

**RELAPSE AMONG AFRICAN ALCOHOL ABUSERS AND ALCOHOLCS  
WITH SPECIAL REFERENCE TO SOCIAL WORK TREATMENT**

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KWA-DLANGEZWA**

(ii)

**DEDICATION**

**DEDICATED TO MY SON KOBENI**

(iii)

DECLARATION

I declare that "Relapse Among African Alcohol Abusers and Alcoholics with special reference to Social Work Treatment" is my own work and that all sources I have used or quoted have been indicated and acknowledged by means of complete references.

*H V Maziruko*  
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SUMMARY

This study analyses relapse behaviour among some African alcohol abusers and alcoholics in certain areas of the Lower Umfolozi Magisterial district. It also describes and examines the treatment approaches used professionally to deal with such clients/patients, as well as the institutional programmes available for them.

An explorative-descriptive research approach was used. Data was gathered from both primary and secondary services. Interviewing was the major research technique used for collecting primary data. Structured and unstructured interviews were held with clients/patients, some family members, and a few professional people. The researcher intended to obtain a comprehensive picture of the problem. The field study was undertaken over a three months period. Literature study and perusal of files stretched over a year to gain familiarity with the subject under study.

A sample of eighty respondents was selected through the simple random procedure using a table of random numbers. A comprehensive interview schedule consisting of mainly closed-ended questions soliciting information on (i) family of the respondent client/patient, (ii) the influence of friends on his/her behaviour, (iii) relation to work, (iv) the type and extent of professional help received by the client/patient, and (v) the respondent's feelings about his condition was also used.

The data obtained was analysed both quantitatively and qualitatively. The findings indicated that there were more male alcoholics and alcohol abusers compared to females. The majority of the client/patient respondents were relatively young,

below the age of forty years. They were mainly the minimally or lower educated people. Many of them were either married or had been married. The majority had, of course, lost their employment, or had been unemployed for a long time.

The problem of alcohol abuse and alcoholics is complicated both for the client/patient, his family his/her immediate social and work environment. The response of treatment programmes both at in-patient and out-patient levels had not produced the desired results. Co-ordination of treatment services and a strong functional network of services and support did not appear to be clearly available for these African clients and patients. Culturally related, and sensitive treatment by professionally social workers was not as yet practised. A clear focus on these clients/patients as a special category was not evident. They did not appear to identify with any particular service point or structure as a helping medium for them. A lot still needs to be done to organize and distribute the services for these clients/patients.

All the problems cited above receive the recommendation of the study. Further in-depth research on the treatment procedures and programmes for these clients/patients are clearly indicated.

OPSOMMING

Hierdie studie ontleed terugval-gedrag by sommige Swart alkoholmisbruikers en alkoholiste in sekere gebiede van die Laer-Umfolozi landdrostdistrik. Dit beskryf ook en ondersoek die professionele benaderings betreffende behandeling en institusionele programme wat vir hierdie doel beskikbaar is.

'n Eksploratiewe-beskrywende navorsingsbenadering is geïmplementeer. Data is van beide primêre en sekondêre dienste verkry. Primêre data is met behulp van onderhoudvoering (as hoofnavorsingstegniek) ingesamel. Gestruktureerde en ongestruktureerde onderhoude is met kliënte/pasiënte gevoer, waarvan sommige familieledes en 'n paar professionele persone was. Navorsers het getrag om 'n omvattende beeld van die probleem te verkry. 'n Veldstudie is oor 'n tydperk van drie maande uitgevoer. Hierbenewens het 'n literatuurstudie en die bestudering van leërs 'n jaar in beslag geneem om vertrouwd te kon raak met die onderwerp van studie.

Steekproefneming, gebaseer op eenvoudige, ewekanssige steekproefseleksie, het agt respondente ingesluit wat met behulp van 'n tabel met gelykkansige nommers geselekteer is. 'n Omvattende onderhoudskedule, bestaande uit hoofsaaklik geslote vrae wat inligting bevat het betreffende (i) kliënt/pasiënt se familieledes, (ii) die invloed van vriende op sy/haar gedrag, (iii) verhouding tot werk, (iv) die aard en omvang van professionele hulp wat die kliënt/pasiënt ontvang het, en (v) die respondent se gevoel teenoor sy toestand ontlok het, is ook gebruik.

Die ingesamelde gegewens is kwantitatief en kwalitatief ontleed. Die bevindinge toon dat daar meer manlike as vroulike alkoholmisbruikers en alkoholiste was. Die meerderheid kliënte/pasiënte was relatief jonk - onder die ouderdom van veertig jaar. Hulle was hoofsaaklik minimaal of laer-geskoolde persone. Die meeste van hulle was getroud of voorheen getroud. Die meerderheid het hulle werk verloor óf was vir lang periodes werkloos.

Die probleem rondom alkoholmisbruik en alkoholiste is gekompliseerd vir beide kliënt/pasiënt, sy familie en sy/haar onmiddellike sosiale en werkomgewings. Respons op beide binnenshuise en buitenshuise behandelingsprogramme het nie die verlangde resultate opgelewer nie. Koördinasie van behandelingsdienste en 'n stewige diensnetwerk betreffende dienste en bystand vir hierdie swart kliënte/pasiënte bestaan blykbaar nie. Kultureelverwante en - sensitiewe behandeling deur professionele maatskaplike werkers was tot nog toe nie toegepas nie. 'n Duidelike fokus op hierdie kliënte/pasiënte as 'n spesiale kategorié ontbreek ook. Dit blyk ook dat hulle nie met 'n bepaalde diens of struktuur as hulpmedium identifiseer nie. Daar sal nog veel meer gedoen moet word om sulke dienste te organiseer en bekend te stel vir sulke kliënte/pasiënte.

Al die voorafgaande probleme word verantwoord in die aanbevelings. Verdere in-diepte navorsing betreffende behandelingsprosedures en -programme vir hierdie kliënte/pasiënte word beklemtoon.

## CHAPTER ONE

### 1. GENERAL INTRODUCTION TO THE STUDY

#### 1.1. INTRODUCTION AND RESEARCH ORIENTATION

In a research project by Lee Rocha Silva (1987:2) the proportion of black male and female drinkers showed a rise between 1982 and 1985 in the Republic of South Africa. It is stated, for example, that in 1982, 54 percent of African males consumed alcohol, in 1985, 62 percent did so ... Where African women are concerned 22 percent were using alcohol in 1982 and 29 percent in 1985. This alarming trend has been a cause for concern to the helping professions dealing with the problem of alcoholism among Africans. What these figures reveal is a conservative estimate of the drinking population and the problem among Africans. What is not known are the details of the incidence of heavy drinking and especially the relapses among heavy drinkers.

One of the major problems in the treatment of alcohol abuse is that of relapse or the return to the use of alcohol after a period of treatment and "recovery". This is a concern which has wider implications for the family, place of work and society. Also of concern is the health and well-being of the relapsee himself and the cost of providing these people with recurrent services.

Thomas (1979:12) indicates (for instance) that there is a notoriously poor estimate of the incidence of drinking in many populations. This is also true among Africans where there is a decided dearth of reliable data and information on the incidence of alcoholics in treatment, and relapsees among them.

In this study, the writer has attempted to look at this problem with the objective of establishing what the features of this problem are, as well as the state of the treatment procedures. In this chapter, the writer will indicate the background and motivation to the study, nature of the problem investigated, as well as the purpose of this research and factors related to the treatment of alcoholism among Africans.

#### 1.2. BACKGROUND AND MOTIVATION

The writer learnt that the South African National Council on Alcoholism and Drug (SANCA) dependence (Durban Society) opened a branch office at Empangeni. This followed on a request from the local welfare community who had expressed concern on the growing problem of alcohol abuse and drug dependence in the local population. In 1982, the services of this branch office were made available to all population groups.

In the same year, the writer, then a qualified social worker, assumed service at this branch office with the responsibility of helping African clients. In the process of stream-lining the case-load, the writer noticed that nearly half of the clients were people who had previously received treatment for alcohol abuse.

It was also established that these clients had been patients of the local private practitioners and/or out-patients at the local hospital. Some of them had been to the rehabilitation institutions at Madadeni, but had gone back to heavy drinking.

Further, exploratory discussions took place with the staff at Madadeni Rehabilitation Centre (Newcastle); Kwa-Simama Clinic at Kwa-Mashu and with local personnel in health services. This revealed and confirmed that relapse behaviour among African alcohol abusers and alcoholics was becoming a frequent occurrence. The cost effect of repeat treatment was a serious concern. Present facilities cannot cope, while exposition to social work and social welfare services requires financial outlay that is difficult to find.

While there has been research on drinking patterns of Africans, Lee Rocha Silva (1987:2) still says:

*"research on the problem of relapse is almost non-existent."*

This influenced the writer to look at this problem and aspects surrounding it. That is, why people who have been treated went back to drinking. This frustrated the professions dealing with these people in that their efforts seemed wasted. Therefore an investigation into this whole problem appealed to the writer. In pursuing this, it meant that this investigation would focus on the nature and the range of treatment programmes available to African clients with alcohol related problems, their effectiveness and also to

establish how the chances of success of treatment can be maximised to reduce the incidence of relapse behaviour.

1.3.

STATEMENT OF THE PROBLEM

The escalating cost of social work and social welfare services in general is high. In particular the services for treatment of alcoholics also tend to be high especially because of the pervasive nature of alcoholism and related problems. This is a concern for helping profession so that while an increase in the services is desirable, it is not possible to do so because of financial restraints. In African society in particular, the cataclysmic effect of social change and attendant disruptive influences have assaulted the value system, leaving individuals without an understandable framework of reference in their lives. The result is to resort to behaviour characterised by frustration, confusion and hopelessness. As indicated, alcohol becomes a catalyst in this negative development. This, to the writer, was the conceptual view of the investigation to be undertaken in the problem of recurrent drinking and relapse. Specific aspects investigated were the following:

- a) The problem of a relationship between alcohol abuse and relapse behaviour.
- b) The effectiveness of treatment services for African alcoholics in relation to this problem, taking into account the specific needs of these clients in their circumstances.

1.4. PURPOSE OF THE INVESTIGATION

The major purposes of the investigation were to study the problem of alcohol abuse and the phenomenon of relapse. In full this indicates that the writer would look into:

- a) The nature of the problem of relapse behaviour among African alcoholics.
- b) The factors associated with this problem and the typical relapsing client.
- c) The range of treatment services and methods, and techniques available; as well as their co-ordination for effective service delivery.
- d) On the basis of empirical findings to recommend measures to be undertaken in dealing with this problem.

1.5. BASIC ASSUMPTIONS

- a) There is insufficient understanding of the problem of relapse behaviour of African alcoholics in the helping professions.
- b) The provision of social work, and social welfare services do not address themselves adequately to the nature and range of alcohol abuse and the problem of relapse among African clients.

- c) The existing treatment services for African Alcoholics still lack co-ordination, therefore, they are not effective in having the appropriate impact on the client.
- d) African alcohol abusers do not understand the value of professional treatment and its efficacy in helping them to deal with their problem of uncontrolled behaviour.

#### 1.6. PRESENTATION OF TERMS

The following terms are explained according to the meaning they have for the study:

##### 1.6.1. Abusive drinking:

Refers to the consumption of alcohol to the extent that it impairs the effective social functioning of the consumer.

##### 1.6.2. Alcoholic:

Refers to a person who has consumed alcohol to the extent that his social functioning has been grossly impaired and who may have sought admission to, or have been involuntarily committed to a rehabilitation centre for treatment.

##### 1.6.3. Casework:

Is a method of social work. It refers to the dynamic therapeutic interaction between the social worker and the patient on a one-to-one basis. It provides for a

counselling and supporting medium with the purpose of helping the patient to achieve a better adjustment between himself and his environment while being assisted to deal with his problem and grow and change.

