *"What we are actually doing now with working with the clients – first we are only working with offenders and for the last two or three years we've got money from DSD to work with the client but also the families also. And we need to reflect our targets also on families. So it is not only working with the offender but working with the whole system: home system, schools, the bigger picture – not only the child."* (Social worker)

Groenewald and Bhana (2016) have said that the South African policies which address the effect of substance abuse do not effectively address the needs of family members affected by substance abuse in terms of supportive services being rendered. This is an important factor, as the implementation and practicality of these policies will influence the different systems of adolescents who misuse substances and display criminal behaviour.

CONCLUSIONS

This study explored some of the factors that could play a role in adolescents misusing substances and engaging in criminal activity. Social service providers who render services to vulnerable adolescents formed part of this study. According to the ecological perspective, several systems form part of adolescents' lives. On a micro level, several factors could influence an adolescent's wellbeing, for instance, genetic make-up and mental health. The role that family plays in adolescents' lives could also be a determining factor regarding substance misuse and criminal behaviour. Peer pressure is another factor that could lead to substance misuse and criminal behaviour.

On a meso level, the socio-economic factors such as poverty and vulnerable communities often lead to an increase in substance misuse and criminal activity. Adolescents also often attend schools in these communities where they are exposed to violence and bullying. Inevitably, gangsterism is another factor on the meso level influencing adolescents' lives, as it could be perceived by them as an escape from poverty and financial constraints.

On the macro level, there are several challenges experienced regarding service rendering. The lack of sufficient services to vulnerable adolescents and their families were of particular concern.

RECOMMENDATIONS

Social work practice

The following recommendations are offered for:

- Much more effort should be put into preventative services such as awareness campaigns in order to limit factors that could lead to substance misuse and criminal activity.
- The role of social workers rendering services to adolescents at risk at schools are paramount and every effort should be made in order to employ more social workers in this area.
- A multidisciplinary team approach should be adopted in order to address the psychological, social and physical harm associated with substance misuse. (Social service providers such as social workers, psychologists and occupational therapists could be part of this team).

Research

- More research is needed to gain insight into the challenges faced by adolescents on a micro (for instance, lack of parental guidance), meso (for instance, peer pressure) and macro level (for instance, insufficient resources).
- Quantitative research on criminal activity and substance misuse amongst adolescents could equip social service providers with more insight into this matter.
- Gang-related activities amongst adolescents are an immense challenge in the social work profession, and more research is needed in order to reduce gang-related activities.

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BOOK REVIEW

Terblanche, L. (2018). Creating Legacy in EAP Business: The South African approach towards Employee Assistance. Pretoria: St. Paul and John Publishers, 651pp, ISBN 978-0-620-79722-1.

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Over the last few decades the field of employee assistance has grown significantly in South Africa. You will find in this book an account of the growth and decline of employee assistance programmes across the length and breadth of South Africa. These programmes took root and flourished in the earlier years in the private sector and have expanded significantly in the past two decades in both the public and private sectors. At the same time models of employee assistance have evolved and been adapted to meet the changing demands of the South African workplace.

From their beginnings as occupational alcohol programmes that were offered predominantly by the South African National Council on Alcohol and Drug Addition in the mining industry, to the development of employee assistance service provider companies, employee assistance programmes (EAPs) today form an essential part of many work organisations, giving a human face to the world of work. Although the development and expansion of EAPs in South Africa was recorded in various forms throughout the years, this book is the first of its kind in South Africa, as it provides a comprehensive account of the South African approach to employee assistance.

The book is comprised of seven chapters, each chapter having being meticulously researched and compiled. Chapter One frames the context of the book by providing a historical narrative of how workplace programmes have developed in South Africa. The chapter begins with the historical development of employee assistance programmes in the mining industry; it then traces the expansion of these programmes into other sectors beyond the mining industry and the role of the Centres for Human Development. These broad processes paved the way for the growth of the employee assistance movement in South Africa.

Chapters Two and Three document the history of EAPA-SA (Employee Assistance Programme Association of South Africa). The development of EAPA-SA is recorded from its original beginnings in the early 1980s as the National Employee Assistance Professional Committee, a professional subcommittee of the Institute for Personnel Management of Southern Africa, to the establishment of the professional organisation EAPA-SA in 1997. Today EAPA-SA functions on both a national and international level, exposing local practitioners to global standards of practice and advances in the field through a variety of workshops, conferences and networking opportunities. Chapter Three is a particularly useful resource for employee assistance practitioners, as it incorporates essential information pertaining to EAPA-SA, namely the profile of EAPA-SA, the Constitution of EAPA-SA, the by-laws to the Constitution of EAPA-SA and most importantly the EAPA-SA's code of ethics. Values of innovation, leadership, mentorship, development and transformation are articulated, values which are particularly relevant to South African society today. Nine ethical principles are outlined and guidelines for applying each principle are explained. Furthermore, a framework is provided to guide members when they are confronted with ethical questions in their work. A highlight in the history of EAPA-SA was the registration of EAPA-SA's professional body by the South African Qualifications Authority in 2013.

In Chapter Four the author reflects on the roles and contributions of key individuals and interested parties in the advancement of the field across the years. This offers an invaluable opportunity for every professional in the field of employee assistance to familiarise themselves with key role players and sponsors in the field. Detailed explanations are provided recording the achievements of the EAPA-SA board and the establishment of the ten chapters of EAPA-SA throughout South Africa. This chapter

appropriately concludes with some reflection on the successes and challenges of EAPA-SA, which are important to acknowledge in order to promote accountable, reflective and developmental practice.

Chapters Five and Six explore employee assistance programmes in practice and well as the training and research conducted on these programmes in South Africa. At a time in our county's history when there is increasing political and economic uncertainty, South African citizens have much to contend with. EAPs have an essential mandate to fulfil in assisting employees to develop and to be as productive as they can be, thereby making a contribution to the economy as well as to the human rights and transformation agenda of this country. This chapter identifies trends in the development of EAPs in practice and ends with a discussion about current contestations and debates in the EAP field.

In the final chapter the book concludes with a discussion of the importance of international collaborations and networking in the employee assistance field. Through international collaborations important relationships have been developed and maintained between South Africa and other countries over the years. As a result of increasing globalisation and technological development, professionals and practitioners need to ensure that they are informed about international developments and progress in the EAP field. However, it is also important that South African practitioners record their own innovations and developments in the field, in order to contribute to practice and research both nationally and internationally. This book helps to spur on this trajectory, as it records the contributions and achievements of the key role players in this field, as well as recounting some relevant anecdotes.

This book is a landmark contribution to the field of employee assistance in South Africa. Through methodical research the author has provided a comprehensive account of the growth and development of employee assistance and of EAPA-SA. It is written in a way that makes it accessible to all academics, managers and employee assistance practitioners. The author carefully includes key findings of studies, research and conference debates which ignite and stimulate ideas, whilst not filling the book with unnecessary academic jargon and complicated theoretical frameworks. Using his knowledge and experience of working within the employee assistance programmes (EAPs) of South Africa, the author has managed to pour his practical experience and academic wisdom into this book. The book is filled with appropriate anecdotes as many of the key role players in the employee assistance field are acknowledged and their contributions recorded. For specialists in the field of EAPs this book comes across a well-researched and comprehensive compilation of the history and development of these programmes in South Africa over almost four decades. It is essential reading for every practitioner and interested party in this field – it is one of those books that you will want to have in your office as a constant reference source that will not simply sit on your shelf.