1.6.4. Group Work:

Group work used as a method of social work is both generic and specialised. Toseland and Rivers cited by Skidmore, Thackery and Farley (1991:76-77) define group work as follows:

*"Goal directed activity with small groups of people aimed at meeting socio-emotional needs and accomplishing tasks. This activity is directed to individual members of a group and to the group as a whole within a system of service delivery."*

There are many types of groups used. In this study "treatment groups" are considered important for the work with alcoholics.

In group work practice the individual remains the focus of concern, and the group the vehicle of growth and change. Enhancement of social functioning through the use of the group is the primary aim of group work in social work.

1.6.5. Detoxification:

Refers to the medical alleviation of the signs and symptoms of withdrawal.

1.6.6. Family Therapy:

Refers to the form of treatment that engages the entire family in the active process of changing behaviour within the family unit. Sessions are conducted on a regular basis by the social workers with the family alone.

1.6.7. Family work:

Refers to family social work practice. The treatment approach involves the spouse and perhaps the children of the client/patient in individual interviews with the social worker, or combined with the spouse. Such treatment may comprise individual counselling, group therapy, didactic lectures and therapeutic films.

1.6.8. In-patient treatment:

Refers to the treatment of the alcoholics at a rehabilitation centre which requires that the alcoholic resides for some period in the centre.

1.6.9. Out-patient treatment:

Refers to the treatment of alcoholism of South African National Council on Alcoholism (SANCA) clinic. This does not require the alcoholic to reside at the clinic.

1.6.10. Occupational therapy:

Refers to the form of supportive therapy consisting of skilful activities. They are designed to keep the patient interested and alert, increase self-confidence, promote social relationships and give the patient a sense of accomplishment. Activities may, for instance, include the following: weaving, needlework and leather work.

1.6.11. Relapse:

It is defined in the Concise Oxford Dictionary (1976) as "fall back, sink again" into wrongdoing, weakness or illness or indolence. The act of relapsing refers to deterioration in the patients condition after partial recovery.

The McGraw-Hill Nursing Dictionary (1979) defines relapse as:

*"The return of symptoms and signs of a disease after apparent recovery."*

The detailed theoretical analysis of this concept is given in Chapter Two. The terms relapser and relapsee are used in this study to refer to the person, a patient or client who has sunk back again to the weakness associated with alcohol consumption and abuse.

1.6.12. After-care:

Refers to the assistance given to the rehabilitating alcoholic and his family or relatives at the conclusion of a period of treatment in a treatment

centre. The main aim of after-care is to assist those involved to readjust to each other and also to the community. The necessary referrals to social work agencies and employers are made.

1.7. FORMS OF TREATMENT

There are usually two major forms of treatment employed in the treatment of alcoholism. These are:

- i) Pre-statutory treatment
- ii) Statutory treatment.

The former is further divided into two categories:

- i) Voluntary treatment within the community.
- ii) Voluntary treatment within the institution.

More elaboration on this aspect is given to Chapter Four.

1.8. STRUCTURE OF THE DISSERTATION

In Chapter One (1) the general orientation to the study is made.

Chapter Two (2) reviews related literature and establishes the research background.

Chapter Three (3) presents an overview of some treatment approaches.

In Chapter Four (4) some institutional programmes for alcohol abusers are discussed.

Chapter Five (5) details the research procedures in the investigation.

In Chapter Six (6) data is presented and analysed.

Chapter Seven (7) concludes the research report.

## CHAPTER TWO

### 2. REVIEW OF LITERATURE AND RESEARCH BACKGROUND

#### 2.1. INTRODUCTION

Alcohol dependence has a high rate of relapse following treatment, (cf Donovan and Hall, 1988:171). Despite the high incidence of relapse after treatment it has only been within the past few years that the phenomenon of relapse has been addressed in the alcoholism and drug addiction literature (Daley, 1987:139). Research, for instance, on recidivism, that is relapse into criminal behaviour, is generally older than research in alcoholic relapse. The Gluecks, American researchers, are famous with their studies on criminal offenders and juvenile delinquency in New York (see Elliot and Merrill, 1961).

They refer to the phenomenon of recidivism as a "habit pattern", and they indicate, for instance, in the study of 1000 delinquents that up to 88,2 percent of delinquents were again involved in acts which resulted in their arrest. They also indicate that the recidivist behaviour of juveniles also characterises adult criminals, and state "criminality obviously becomes habitual with many criminals" (cf Elliot and Merrill, 1961:135).

In South Africa there are still few studies on this subject of alcoholic relapse. Among the most notable are the ones by Thomas (1979) and Langley (1985). This does not, however, mean that research on drinking and drinking related problems has not been part of research activity in South Africa. The South African National Council on Alcoholism and Drug Dependence has undertaken, through its staff, a certain amount of research into drinking and related problems.

In this chapter the writer looks into some concepts related to relapse behaviour and also deals with factors related to relapse and the point of view in social work treatment.

## 2.2.

### REVIEW OF LITERATURE AND RESEARCH BACKGROUND

In 1981, a conference under the title of "Alcohol in Perspective" was held at the Rand Afrikaanse University. It dealt with many aspects related to alcoholism and alcohol related problems.

Van den Burgh (1981) presented a paper on the drinking patterns of the various population groups in South Africa that highlighted not only the behaviour patterns but also the incidence of drinking in South Africa. Academic research on the subject of drinking and alcoholism has also received some attention but to-date the problem of relapse behaviour among African patients has not received much attention. This has to be understood in relation to the level of after-care, and after-care programmes for these patients, which on the whole are almost non-existent.

In South Africa today, the problem of rapid social change in many spheres of social life of the African people affect their personal and social organisation in various ways. Traditionally African people lived in a closed-knit social organisation built around the tribe, clan and extended family system. The individual was one with the tribe and its social groups. Interaction was in many instances, primary and with known individuals, in a familiar locality. With migration to the towns and cities this has changed. Life, for instance has become so complex for African people who now face tremendous social, political and economic problems of a new order. These result in interactional difficulties with consequential increased personal disorganisation (cf Rocha-Silva, 1987). The social supportive structures of the extended family system and the kinship have been put under severe pressure because of social change that their operation is severely weakened (cf Nzimande, 1985).

This aspect, that is, the problems experienced by African people and the consequences thereof, together with the particular psychological and psychic interpretation of problems based on certain cultural aspects, will be commented upon in this study.

Daley (1987) believes relapse is a highly common and predictable component of recovery for the majority of substance users. However, it often presents a major problem for those providing treatment services. High rates of relapse can be demoralising to staff and have negative impact on motivation. Social workers are particularly challenged to recognise and deal with the

reality of relapse behaviour and to examine their attitude and perceptions of this problem. They also need to increase their knowledge and develop most effective skills in working with relapsers, their family members and those significant people immediately affected by the relapsing person's behaviour.

Knowledge on relapse, and behaviour related thereto, is slowly gaining ground among the other population groups. This should help in dealing with this type of problem among Africans as well.

2.3. CONCEPTUALISATION ON RELAPSE BEHAVIOUR - SOME RESEARCH ON THIS CONCEPT

Relapse behaviour is a common occurrence in the treatment of the alcoholic and is often referred to as that feature which makes rehabilitation so "hopeless." For some, relapse is indicative of "complete failure" by the individual to rehabilitate himself. For others it is an indication of failure or incompetency of services. The compendium of circumstances that characterise each client's or patient's relapse behaviour are usually factors not taken into account when looking at the relapse (Daley, 1987:141).

The current view of alcoholism is that it is a disease, hence treatment is in line with the traditional disease approach. Langley (1985) quotes Jellinek (1960) and Zimberg (1982) whose research lay emphasis upon the traditional disease approach. These include:

- a) Medical detoxification.
- b) Providing patient with information for their disease and its consequences.
- c) Helping patients to overcome denial mechanism and accept alcoholism.
- d) The use of support groups like Alcoholic Anonymous. He states that the key feature of the disease approach is the emphasis upon alcohol education once the medical programme has been undertaken. In this approach little attempt is made to teach the patient social skills (described in Johnson and Johnson as the basis of personal growth; 1982:44) for coping with situational factors which may trigger relapse behaviour. This should include the building of self-image and understanding by the client of himself as a person. Most treatment "structures" employ what is called team approach consisting of medical practitioners, psychologists, social workers and nursing personnel. The counsellors in the team often also tend to fall in line with the medical approach.

The fact that the client is viewed as a sick person also brings about the concept of chronic sickness. The condition might eventually be seen as arising from factors on which the client has no control. Some diseases, in terms of the germ theory, will strike a person no matter what. That is, as long as the germ can get a hold the

person will get sick. Hence the patient, a victim, is subject to relapse throughout his life. While some counsellors might believe that cure is possible, the majority accept that abstinence for any length of time is no assurance against a return to the destructive consequences of drinking.

The attitude of the counsellors is important in their behaviour with the client. The primary danger involves the risk of the counsellor rejecting the client overtly or covertly since most counsellors accept the chronic nature of the "disease."

#### 2.4. COMMON RELAPSES

Some conceptualisations on this subject figure that there are common features in relapse behaviour which may be grouped as follows:

- a) withdrawal relapse.
- b) gaining control relapse
- c) crisis relapse.

The participating factors, the meaning, the function and usage of alcohol and the dynamics of each of the above differ. They will obviously involve different perspectives in approach to treatment.

##### a) Withdrawal relapse

The withdrawal relapse occurs within the first few weeks of treatment and is related primarily to withdrawal and inability to function

adaptively in the absence of drug dependency. During this period the client is experiencing several difficulties over which he feels he must seek relief. Psychologically, when the client is expected to stop drinking we are actually expecting him to enter into a world of the unknown. This is highly stressful and very frightening. Under those conditions regression can be expected (cf Joubert and Langley 1990:169).

The client/patient has not as yet developed adequate coping abilities. The support of the treatment centre's programme has been withdrawn in favour of "another one" with which the individual has yet to adjust. Another hazard is that the impression might be created in therapeutic circles that may equate the sobriety attained under institutional conditions as treatment success.

b) Gaining control relapse

It is not uncommon for a patient who has maintained sobriety and made seemingly very satisfactory progress to relapse after four to six months in treatment. This relapse is often a sub-consciously (or consciously) planned one, the planning being reflected in the management of the medication in that he/she will seldom drink on medication. Another common feature of this relapse usually presents itself in the form of controlled drinking for a few days, a few week-ends and sometimes a few weeks. As Marlatt

et al (1973) argue: "there is sufficient evidence to show that the first drink does not lead to loss of control in the alcoholic." Joubert and Langley (1990:170) also argue that a lapse should be seen as a mistake not as a total failure, that clients should be trained to cope effectively with the lapses and view them as learning experiences.

The cumulative effects of lapses eventually test and strain the person's ability to remain in control. The person at first rationalises a lapse as having "gone a bit too far", and "deceives" himself that this will not happen next time. The control he thought he had gained slips and relapse sets in.

c) The crisis relapse

This relapse can occur at any stage in the treatment process and is usually unplanned and occurs in binge form. Furthermore, there is usually a very clear precipitating event or crisis which the alcoholic feels ill-equipped to deal with. In this characteristic manner he will seek relief from the crisis by drinking. The pattern during this relapse is not one of missed appointments or poor attendance, often the patient will drink despite taking the antabuse treatment - it is relapse without preparation or clear warning signs.

This relapse behaviour is interesting in its own right. The client/patient is on medical treatment but despite that he still goes for a binge. The influence of the psychological make-up of the person is clearly indicated. The difficulty in treating the alcoholic arises from the tendency, by some events, to isolate drinking behaviour from psychic life. Alcoholics are inclined to regard their drinking as a mysterious "foreign body" occurrence, unrelated to their feelings and experience in life.

These common relapses as observed and categorised from agency records do not present a full picture. Obviously they do not explain theoretically and qualitatively all aspects of behaviour dynamics involved in each category but are illustrative of the broad problem.

## 2.5. SOME THEORETICAL PERSPECTIVES ON THE NATURE OF RELAPSE

Perspectives on the nature of relapse behaviour tend to indicate the condition of the individual and the dynamics of his life circumstances. There is a view now which sees relapse as a process. According to Joubert and Langley (1990:169-170).

*"relapse is not the taking of the drink, rather, the act of taking one drink is the step in the relapse process. The relapse process begins long before the first drink when the client becomes incapacitated in sobriety. This psychologically-oriented view takes into account psychological disturbances in the person."*

Another view posits relapse as an event of resumption of behavioural drinking after a period of abstinence. This view sees relapse as a dead-end (Joubert and Langley, 1990). Joubert and Langley term this a medical model. Daley (1987) views are the same in looking at the phenomenon of relapse behaviour.

Langley (1985) further discusses two models, that is, the developmental model and cognitive behavioural model.

#### Developmental model

The developmental model views relapse as being primed by neurological damage caused by alcoholism in the first instance. Neurological damage leads to heightened stress sensitivity which triggers the relapse process. Resumption of drinking is considered an outcome of the relapse process, rather than the beginning of this process. Skills training consists of training patients to:

- recognise thirty-seven "warning signs" of relapse; and cope effectively with these "warning signs."

#### The cognitive behavioural model

The cognitive behavioural model views drinking as a learned behaviour. Individuals use alcohol to cope with subjectively difficult situations in which they have low self-efficacy.

Self-efficacy a term coined by Bandura (1977) and refers to an individual's belief that he is able to cope effectively in particular situations. These situations are not necessarily stress-related. An individual may, for example, have learnt to use alcohol as a means of enhancing positive emotional status. In essence, the individual has failed to learn adaptive alternative for responding to difficult situations. The cognitive-behavioural model advocates teaching coping skills for dealing with impinging situational demands.

The social learning perspective advances the premise that alcohol may be used as a generalised coping mechanism and that the use of alcohol to cope will promote heavier drinking and alcohol abuse. The coping behaviour is related to the stressful situation.

## 2.6. SOME PSYCHO-SOCIAL FACTORS IN RELAPSE BEHAVIOUR

In alcoholism, relapses are associated with certain factors that result from an interaction of effective behavioural, cognitive environmental, psychological and treatment factors. The interplay of these factors singly or combined show themselves in the behaviour of the individual at different stages. These, combined with the loss of supportive factors, gradually contribute to the downward movement. Daley (1987:138-139) discusses five of these factors which are presented hereunder. These are:

#### 2.6.1. Affective factors

These include feelings or mood states, either negative or positive. Clinical experience and studies indicate that such common negative emotional states as anger, anxiety, boredom, depression and loneliness can precipitate relapse.

*"alcoholics frequently lack the ability to respond assertively in anger and frustration. Assertiveness appears to be a vital coping skill in the prevention of relapse. An alcoholic who fails to respond assertively to frustration and anger will experience a decreased sense of self-efficacy."*

Burling et al (1989) have treated the concepts self-efficacy and relapse indicating a relationship between the two. However, detailed analysis of the relationship between the two concepts is not covered in this study.

#### 2.6.2. Behavioural factors

Competence such as stress management, problem-solving and social skills may indicate how a relapse is being handled. A substance abuser who has not learned to skilfully refuse substance offers, or demands is at higher risk for relapse. Similarly, if an abuser has not developed effective and appropriate leisure time skills he/she may resort to substance use to decrease boredom, diminish loneliness or "have something to do." Cooper et al (1988) in their social learning theory state that people who exhibited abusive patterns of drinking differ from "healthy" drinkers in their ability to cope with the demands of everyday life and their beliefs about alcohol.

### 2.6.3. Cognitive factors

These include beliefs, attributes and expectations. A person might have false beliefs about behaviour - like thinking that he can drink and control his drinking if he likes - when normally he has not exercised that level of responsibility. Among African people there is an added dimension which attributes unfortunate behaviour to matters caused by other people who have the power to cause ill-luck (ukubulawa).

Some substance abusers who attribute relapses to factors out of their control, or believe they cannot remain abstinent are likely to live out - this expectation. Such a cognitive view of life is likely to increase a sense of helplessness and cause the individual to be prey to a host of negative factors.

### 2.6.4. Social environmental factors

Cultural and social influences do also have an impact on relapse behaviour. In some cultures abstinence and individual responsibility are aspects that are not emphasised vis-a-vis a person's sense of responsibility being part of the network whose attitude towards participation in intoxicating drinks is taken as normal even when excesses are engaged in. The socialisation process may also encourage this behaviour, for instance, a person who is abstaining may find no support but ridicule that he is not able to participate in what all "normal" people do.

Langley (1985) stresses the importance of the environment in the determination of behaviour. He cites the ecological approach to behaviour as formulated by Mailick (1977); Siporin, (1975); Gitterman, (1971) and Germain (1980), among others. He suggests that neither people nor environment can be understood apart from the context of their reciprocal relationship. Behaviour is seen as the efforts of the organism to achieve goodness of fit between itself and the environment. Within such a framework, relapse, a return to an earlier lower level of behaviour, represents an effort by the organism to achieve adaptiveness between itself and its environment. For example, a young man may relapse in response to social pressure accompanied by ostracism from his peer group for failing to participate in their drinking activities. Drinking as an attempt to restore his social network, facilitates a better fit with his environment.

As has already been indicated earlier in this chapter the difficult period in which African people are going through has special input regarding their problem of relapse. The high level of stress induced by unstable conditions and tensions at community level result in many people engaging in solace-seeking behaviour.

Certain characteristic features in African society load the dice in favour of relapse. Prominence of drinking places in the townships together with numerous shebeens serve as an attraction to a drinker that he may find difficult to resist. At both these places friends may be enjoying their drink in the

open, making it easy to call their friends to join them. It is difficult to resist and pass by your friends because this might lead to some form of ostracism. Once with the buddies the person might be on the road to relapse.

#### 2.6.5. Psychological factors

Conscious and unconscious motivations as well as psychological problems affect the individual behaviour and may lead to their inability to handle problems objectively. A recovering patient may put himself in situations that jeopardise and affect his recovery. For instance, while undergoing after-care, he may feel that he wants to show other people that he is not the fallen person they think he is. Such behaviour might cause him to mix with former colleagues, thus putting himself at a greater risk of engaging in their behaviour. Also unresolved psychological conflicts including anxiety, phobias, depression and intense mood swings may precipitate relapse forms of behaviour. The changes in marriage in African society and new relationship patterns might cause many a husband to develop stress related behaviour. He is forced to engage in roles for which he has prior cultural and social meaning, hence he requires more socialisation in performing this (cf Mashego, (1990).

#### 2.7. TREATMENT RELATED FACTORS

The treatment milieu and approaches may assist the individual towards recovery but may not relate realistically to the problems that the individual will face once he realises his situation.

It is often recognised that treatment is not value free but is also influenced by certain cultural interpretations. The experience of a problem by a client is due in part to exposure to the circumstances which gave rise to the problem. But the culturally distinctive interpretation made of those objective circumstances is also a significant part of the experience. Any culture provides a repertoire of explanations for problems, explanations related to aetiology, symptom recognition, the course of an illness, the assumption of a special role for the sufferer, expectations concerning treatment procedures and a definition of desirable outcomes, (Green, 1982:32). It is in this vein that the argument by Ziter (1987:130-135) is of significance to this study. She states that for treatment to be effective with Black alcoholics, treatment programmes should be culturally sensitive. In addition, in a country like South Africa, as in America, the problem that African (Black) people suffer and the treatment engaged in should incorporate Norton's concept of the Dual Perspective (cf White, 1982:9). The Dual Perspective is the conscious and systematic process of perceiving, understanding and comparing simultaneously the values, attitudes and behaviour of the large societal system, with those of the client's immediate family and community systems. It requires substantial knowledge of, and empathy toward both systems as well as an awareness by the worker of his/her attitudes and values. Thus dual perspective allows one to experience each system from the point of view of the other.

Ziter (1987) states:

*"it is an important part of black experience in which black families negotiate and live in the two cultures - the immediate nurturing black world and the more hostile sustaining white world, all black families pay a price."*

If the problem developed with this socio-political background in view, it is important also that this duality must be recognised in treatment. This is particularly significant in that most Africans are trying to be part of the larger system. It is this system that imposes greater challenges in an effort to gain adequate functioning. When a person becomes an alcoholic the larger system throws him out, he can no longer be seen as a good worker for instance. For example, he will be seen as a person who absents himself from work. The smaller system in the black environment, often has no sustaining structures to help this person. Under such frustrating and trying circumstances relapse becomes inevitable.

Centres of treatment are currently and culturally not, in the world view of Black experience, including their treatment programmes. In the next chapter more argument about this is advanced.

## 2.8. COMMON MISLEADING BELIEFS ABOUT RELAPSE BEHAVIOUR

The demanding nature of counselling services involving alcoholics is challenging and frustrating. Relapse behaviour by the client, although sometimes not ruled out by the staff of the treatment centre is always looked at negatively. The persons undergoing treatment themselves have misconceptions and

preconceptions despite the therapist - counsellor's effort to be professional. Hence the argument by Leigh and Green (1982) for a specific knowledge base has relevance for this study. They state that:

- These social workers need to understand the resources, strength, needs and problems of those families in the same way that their clients do.
- The particular intervention model should take into account the structure and the functioning of the Black family as members of this family system understand it.
- This requires a client-oriented approach and not model utilisation, in which manipulatively, to squeeze in the needs and problems of the client.
- In this way, the problems of misconception and preconception, no matter how subtle they may be, need to be dealt with.

Through misconceptions also clients are often blamed for their behaviour, without the consideration to the circumstances surrounding the individual. Some of these are discussed below:

#### 2.8.1. The alcoholic is not motivated

Motivation is closely related to a person's ability to handle problems and stresses in recovery and is affected by psychological, social and physiological variables. The inability of the client's/patient management of his/her position should not be labelled

as failure and that the client is not motivated. As indicated earlier that relapse was a process; recovery is also part of the process. The development of coping skills relates to the stress factor that becomes the last straw to break the camel's back.

Also indicated is that each client travels this difficult road to recovery by himself. In this instance, consider the advice by Zitter (1987) that statements about alcoholism and (in particular) Black families must be made cautiously. Unanswered questions and confusing semantics plague the field of alcoholism. The diversity of Black families changing social structures for instance, and the lack of a clear conception of the functioning of individuals in this family "unit", vis-a-vis their immediate environment and the larger one, should be clearly given attention and be understood.

#### 2.8.2. Inappropriate advice

It might be stated that the person relapsed because treatment advice was not used properly. Although true in some instances, in many treatment cases, treatment may not have been helping the person. The appropriateness of the treatment model is thus important as already hinted above.

#### 2.8.3. Damage is not severe enough to warrant stopping

The belief that the person has not "hit bottom" yet, is probably the most commonly held myth and is a major factor in failure to intervene with substance

and alcohol abusers. The alcoholic is usually aware of the damage being done by continued use of intoxicating substances, but impaired judgement may lead him to believe that damage is not that severe. Sometimes the view is that the person must learn a lesson when he reaches the lowest point, he will be more motivated and amenable to efforts to raise him from this fallen condition. The negative factor in this assumption is that of not recognising what may be the compulsive stress factor precipitating damage to the person.

2.8.4. Some relapse-chronic problems cannot be helped

In spite of our commitment to the belief that a person is capable of growing and changing, some counsellors eventually doubt the ability of certain clients to recover. This belief might find support because of the clients continued relapse behaviour. Perhaps it will be more realistic to work with this client in trying to reduce the frequency and severity of relapses and focus efforts on early relapse prevention.

The problem of relapse cannot be seen outside the system of treatment and the approaches used. In the following chapter specific coverage of treatment approaches is undertaken.

In the foregoing chapter, the phenomenon of relapse behaviour has been looked at in terms of certain perspectives. This study is concerned with relapse behaviour of a specific category of clients rather than the whole spectrum of what is involved in

relapse. It is somewhat narrower in the sense that the focus will be mainly on this type of behaviour in so far as African patients/clients are concerned.

The different perspectives discussed looked at the questions of aetiology manifestations, behaviour type and treatment approaches in dealing with this problem. The fact that there is a dearth of literature and empirical information on African relapsers did not make it possible to undertake an evaluation-oriented study. Most of the time exposition of the literature was used for information gathering and building some ideas for this particular study.

In social work, the relationship between the nature of the problem and the social and cultural milieu where it occurs is acknowledged. Therefore, relapse behaviour is not being seen in a broad sense but in so far as it affects particularly African people taking into account the conditions under which they live.

Much of the research on African alcohol abusers looked at the problem in relation to the work situation, and few studies were of a general nature. Among these, are Miles (1964) "The Drinking Patterns of the Bantu in South Africa" and Schmidt and Botha's "Die drinkpatroon van die Bantoe in a stedelike gebied."

The Employee Assistance Programme is a prime example of commerce and industry's concern and initiative in dealing with alcoholism at work. (The Centre Volume 6 No 3 June 1989).

The conceptual view of the programme as given by Starker (1986) is illustrative in that the work situation was particularly relevant for industry and commerce. This is so because drunkenness taking place under this situation might have severe implications for the work environment.

The ordinary relapsing client at community level can make use of community social and health resources. South African National Council on Alcoholism through its branches spearheads service provision, including for African clients. However, the person in the community might not have a supportive service that helps even in the dictation of the onset of the problem,, long before he reaches relapse stages. An illustration of such a good programme in industry is given below in Starker's description of common indicators of deteriorating and unsatisfactory job performance that have to be noticed of an employee.

2.8.4.1. Absenteeism

- Excessive sick leave.
- Taking frequent Monday's off, long week-ends and absences immediately after pay days.
- Higher absenteeism rate than other employees for colds, flu, gastritis.

- Instances of unauthorised leave.
- Peculiar and increasingly improbable excuses for absences.
- Lateness in the mornings, at the commencement of shifts or in returning from lunch.

2.8.4.2. On the job absenteeism

- Continued absence from office, desk, machine or work post.
- Frequent trips to toilet, coffee machine or water fountain.
- Long coffee breaks.
- Leaving work early.
- Going to sleep on the job.

2.8.4.3. High accident rate

- Accidents on the job.
- Accident off the job, (but affecting job performance e.g. loss of licence).
- Other employees involved in accidents caused by this person.
- Near misses.

2.8.4.4. Generally lowered job efficiency

- Difficulty in concentration.
- Spasmodic work patterns.
- Difficulty in recalling instructions, detail or own mistakes.
- Increasing difficulty in handling complex assignments.
- Missing deadlines.
- High error rate.
- Poor decision-making, poor judgement.
- Wasting material.
- Complaints from users of products.
- Improbable excuses for poor job performance.

2.8.4.5. Poor employee relationship on the job

- Over reaction to real or imagined criticism.
- Rapid changes of mood.
- Complications arising from borrowing money from co-workers.
- Complaints from co-workers.

- Unreasonable resentments.
- Avoidance of co-workers.
- Involvement in conflicts or fights.

2.8.4.6. General presentation and behaviour

- Coming to or returning to work in an obviously abnormal condition.
- Smell of alcohol on breath coupled with unusual behaviour.
- Behaviour or actions which may draw comments or complaints from customers or the general public.

A number of factors in relapse behaviour indicate both the situation of the person involved and the treatment aspect. The operation of any one factor or combination of factors is closely related to the circumstances under which recidivistic behaviour takes place. Further, under the psychological point of view, interpretation of behaviour and the meaning of a particular group of people attached to the phenomenon are also factors which will either be helpful or not in any particular situation.

Therapists, including social workers do at times show pessimism in dealing with relapse behaviour. Schachter (1982:436) puts this succinctly:

*"obviously there is much basis for pessimism, and there is probably overwhelming professional consensus that addictive-appetitive behaviours are markedly resistant*

*to long term modification. This, however, should be tempered with the notion and the fact that success rates, no matter how small, should be encouraged."*

Treatment in relapse behaviour forms a very important aspect. As already indicated, sensitivity in relating to the particular circumstances of the client/patient is very important. Whether we admit it or not alcoholic and substance abusers are walking a difficult road all by themselves. It is the challenge to therapeutic programmes to help them walk this road with support. Realism in treatment out-comes is an important factor in view of what is sometimes believed that "once an alcoholic, a person will be an alcoholic for life."

The exposition and discussion in this chapter should help to direct the study along the following themes:

- The investigation of the nature and process of relapse among African people.
- The particular factors associated with the problem of relapse between the individual and his environment.
- The treatment services in relation to the availability, utilisation and relation to the relapser's need and problems.

## 2.9.

### SUMMARY

The subject of this chapter is the review of some literature on alcoholism and abuse as well as factors involved in relapse behaviour.

The analysis tried to indicate the relationship between the problem of alcoholism, the behaviour aspects there in, and relapse behaviour.

However, since this is not an experimental study, evaluative research was merely mentioned. The major points of view highlighted in this chapter will form part of the analysis in the entire study.

Finally, the review of literature aimed at giving direction to the empirical investigation in the study.

## CHAPTER THREE

### 3. AN OVERVIEW OF SOME TREATMENT APPROACHES

#### 3.1. INTRODUCTION

The ultimate goal of treatment intervention with an alcoholic is to harness his own level of initiative to help him once again to function "normally" in society (Ackerman, 1979:18).

By the time the alcoholic seeks treatment, his personal, social and financial resources have usually been exhausted, yet often, he is still reluctant to accept help (Fehr, 1976:63).

Alcoholism cases are usually reluctant help-seekers. This is particularly true of a client who is experiencing relapse behaviour. The pessimistic attitude about his behaviour does not only affect him but permeates the family and his primary group.

Some treatment approaches are herein discussed for background information in understanding the relationship between treatment and relapse behaviour.

#### 3.2. THE NATURE OF TREATMENT WITH ALCOHOLISM

Treatment services for alcoholic and drug abusers can be divided into two categories namely; pre-statutory treatment and statutory treatment. The specific coverage of these two categories is in Chapter Four.

The three approaches are discussed here under.

3.2.1. The medical approach

It has already been indicated that alcoholism is also viewed as a disease. By the time most people avail themselves of, or are forced into treatment, they would already be showing distinct signs and symptoms of physical distress. Hence it becomes necessary for immediate medical intervention.

The immediate relief of physical distress is of great importance in dealing with (those) symptoms such as delirium tremens that indicate the extent of physical distress the person is unable to handle. In all his welter of fear, resistance behaviour and physical pain, some relief of distress is not only a boon to him but constitutes a tangible proof that we want to help him.

The basic assumption of this approach is that the alcoholic is a sick person in the physical sense of the word. Therefore, he must first be physically rehabilitated before he can benefit from any other form of treatment (Thomas, 1979:27).

During this treatment procedure the medical practitioner has to examine the client and prescribe treatment to deal with withdrawal symptoms. This helps in stabilising the neurological functioning of the client while efforts are undertaken to restore physiological functioning and to build physical strength. Most of the time the client is under the supervision of the nursing sister who manages this process together with the medical practitioner.

With the use of this approach very little skill development in behaviour management on the part of the client takes place. Behavioural aspects are not elicited as yet, only the chemical functioning of the body is dealt with.

### 3.2.2. Behavioural approach

The behavioural approaches based on theories of learning are variously called behavioural therapy, behavioural psychotherapy, behaviour modification and behavioural casework (Herbert, 1986:95). The work in these theories aim at modifying behaviour through social learning techniques. According to O'Leary and Wilson, as quoted by Herbert (1986:97);

- Behaviour modification is based on a model in which abnormal behaviour is viewed not as a symptom of some kind of underlying quasi-disease process, but as a way a person has learned to cope with stress and difficulties of living ...;
- Since abnormal behaviour is learned and maintained in the same manner as normal behaviour ... it can be treated directly through application of social learning principles ...; and
- Behaviour modification emphasises the principles of classical and operant conditioning, but is not only restricted to them.

The goal of behaviour modification is eventually to help individuals to control their own behaviour and achieve self-selected goals. In treatment programmes it is used as a helping medium in dealing with areas such as (i) anxiety-reduction, (ii) conflict resolution, (iii) addictive behaviour and substance abuse, (iv) poor self-esteem and related problems, (v) social skill deficits, (vi) stress inoculation and (vii) development (Herbert, 1986:98).

The category of alcoholic clients and relapsers suffer from the problem mentioned above.

Different models are utilised under this spectrum of theories with the aim of altering the reinforcing value of alcohol and drinking behaviour in order to teach the alcoholic to unlearn the psychological responses. The development of alternative forms of behaviour is the prime consideration. The client is helped, for instance, to make use of relaxation techniques, to relieve tensions and enable him "to be himself as normal as possible."

The effectiveness of any particular modality employed is determined also by circumstances that surround the behaviour of the people involved. Behaviour is culturally determined so is the meaning given to the problematic nature of behaviour. As indicated by Zitter (1987) earlier on in this text some treatment programmes may not be in the world view of a particular cultural group.

Followers of this approach see alcoholism as a "learned" behaviour. Because of this view, the focus of this approach to alcoholism is on the relevant learning contingencies in the development and maintenance of drinking behaviour (Hannan, 1978).

### 3.2.3. The psychotherapeutic approach

Fehr (1976:637) believes that psychotherapy has remained the therapeutic mainstay in the treatment of alcoholism. The ultimate goal of this approach is to harness the client's own inherent resources at his own level to help him once again to function normally in a society.

Perry et al as quoted by Thomas, (1979) states:

*"This approach is comprised of a minor range of approaches ranging from directive to non-directive, including individual and group counselling, physical and work therapy, vocational counselling (job) training and placement, family casework and after-care."*

The type of approach used according to Blignaut, also quoted by Thomas (ibid) depends upon;

- a) The personality of the therapist;
- b) The personality of the patient;
- c) The therapeutic relationship which has been established between them."

In essence, it means the model of the helping approach adopted should be unique and appropriate to focus on the needs of the clients.

For the purpose of the study, this means that the helping modality focus on the particular needs of the African clients, their world view and understanding of the treatment procedures.

While it is true that the alcoholic's own attitude to treatment largely determines his prognosis, it is frequently still the task of those rendering the service to motivate him into becoming a truly voluntary or willing patient. This includes: helping the alcoholic to accept rather than to deny his problems aiding him to gain insight into his problem, and realistically the consequences of his behaviour should it continue, assisting and supporting him in effecting a behavioural change by utilising his own resources as well as those in his immediate environment. In promoting such behavioural change the treatment needs to encompass the alcoholic's family. It also needs to extend the help given to him while assisting him to make the transition back into the community as a responsible citizen as smoothly as possible.

The alcoholic frequently needs to be completely removed from the environment in which he has been able to obtain alcohol freely.

Verster, (1976:32) maintains that the alcoholics often feel unsettled in a general hospital ward, and that it is preferable for them to be admitted to special alcoholic units where they will be amongst others who encountered the similar problems.

In the present study, it must be noted that all treatment centres employ social workers on their staff. The major roles of the social workers in treating the alcoholic and abuser are as follows:

- Motivation of the alcoholic.
- Providing support to the alcoholic through case work and group work, as well as providing and interpretation information within the individual and group meetings.
- Helping members of the alcoholic's family to understand, accept and cope with the probes.
- Providing after-care in the form of helping the alcoholic to become re-established in work.
- Helping the alcoholic and his family to become re-intergrated into the community from which they have withdrawn.

In spite of the fact that there are relapsers, up to sixty percent reported by rehabilitation centres, this indicates that treatment is not always effective. Literature studied indicated some of the following problems:

- a) Lack of adequate education. The clients are discharged from rehabilitation institutions before they have accepted their problems, and the fact that they may need a long term recovery programme as well as significance of abstinence. This, of course, is related to the admission and discharge

policies of the institutions, many of which do not pay sufficient attention to the individual problem of the alcoholic. Many treatment centres are not structured to handle short term residential stabilisation. That is, there is a low availability of facilities to treat patients or clients on a short term basis when they experience problems of a crisis nature. What usually happens is that a client will only have access to a residential institution after a complete relapse, yet it may happen that a person needs momentary isolation from his environment to deal with temptation that is overwhelming.

The above-mentioned treatment approaches (as per literature) were found to be applied even to the areas included in this study. According to Nel (1987:13). "The Themba Centre for Treatment of Black Alcoholics is said to be taking into account the cultural background of the client but the specifics of the background were however not spelt-out (cf Chapter Two). This argument is advanced for three reasons:

- i) The sociological evaluation of the Black family its structure and dynamics of family interaction is still non-existent.
- ii) The role of the family in the socialisation process and interaction of its members vis-a-vis the small and the larger worlds referred to in Chapter Two.

iii) The fact that on the whole, the social service system lacks adequate knowledge of the indigenous social support systems in the Black community (cf Leigh and Green, 1982:97-100). It is not uncommon for social workers in practice to use what is called popular knowledge about Black culture.

Like the treatment approaches, the treatment aims as established were are of a general nature.

### 3.3. AIMS OF TREATMENT APPROACHES

The following may be considered the broad objectives at which all forms of treatment are aimed:

- a) To restore the physical and mental health of the dependent to the optimum.
- b) To bring the dependent to the realisation that his condition is treatable.
- c) To make the dependent realise that there are facilities available for his treatment and that he can make use of such facilities.
- d) To establish the contributory factors to the person's dependence.
- e) To help the dependent to develop insight into his problems.

- f) To help the dependent to remove the causative factors or at least learn to deal with them more effectively.
- g) To help the dependent to find alternatives to the use of dependence producing substances.
- h) To allow the dependent to develop a new sense of worth.
- i) To teach the dependent to realise the value of an ordered existence as a responsible person.
- j) To prepare the dependent for his re-intergration into community, Botha (1979:18).

As already indicated, these objectives, designed to achieve effective and efficient treatment, are of a general nature. It, therefore, requires, that in their operational specific foci should be established to relate appropriately to African clients by the treatment centres and rehabilitation institutions.

#### 3.4.

##### SUMMARY

In the foregoing chapter, an overview of the treatment approaches was given.

The team approach is an essential structure in the operation of these approaches. In actual practice, the approaches do not work in the neatly categorised manner as indicated herein but they are employed in an eclectic manner.

## CHAPTER FOUR

### 4. INSTITUTIONAL PROGRAMMES

#### 4.1. INTRODUCTION

The institutionalisation of African clients suffering from the problem of relapse behaviour has been steadily gaining ground. Previously alcoholic patients were treated at psychiatric hospitals. Thus, the development of places such as Madadeni Rehabilitation Centre (Newcastle) and Themba Treatment Centre (Dirkiesdorp) is an important development.

These institutions deal with African clients/patients only. There are many other rehabilitation institutions (see Thomas, Adele, 1979) treating relapse also among White alcoholics after In-patient treatment at Rehabilitation Centres in South Africa). In this study there would be no comparison of institution serving different population groups.

Before particulars of existing treatment programmes are given, it is necessary, to state that in South Africa, there are too many groups of institutions for which provision is made. In terms of the provision of Section 41 of 1971, the state may establish rehabilitation centres from available funds, these may be maintained and administered for the treatment of alcoholics, drug dependence and social deviates.

Rehabilitation centres are, therefore, state institutions which provide mainly, although not exclusively compulsory statutory treatment.

The second group of treatment institutions are known as registered rehabilitation centres. These institutions are registered under the provision of Section 21 of Act 41 of 1971. The establishment, maintenance and administration of registered rehabilitation centres are the task of either a welfare organisation or a denominational body. Admission is generally voluntary but may take place under Sections 44 or 31 of the respective Act. Two institutions mentioned above, the Themba and Madadeni Centres, respectively fall between these two categories.

#### 4.2. FORMS OF TREATMENT

There are usually two forms of treatment undertaken by rehabilitation institutions and welfare organisations. These are pre-statutory treatment and statutory treatment (cf Chapter Three).

##### 4.2.1. Pre-statutory treatment

##### 4.2.1.1. Voluntary treatment within the community

Persons dependent on alcohol and drugs come to the attention, in various ways, of practitioners in the various helping professions, that is, practitioners such as social workers, medical practitioners, psychologists and ministers of religion. Numerous dependents receive assistance as the patients of such practitioners, as the clients of welfare organisations or as individual members of congregations. Although

medical practitioners also use chemical treatment in such cases, this type of treatment consists chiefly of a counselling situation and the utilisation of and referral to additional resources within the community.

#### 4.2.1.2. Voluntary institutional treatment

Here we are concerned particularly with the treatment of dependents in psychiatric and general hospitals or registered rehabilitation centres. Psychiatric hospitals differ with regard to the admission policy they apply to dependents. In general, however, dependents are admitted for observation, for the treatment of acute conditions or if they are certifiable owing to an alcohol-linked psychosis. With regard to general hospitals, the approach differs from province to province. Generally speaking, however, treatment comprises detoxification and treatment for acute medical conditions arising from or related to the patient's dependence.

Registered rehabilitation centres are built and maintained for the purpose of providing a specialised treatment service to persons dependent on alcohol and drugs. Treatment is generally short-term and comprises an intensive multi-disciplinary treatment programme; a fixed rate is charged.

#### 4.2.2. Statutory treatment

Statutory treatment is provided under one of two Acts. In the case of Blacks, Whites and Indians, the abuse of dependence producing substances and Rehabilitation Centres Act 41, of 1971, and in the case of Coloured

persons the relevant law is the Coloured Persons Rehabilitation Centre Law 1 of 1971 of the Coloured Persons Representative Council.

The Act contains descriptions 29(i) and respectively, of the types of persons who come under consideration of treatment in terms of statutory provisions. Before a person may undergo statutory treatment it is therefore necessary to determine whether he is a person as contemplated in one or more of these descriptions. According to Act 41 of 1971 we are concerned with a person who:

- a) Is dependent on alcoholic liquor or dependence - producing drugs; and in consequence thereof squanders his means or injures his health or endangers the peace or in any other manner does harm to his own welfare or the welfare of his family.
- b) Because of his own misconduct or default (which shall be taken to include the squandering of his means by betting, gambling or otherwise) habitually fails to provide for his own support or for that of any dependent whom he is legally liable to maintain.
- c) Habitually begs for money or goods or induces others to beg for money or goods on his behalf.
- d) Has no sufficient honest means of livelihood.
- e) Leads an idle, dissolute or disorderly life.

It is apparent from any analysis of these descriptions that we are concerned, in the relevant Acts, with three categories of persons viz, alcoholics, persons dependent on drugs and persons who may be said to be socially deviant. The following three forms of statutory treatment may be distinguished.

i) A postponed order

Section 31 of Act 41 of 1971 provides that a magistrate, if he finds that a person falls into one or more of the above categories, may postpone the making of an order for compulsory treatment for a period not exceeding three years, upon certain conditions. The intention is to bring the person concerned to appreciate the gravity of the situation, but yet to give him the opportunity to co-operate in order to undergo treatment within the community.

ii) Voluntary statutory treatment

The Act makes provision for voluntary statutory treatment. By this is meant that the person seeks aid of his own accord, that he requires treatment for his dependence, but he is unable to pay for such treatment. In such cases provision is made in Sections 44 and 31 respectively, of the above-mentioned Acts for voluntary institutional treatment. This is at state expense, with only a minor contribution from the person himself, if this is within his means. The maximum duration of this form of treatment is six months.

### iii) Compulsory institutional treatment

Unfortunately there are always those persons who are not prepared to admit to, or are unable to realise that because of their abuse of dependence producing substances, or their social deviation, their own welfare and that of their immediate family suffer to such an extent that treatment has become essential for them. With a view to assisting such persons, a magistrate, after proper investigation, may order that a person who fits the description in Section 29(i) may be referred to a treatment institution to undergo treatment for an indefinite period. By the term indefinite is meant that the duration of the person's detention will be determined by the extent and rate of his progress in the treatment programme.

#### 4.3. PERIOD OF TREATMENT

This is an important aspect in the treatment programme for alcoholism. Although the time factor is mentioned in the relevant legislation, the needs of the client/patient are paramount to the consideration of time. That is, a treatment period is not a system but it is client-oriented.

During the period of treatment, the teamwork approach is used to effect multi-disciplinary treatment. By this is meant treatment by representatives of various helping professions who co-operate as a team. Team-work is defined by The American Heritage

Dictionary as the "co-operative effort of an organised group to achieve a common goal" (cf Compton and Galaway, 1975:610).

Further, in the words of Skidmore and Thackeray (1982:136) the team has been defined as a close, "co-operative democratic, multi-professional union devoted to a common purpose - the best treatment for the fundamental needs of the individual. Its members work through a combined and intergrated diagnosis; flexible dynamic planning; proper timing and sequence of treatment; and balance of action. It is an organismic group distinct in its parts, yet acting as a unit; that is, no important action is taken by members of one profession without the consent of the group.

Teamwork is predicated on the individuality of the precipitating discipline. It is a fellowship of people's ideas. Team members are obligated to delivery of their professional functions but also to be aware of what is going on in other phases of treatment. The various treatment institutions differ from each other with regard to their views of and approaches to the dependency question. This fact is reflected in the treatment programmes of various institutions and centres, and the result is necessarily that there are differences in the constitution of the multi-disciplinary treatment teams. Nevertheless, these teams generally consist of some combination of representatives of the following disciplines; medicine, social work, psychology, nursing, theology, occupational therapy, psychiatry, physiotherapy and physical education.

The team members get involved in a planned manner throughout the phases of the treatment programme which may consist of the following:

4.3.1. Phase one

During this phase, the pharmacological approach is used with mainly the medical and nursing personnel in attendance. It is referred to as the detoxification phase. Different drugs to work on the patient who may be in a state such as delirium tremens, are used, followed by others to manage him through this critical medical phase.

4.3.2. Phase two

This phase is mainly based on clarification once the patient/client has stabilised, the psycho-social aspect of treatment is commenced. First the particulars of the individual are taken, and he goes through sub-phases in which he is assessed as to his conditions; psychological and emotional, then it is decided what treatment he will have to undergo. During this stage the alcoholic client/patient who has relapsed is attended to, in his humanhood to make him part of the process of treatment.

4.3.3. Phase three

Entry into the difficult process of counselling is initiated. The treatment model used by the institution is employed. Usually a model may consist of work with clients through individual and group counselling.

Some of the important aspects covered herein are the following:

- The problem definition with the client so that he has understanding of what is happening to him and the manner in which it is happening.

This long phase is also designed to help the client to understand the relapse process (cf to Chapter Two). According to Daley, (1987) the following are the important aspects involved in this phase;

- i) Identifying and handling urges or craving to use substances.
- ii) Identifying high risk factors.
- iii) Identifying and handling of social pressures to use substances.
- iv) Anger management in sobriety.
- v) Boredom and sobriety.
- vi) Relapse intervention, that is, preparing the patient to deal with emotional, cognitive and behavioural responses to actual relapses and discuss what he needs to do, to minimise damage during relapse.
- vii) Building with the client a long term sobriety plan.

During this phase the aspect of cultural sensitivity and working within the world view of the client is very important. It is vitally important that the significant others in the life of the client are introduced and made part of the treatment process. They too, need the development of both coping and support skills to assist the patient upon his discharge.

#### 4.3.4. Phase four

##### Preparation for discharge

Here the patient is prepared for discharge from the supporting environment of the institution. As has already been indicated above, he has to manage himself as an individual. It is a long road which he has to travel though, he may be fortunate to walk with supportive primary groups, in the final analysis it is he who does the walking.

Social work management provides that he must enter an after-care programme. This concept of after-care was discussed in Chapter One.

After care is of the utmost importance to the client. The process of preparation starts with referral to social work agencies and employers, before the client is ushered to the outside world. There should be careful follow-up and support system which involves the institutional staff and field workers, with the latter gradually assuming more responsibility as months go by

after the client has left the institution. The apparent success of the treatment will be evaluated on how the individual manages in this situation.

#### 4.4. OUT-PATIENT PROGRAMME

Not all patients/clients are treated under institutional conditions. A great majority are treated under out-patient conditions, depending on their state of being. This form of treatment has the following advantages:

- It does not disrupt the family life or affect the patient's occupational position or income.
- It is less expensive than in-patient treatment and is not dependent on the availability of beds.
- It provides a good indication of how motivated the client is in obtaining help with his problem since he has to visit the out-patient clinic regularly on his own accord, in order to obtain the desired help.

It is vital in treatment that the alcoholic be totally honest with his therapist and shares information on both minor and serious relapses, so that the therapist may use appropriate techniques. Unlike in the institutions, the out-patient therapist does not have the treatment structure that will allow for continuous monitoring of the patient's behaviour. The phases structure as already described above is also applicable here.

4.5.

SUMMARY

Programme management is an important aspect in the treatment of relapsing alcoholic patients. The model utilised by the institution and agency is an important vehicle in operating the programme elements involved. As indicated with the time factor the system is not the main factor but the needs and the problems of the patient/client.

The analysis and interpretation of data in Chapter Six will take this into account.

In Chapter Five the writer will continue with the research methodology.

## CHAPTER FIVE

### 5. RESEARCH PROCEDURE IN THE INVESTIGATION

#### 5.1. INTRODUCTION

This research on relapse among African alcohol abusers and alcoholics with special reference to social work treatment offered, is undertaken with the view both to investigate the problem and to add knowledge through empirical research. As already indicated, there is a dearth of specific information dealing with the specific element of relapse behaviour among African alcoholics. Therefore, research design is of particular importance in this investigation.

#### 5.2. RESEARCH DESIGN

When designing a research project the particular objectives of the research direct how the investigation is going to be undertaken. In social work, because of inadequate information which exists, as in this particular study, it is, therefore, not possible to conduct "purely" experimental studies. According to Motshologane, (1974:9).

*"Every scientific research project has its basic aim, the acquisition of new knowledge and understanding. To arrive at this objective one or more research*

*project procedures and techniques may be used. The research project is usually determined by its nature."*

As a result, when a problem is poorly understood it is better to resort to a exploratory/descriptive type of research. This is usually the case if the researcher possesses little objective information about the nature of the problem and the specific interplay of the key variables and factors influencing it.

Alcoholism studies, also among African people, have been undertaken and appear in journals of social work and other research projects. But to date no specific study has been done on the problem of relapse among Blacks of the nature undertaken by Thomas (1979) "Relapse Among White Alcoholics After In-patient Treatment at Rehabilitation Centres in South Africa With Special Reference to the Social Work Treatment Programme Offered", and Langley (1987), "Relapse Prevention Programmes for Alcoholics."

This then means that this investigation should first of all work towards creating knowledge related to the phenomenon under study. The descriptive approach undertaken should enable the research to achieve this purpose.

Explorative/Descriptive research is either quantitative or qualitative, or both and in social research it is usually a jumping-off point for the study of new areas in a more rigorous manner on the basis of acquired knowledge. A descriptive research is, however, characterised by more systematic and also

vigorous techniques for selecting the sample (random sampling and assignment), and for collecting and analysing the data (cf Austin in Grinnell, 1981:298-299). These attributes of scientific research will be observed in this study. The phenomenon of relapse in its nature and characteristics will be systematically analysed in order to obtain the true picture among African relapsers. The treatment methods which had been available to the population under study and hence members of the sample group, were equally subjected to descriptive analysis as to their efficiency, relevant to the client/patient, who had undergone the treatment procedures.

### 5.3.

#### LITERATURE STUDY

According to Sibaya (1989:25) "Literature study is imperative for each stage of research and information sources must continually be identified and consulted during the course of the study." The value of what Sibaya says lies in the fact that it helps the researcher know and understand the importance of relevant literature used in any particular research project. By relevant literature we mean the sources of information which enable the researcher to plan on the basis of acquired information, systematically developing the ideas and process of the research project, substantiated from the sources used.

The procedure used in this study involve the following:

- i) A systematic and a critical study of available literature in the field under investigation both South African and overseas. This enabled the investigator to become familiar with the problems encountered. The goal was to ascertain what was known about the topic and the degree of certainty and doubts which surround conventional wisdom and scholarly research (cf Grinnell, 1981).
- ii) Extensive consultation and use of other sources of information where this subject is treated in a written format. Also, in order to gain insight into the investigations and the degree to which previous work has been cumulative or not, and which can be evaluated. This also enabled the planned investigation to be linked to scholarship which already exists in this field and justify the unique contribution of this investigation.
- iii) Because of the problem mentioned earlier of inadequate information in this subject, other related information from research projects used is critically analysed for use in this study.

#### 5.4.

#### SAMPLING

Descriptive studies of the nature undertaken in this study rely on the information obtained from a sample. No research project can investigate the whole total population, but relies on a small portion of the "total set of objects, events, or persons which together comprise the subject of the study" (cf Seaberg in Grinnell, 1981:71). Fortunately a substantial body of theory has demonstrated that the

research worker needs to observe in a population only some of the people or phenomena involved (sample) to gain a usable idea of the characteristics of all the subjects (cf Arkava and Lane, 1983:157).

Usually two sampling procedures (probability and non-probability sampling) can be used in social work research and determine the scientific character of the study. The representativeness of the sample of the population from which it is drawn, related to the extent to which it contains the similar variables of substantive character that are of concern to the study as does the population.

The sampling procedures used in this study are the following;

- i) The study of 168 files at South African National Council for Alcoholism and Drug Dependence (SANCA) Empangeni Branch. In these files were clients who had been treated at different treatment centres (institutional) but who had been discharged after being "cured". But some of these clients had gone back to drinking.

This was the sampling frame of clients who could be traced. Out of this the researcher used the simple random procedure. The clients were identified with numbers, then the required amount was drawn which eventually consisted of 80. A table of random numbers (cf Seaberg in Grinnell, 1981:78) was used. The last two even numbers were circled. Out of these even numbers 80 were selected. This 80 formed the sample. The possibility of replacement with the remaining

figures was planned for in case the identified number-client could not be reached for any reason. Indeed this was found to be the case as some of the clients changed their addresses without informing the agency.

#### 5.5. RESEARCH INSTRUMENT

The research instrument refers to the tool and mechanism which the researcher uses to elicit the required data from the respondents as identified in the sample. The research instrument was the interview schedule which was personally administered by the researcher. Each respondent was interviewed at his or her own home/place of residence. Despite the fact that these respondents were or had been clients at South African National Council on Alcoholism (SANCA) the purpose of the interview was clearly explained to them as distinct from the usual work the social worker (now a researcher) had with the clients. Altogether the field investigation lasted for three (3) months.

#### 5.6. PRE-TEST

Before the commencement of the study, the researcher personally pre-tested ten (10) clients (in an institution setting) who were relapsees according to the record files. This view on pretesting is elaborated upon by Bailey, (1987:141-144). "Pretesting can be administered to a few respondents so that its flaws can be identified and corrected." The pretest should be conducted in the same manner as the final study. If it is a mailed questionnaire,

the pretest should also be mailed. If it is an interview study, the pretest should be an interview. During the interview the interviewer can probe for the respondent's understanding of the various questions. Among the most common problems are that the respondent considers some questions redundant, finds some answer categories inadequate, and objects to the manner in which questions are worded. Respondents will also frequently offer additional questions that they feel should have been asked.

The interview schedule was used. The respondents were both male and female alcoholics undergoing treatment. Where it was found that a particular question seemed "confusing" the question was rephrased on the basis of experience acquired. The instrument was perfected.

#### 5.7. INFORMED CONSENT

In undertaking research, the rights of the human subjects is not to be harmed physically, psychologically or emotionally. The right of self-respect should be maintained as well as the right to refuse to participate in the research (cf Seaman and Verhonick, 1982:74). This was particularly important for the respondents involved because they were still and/or had been clients of a welfare organisation. It was important to indicate that the research project was independent of any other service they were entitled to.

Therefore, the principle of informed consent strictly applied. Informed consent means that the subjects have full knowledge and understanding about the research project in which they are being asked to participate. The volunteers should be free to decide to participate or not after they have been fully informed about the research (cf Seaman and Verhonick, 1982:75). This was done prior to each interview.

5.8. SCOPE

According to Sibaya (1989:31) "the scope is necessary in order to ascertain in what part of the world the study was undertaken." Geographically the area of this study was the Lower Umfolozi Magisterial area. Population wise, only African clients were selected for the sample.

5.9. COLLECTION OF DATA

As already indicated, the data was collected by the researcher. It was processed manually. In the presentation and analysis of data, frequency distributions were constructed both for male and female respondents.

5.10. LIMITATIONS OF THE STUDY

In most studies two categories of limitations are usually found. These are classified as conceptual (or definitional) and methodological.

Conceptual or definitional limitations are present in any study in which "global terms" are used. In this study such terms are "behaviour", "alcohol abuse", "treatment", among others. The inter-changeability of terms is both a problem and weakness.

Methodological limitations related to procedures and interpretations. Sampling procedure was limited to the population in one area. The behaviour of the respondents was interpreted on the basis of frequencies alone. No other information was available from other professional disciplines to supplement the writer's own procedures.

The sensitivity of the investigation of this nature requires more time for case study type of investigation. Resources of an individual investigation cannot afford the high cost factor that might be involved.

#### 5.11. SUMMARY

In the foregoing chapter, procedures in the investigation were dealt with. The problems encountered during the course of the study were also indicated.

## CHAPTER SIX

### 6. PRESENTATION AND ANALYSIS OF DATA

#### 6.1. INTRODUCTION

The research data presented for analysis in this chapter pertains to the relapse phenomenon among African alcoholics. Different questions were asked of the respondents, in order to elicit their views as to what caused, and was involved in the problem of relapse behaviour

As indicated in Chapter Five, the descriptive research design can be quantitative and qualitative. Quantitative research studies utilise social survey methods, structured questionnaires and the like. Qualitative Research studies usually rely on participant observation and methods and purposeful observation. The latter is based on the assumption that actors in the social situation can tell us most about what they are doing and why (cf Epstein in Grinnell, 1988:187-189).

The data collected is presented in the form of frequencies, some of which were converted into percentages. Other forms of presentation were also attempted for clear analysis.

The major purpose of the investigation was to study the problem of alcohol abuse with special emphasis on the phenomenon of relapse behaviour especially among African alcoholics. This means looking into;

- The nature of the problem of relapse among African alcoholics.
- The factors associated with this type of behaviour and problem in an attempt to describe a typical relapsing client.
- The range of treatment services and methods as well as techniques available. Also, how these were co-ordinated for effective delivery of service and the impact on the consumers.

The issue of co-ordination is crucially important between out-patient and in-patient treatment, as well as the supportive network services, in the process of treating such clients.

In this study, mention was made of three treatment organisations. Kwa-Simama which is an out-patient treatment centre; Madadeni Rehabilitation Centre as well as Themba Rehabilitation Centre which are institutional treatment centres. The out-patient organisation in addition to treatment, provides for preventative work, while the institutions provide, in addition to treatment, rehabilitation services.

As indicated in Chapter Five, eighty (80) respondents were interviewed and their responses are presented and analysed. In addition, the researcher entered into purposeful conversation with the clients in an effort to understand more about the circumstances associated with relapse behaviour of the clients. These respondents had been through treatment programmes, firstly on an out-patient basis and secondly, on an

in-patient basis. In all probability they had been discharged after they had been declared "cured." However, these were still clients who had reverted to their former (drinking) behaviour. This is what we referred to as the relapse phenomenon. In this presentation different themes form sections under which data is presented and analysed. The first theme deals with the personal particulars of the respondents.

## 6.2. SOME PERSONAL CHARACTERISTICS OF THE SAMPLE

Four are presented here-under for analysis.

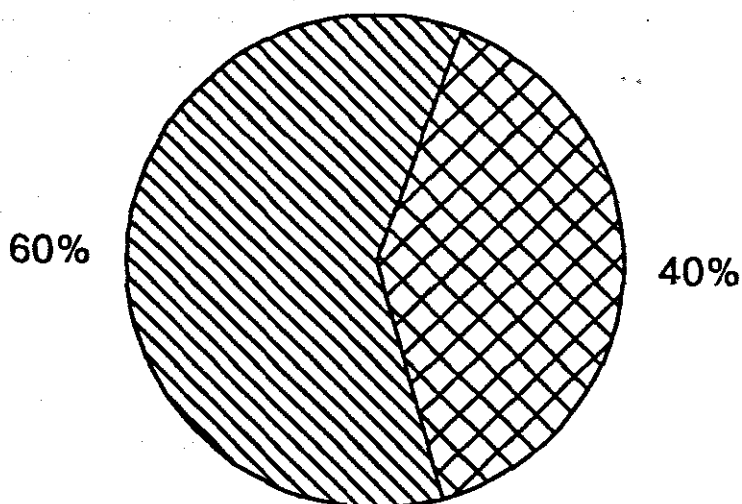
### 6.2.1. Sex of the respondents

The sample was made up of both males and females. There had been no specific manipulation as to the numbers of each to be included. It was purely a chance factor in terms of random sampling procedures.

Figure 6.1. below presents the sample features.

#### SEX OF RESPONDENTS

FIGURE ONE



Males : 48(60%)

Females : 32(40%)

N=80

The figure indicates that sixty percent (60%) of the sample were males and forty percent (40%) were females. The figures quoted from Lee Rocha Silva, in Chapter One, present a similar picture of the preponderance of males as alcohol drinkers. Similarly Gumede (1986) states:

*"From May 1969 to 20 November 1983, the clinic of (Kwa-Simama) treated 2 432 new patients. Of the patients treated, 57,12 percent were males and 42,88 percent were females."*

In African society and in particular Zulu society, men have been permitted to drink and did not suffer from the same sanctioning behaviour as women. Further, as

Gumede states, industrialisation in South Africa brought about a movement from rural to urban areas of African people as well. In the new areas, they lived under socially changed conditions, some of which were dehumanising. Drinking became the major pastime activity after work. It was mainly males who suffered under these conditions as most of the women folk still remained in the rural areas (cf Nzimande, 1985). The deterioration in social living, unmooring of cultural values and norms resulted in a high incidence of alcohol abuse and violence as seen in personal disorganisation.

However, the picture is different now with the development of townships and other forms of living.

#### 6.2.2. Age of the respondents

In general most societies do tolerate drinking behaviour. This is evidenced by the fact that liquor is sold under licence. However, compulsive drinking in any society is associated with a problem and is unacceptable. Societies all over the world do place restrictions in terms of age as to when a person "can be permitted to start" drinking. However, under changed conditions in the life of a people, especially under the impact of social change, it becomes difficult to operate the definitive forms of behaviour of the socialisation process.

The age factor in drinking may also be related to the history of the problem the individual has and whether or not the client responded positively to treatment. The age profile of the respondent is given in the table below.

TABLE 6.1.

CLASSIFICATION ACCORDING TO AGE

AGE	NUMBER	PERCENTAGE
21 - 25	4	5,0 )
26 - 30	10	12,5 )
31 - 35	6	7,5 )
36 - 40	20	25,0 )
41 - 45	10	12,5
46 - 50	14	17,5
51 - 55	6	7,5
56 and older	10	12,5
TOTAL	80	100,0

N=80

On the basis of the data above, it is not possible to state explicitly which particular age group suffered most from relapse behaviour. The data shows that fifty percent of the group under forty years had this problem and the same percentage is reflected for the group over forty years.

According to literature from South African National Council on Alcoholism, "The Centre", all age groups abuse alcohol. The March 1990 issue, for instance, devoted to adolescent alcoholism, indicated that younger people were frequently abusing liquor and ran the risk of being alcoholics. Gumede (1986) states that:

*"Clinical experience shows that in 1971 the average age of the alcoholic was thirty five years or more, but by 1983 the average age had dropped to twenty years."*

In the data, in the table above, twenty five percent (25%) of the sample were below thirty five years, some as young as between twenty one and twenty five years. The view of Sartor (1990) is that the failure to manage developmental tasks, as indicated by some theories, might be one of the reasons that cause young people to resort to drinking. The age group between thirty six and forty five years accounted for (37,5) percent of the sample. The view by Gumede (1986) is pertinent for this research here also. He stated that between the years 1970-1983, the age group of thirty to forty years was the group mostly affected. This is the age category where maximum production is expected in both one's working life and personal life. In his research, Gumede (1986), found that the age group of fifty years and over experienced a slight increase in alcohol dependency.

This is attributed to the failure to cope with changed life-styles; and either the loosening of, or loss of, the primary social network.

## 6.2.3.

Educational level of the respondents

Education is one of the important factors in the preparation for adulthood. That is, whether the individual will experience positive and constructive adjustment to the societal structures for his livelihood, as indicated in the analysis above. The investigation also sought to establish whether the possession of education was a factor in compulsive drinking.

TABLE 6.2.

EDUCATION LEVEL OF RESPONDENTS

EDUCATIONAL ATTAINMENT	NUMBER	PERCENTAGE
Below Standard 6	36	45,0
Standard 6	14	17,5
Standard 7	4	5,0
Standard 8	10	12,5
Standard 9	4	5,0
Standard 10	10	12,5
Post-graduate qualifications	2	2,5
TOTAL	80	100,0

N=80

The majority of the respondents (62,5) percent had an educational level of standard six and below. The remaining (37,5) percent had an educational level of standard 7 and above. One in fact was a university

graduate. The majority of those respondents with a lower educational qualification had either lost their employment or were uncertain about their employment position. They had been in the lower categories of employment without any opportunity for personal growth and development. They knock off from work and rush for a drink as a routine way of life.

While these figures are of significance, this must be treated with caution. More of the educated people can afford professional services other than institutionalisation.

In fact, the researcher interviewed some educated people with a compulsive drinking problem who were against becoming clients of the welfare organisation. They stated clearly that they preferred "more dignified" methods of treatment which did not "expose them".

#### 6.2.4. Marital status of the respondents

The marital status of the respondents, was investigated in order to establish whether there was any relationship between this and the problem of compulsive drinking that led to relapse.

That is, whether their marital status had any influence whatsoever on the behaviour of the respondent. The table below presents information on the marital status of the respondents.

TABLE 6.3.

MARITAL STATUS OF THE RESPONDENTS

MARITAL STATUS	MALE	PERCENTAGE	FEMALE	PERCENTAGE
Married	34	42,5	18	22,5
Divorced	2	2,5	2	2,5
Single	10	12,5	12	15,0
Separation	2	2,5	0	0,0
TOTAL	48	60	32	40,0

N=80

N=48 males

N=32 females

From the data above sixty five percent (52) of the respondents, males and females, were married; 27,5 percent (22) were single, and a total of 7,5 percent (6) were either divorced or separated. During the investigation the in-depth interview revealed that marital problems were an aggravating factor in drinking. These individuals had experienced problems of communication in handling interpersonal relationships. For males in particular, they indicated that their wives were domineering, hence alcohol was used as a coping mechanism. As Cooper, Russel and George (1988:218) state:

*"...alcohol may be used as a generalised coping mechanism and that the use of alcohol to cope will promote heavier drinking and alcohol abuse, a prelude to relapse behaviour."*

Further, that in the marriage relationship personality clashes are a likely occurrence (Block, 1983:273). Some people resort to liquor to deal with such clashes.

Interestingly, an almost equal number of single male and female respondents were found in the sample. These people lived alone, a new feature in the social structure of the Zulu people that has come about as a result of social change, breakdown of the kinship system and urbanisation. Drinking as a pastime and coping mechanism with loneliness now characterised their lives. It was not surprising that this behaviour might have got out of hand (cf Marty Mann, 1970). Circumstances of family breakdown such as divorce and separation are negative in the lives of individuals. It was found to be true with some of the respondents in the sample. The psycho-social collapse suffered by such individuals led to drinking abuse behaviour that eventually led to compulsiveness.

#### 6.2.5. Admission and institutionalisation of respondents

The previous chapters have indicated figures of respondents who abused alcohol and eventually relapsed. The ordinary person goes through different stages of treatment before admission for institutionalisation. Out-patient respondents usually graduate to be institutional inmates because of their relapse behaviour.

TABLE 6.4.

THE FACTOR OF RE-ADMISSION IN RELAPSE

NUMBER OF ADMISSION	NUMBER	PERCENTAGE
Once	58	72,5
Twice	20	25,0
Thrice	2	2,5
TOTAL	80	100,0

N=80

A high number of re-admissions 72,5 percent (58) of the respondents were first admitted to an institution after a period of treatment at an out-patient centre, which was a social welfare agency and or a clinic.

A quarter of the respondents (20) were re-admitted to a rehabilitation centre while (2,5) percent (2) of the respondents were undergoing treatment there for the third time.

From the above it appears that the first admission has a limited success in dealing with the problem of respondents hence the number of clients re-admitted. This has implications on the initial impact of the treatment programme and the welfare of the respondents in looking at this recidivist process.

6.3. PARTICULARS RELATED TO THE FAMILY

The family is regarded as a haven for its members, especially in circumstances of need. In a problem of this nature it is important to establish whether the individual has a family or not, in view of the supporting role of the family. Family dynamics over and above the physical aspects of accommodation and economic aspects, account for the eventual behaviour displayed by the individual in dealing with his needs and problems. Drinking behaviour affects the dynamics of family life.

6.3.1. Living circumstances of the respondents

Accommodation of any individual is an important factor to his security, especially under problematic conditions. Being without accommodation and no visible family structure can be psychologically damaging to the respondent, leading to frustration behaviour. Currently the concept family, with special reference to the African family, may mean different things to different writers. Reference here is made to a basic structure of individuals in a kinship relationship that subscribe to a general notion of the family of husband and wife with children.

Table 6.5. examines this:

TABLE 6.5.

LIVING CIRCUMSTANCES

LIVING WITH FAMILY	NUMBER	PERCENTAGE
Family	70	87,5
Relatives	8	10,0
Aged Parents	2	2,5
TOTAL	80	100,00

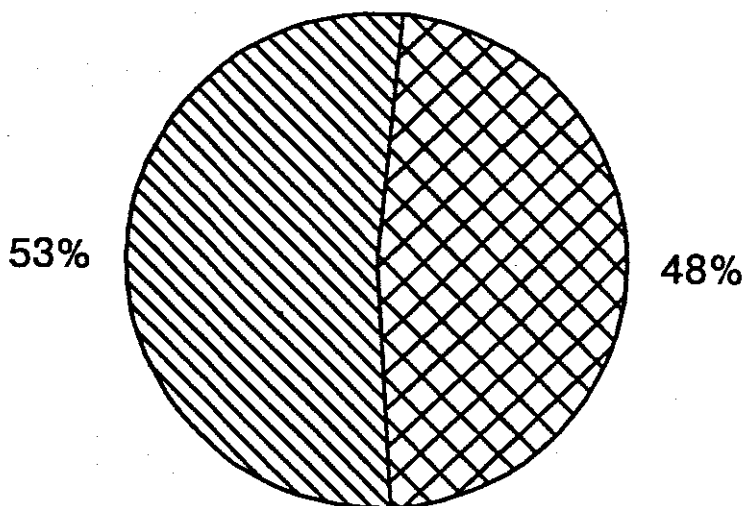
A very large majority of respondents, both male and female, 87,5 percent (70) stated that they were living with their families or had a family. In view of this, the circumstances of their behaviour should be related to the life of the family and the family's ability to support a member with a problem, or its inability to do so. Living circumstances in any family are affected by a number of factors. It has already been said that the African family faces a number of hurdles that interfere with its ability to play a meaningful role in dealing with such a pressing problem as relapse behaviour, for instance.

6.3.2. Relationship and circumstances with the respondent's parents

Parents, if still alive, do play a role, albeit psychological. In Zulu African society, for instance, it is not unusual for a forty (40) year old to consult his seventy (70) year old father for some advice when faced with a problematic situation. The relationship

between the young and old and even the old departed is a matter of fact in Zulu philosophical way of thinking. All such members are important elements in the family group. In this investigation, it was also established whether parents had any role to play with their "children" who have a problem of drinking.

FIGURE TWO:



POSITION WITH PARENTS OF RESPONDENTS

- 42(52.5%) - Parents alive
- 38(47.5%) - Parents not alive

Slightly more than half of the respondents 52,5 percent still had their parents while the rest stated that their parents were deceased. They were however, not living under the same roof with their parents, which factor minimises the role of parents. Further, it became apparent that the ageing parent did not exercise any specific influence on their sons and daughters who were living in their families.

6.3.3. Attitudes of the family members toward drinking behaviour of the respondent

The person with the problem in the family circle affects in one way or another the dynamics of interaction in this primary social unit. Therefore, the attitude(s) of the family members are regarded as a crucial factor in the whole problem of drinking behaviour of the respondents, and his successive relapses. Whether or not the family would be supportive to its member with a problem, depended on their attitude especially those of the spouse, to his or her problem. In Table 6.6. below the attitudes of the family members as reported by respondents, are indicated.

TABLE 6.6.

ATTITUDES OF THE FAMILY MEMBERS TO THE PROBLEM OF RELAPSE

ATTITUDES OF FAMILY MEMBERS	NUMBER	PERCENTAGE
Negative attitude	64	80,0
Indifferent	10	12,5
Sympathetic	6	7,5
TOTAL	80	100,00

According to Table 6.6. more than three quarters of the respondents stated that their family members had negative attitudes towards drinking, while the rest stated that their families were either indifferent or sympathetic. The respondents indicated that their family members bombarded them with citations of negative factors associated with their problems such as divorce and separation. They occasionally referred to their behaviour as evil, a factor which was not supportive at all (Moore, 1962). Many factors were associated with negative attitudes of the family members, since an alcoholic breadwinner often deprived his family even the basic necessities in life. A more positive attitude from the family members is, however, necessary for support of the alcoholic. Hence, Nel (1987:10) writing about Themba Centre, states "the family plays a vital role in the recovery programme of the clients."

#### 6.3.4. Family understanding of relapse behaviour

The understanding by family members of the problem the alcoholic individual has and the consequent behaviour were important factors also investigated. This understanding is crucial to the behaviour of the family members themselves especially in so far as in helping and encouraging the respondent to maintain the treatment.

Skidmore and Thackeray, 1982:348-350) state:

*"... family support is essential and family members sometimes need help to realise the struggle the alcoholic has ..."*

The feelings of the respondent about the family understanding is indicated below:

TABLE 6.7.

FAMILY UNDERSTANDING IN RELAPSE BEHAVIOUR

UNDERSTANDING BY FAMILY	NUMBER	PERCENTAGE
Family understanding	62	77,5
Family not understanding	18	22,5
TOTAL	80	100,0

N=80

In terms of the above table, more than three quarters of respondents 77,5 percent (62) felt that their families understood their problem. This was indicated by the fact that the family members assisted the person in seeking treatment. This behaviour by the family did not, however, as indicated in the previous table, imply acceptance of the behaviour of the respondents. It could, therefore, be termed qualified understanding. Thus this understanding alone did not provide adequate supporting care by which the individual could be helped. However, this must be understood in perspective as Skidmore and Thackeray put it:

*"... the extent which families suffer from the effect of alcoholism is difficult to describe. Not only do they suffer monetary deprivation, but also have to endure personal rejection by neighbours and friends, anxiety and guilt feelings and humiliation ..."*

Further, the above authors state the wife of an alcoholic husband may herself often develop many problems associated with the difficult situation she is facing. By the time the husband is willing to seek effective help she often harbours a feeling that it is impossible to do anything for him. The complicated nature of problem of alcoholism may result in some significant change in the personality and behaviour of the spouse.

It is for this reason, for instance, that Skidmore and Thackeray (1982:39) state:

*"... in almost all families there is disorganisation and distress over the alcoholic's problem. Therefore "[it is]" important ... to work with the alcoholic personally and also equally important for the social work treatment programme to give aid and support to his or her spouse/children or parent."*

#### 6.3.5. Family support of the respondent

When the family has fully accepted the fact that the member of the family who has a drinking problem is suffering from a disease through no fault of his own, this factor might in turn produce a different reaction from the family.

This aspect is reported under Table 6.8.

TABLE 6.8.

FAMILY SUPPORT BEHAVIOUR

FAMILY BEHAVIOUR	NUMBER	PERCENTAGE
Supportive	68	85
Not supportive	12	15
TOTAL	80	100

Table 6.8. shows that a very large majority of the respondents 85 percent (68) were supported by their families. They claimed that the family, or family members assisted them in seeking help. This appears to be a contradiction to the information in Table 6.7. showing the large number of family members who were negative to the respondent's relapsing behaviour. This necessitated clarification.

In Zulu society it is said that "UMUNTU AKALAHWA" (translated to mean that "you cannot throw away a person).". Despite his problems he is still a member of a family.

Hence loss of family contact and support has a devastating effect on the individual (Nzimande, 1985). Therefore, family members still support these people despite the negative attitude they have about their behaviour.

In the second category a minority of respondents 15 percent (12) reported that their families were not supportive at all. Investigations indicated that the

relationship among family members were characterised by hostility and resentment towards the alcoholic. It is worth noting that these respondents were either staying with the family or relative. That on its own is some form of support in that the person had a roof over his head and could get food. It did appear, however, that these people could not offer the social and psychological support expected and required by the respondent. Therefore, they could not be said to be unsupportive in the strictest sense of the word.

### 3.6. The social environment as a factor in the problem of relapse

In traditional Zulu society, the social organisation provided for a structure of relationship, and normative behaviour. Each person was socialised into understanding how these worked. The group nature in the social organisation made it possible for the family members to rally around the individual when he experienced problems. The belief was that the problem the individual suffered and its consequential symptoms reflected on the group as a whole (Preston-Whyte and Sibisi, 1975). There is a complementary concept to the saying that "umuntu akalahlwa", it is "ukusingathwa" (that is, being assisted and cared for by others).

It should also be noted that the concept of family fused with what can be referred to as the clan through a form of classificatory relationships. An individual expected, and would, in fact get help from a wide spectrum of family members and relatives. The

supporting behaviour of the family is looked at with this background (Krieger, 1965:36). Table 6.9. presents the information:

TABLE 6.9.

THE FAMILY AS A SUPPORT SYSTEM

SUPPORT BEHAVIOUR	NUMBER	PERSPECTIVE
Supportive family	74	92,5
Non-supportive family	6	7,5
TOTAL	80	100,0

N=80

Almost all of the respondents 92,5 percent (74) expressed that they were helped by their families. The form of help they referred to consisted of discussion of their problem and engaging in forms of customary and helping tactics to deal with the problem of drinking. It should be understood that the cultural interpretation of the problem was permanent. James and Leigh (1982) do point out that the cultural interpretation of the problem is paramount in the minds of the client. However, the crucial point is that this may not be enough to understand the problem in totality, especially for people caught in transforming stages in life as indicated earlier. The inability of this family help, cited by the majority of the respondents, to be fully effective can be understood in this light.

The minority of the respondents 7,5 percent (6) felt that they did not get help they thought and felt they needed from their family members. The argument above when the issue of family support was discussed holds true for this aspect as well.

In terms of the analysis above, it would appear that respondents were drinking to deal with personal problems. From the nature of the reasons the writer summarises that the respondents exhibit the problem of individualism and loss of group protection.

#### 6.4. THE INFLUENCE OF FRIENDS IN RELAPSE BEHAVIOUR

The particulars related to the influence of friends as a factor and cause of relapse behaviour were also investigated. This aspect has been dealt with exclusively in literature on alcoholism and drug dependence. Friends do influence an individual to try it out. The influence factor is elaboratively dealt with by Sartor (1990) in adolescent alcohol abuse and adolescent alcoholism. Friends do also prevent the individual who wants to "get out" and discard the habit. Therefore, it is, sometimes found that some people fail to exercise their will to decide for themselves. Hence, they keep on finding themselves going back to the habit. Table 6.10. presents this information.

6.4.1 Influence of friends in relapse behaviour

TABLE 6.10.

BEHAVIOUR OF FRIENDS

BEHAVIOUR ATTITUDE	NUMBER	PERCENTAGE
Positive	76	95
Negative	4	5
TOTAL	80	100

N=80

According to Table 6.10. almost all of the respondents 95 percent (76) felt that their friends had a "positive" attitude towards drinking. In Zulu society, like in many other cultures, drinking liquor was sometimes taken as a sign of manhood. If a person did not drink liquor he was seen not to partake in the "nice things" of the men folk. Investigation established that the so-called positive attitude was the encouragement to drink by friends and associates. Such friends had not dissuaded the individual from taking it again, even after he had been for treatment, hence relapsing behaviour.

A small number of respondents 5 percent (4) felt that they had friends with a negative attitude towards drinking. What happened, however, was that they separated themselves when wanting to drink. They did not use the circle of friends as a support medium. They only concentrated on their friends who were critical of their drinking.

6.4.2. Persuasive behaviour of friends as a factor in the problem of relapse

A very important aspect in looking at the phenomenon of relapse is the factor of persuasion of the respondents by their friends in continuing with drinking liquor. Table 6.11. presents this.

TABLE 6.11.

PERSUASIVE BEHAVIOUR OF FRIENDS

BEHAVIOUR	NUMBER	PERCENTAGE
Persuasive	78	97,5
Not persuasive	2	2,5
TOTAL	80	100,0

N=80

From this table it is clear that all, but two of the respondents 97,5 percent (78) fell for drinking again under persuasion by their friends. Persuasion is one of the strongest forms of social pressure. It is particularly effective with persons who are vulnerable to persuasion. In this respect Marlatt (1984) states that:

*"social pressure is the situation in which the individual is responding to the influence of another person who exerts pressure on him*

*to engage in the taboo behaviour. It would appear that the respondents were vulnerable because they all succumbed to pressure."*

Only two respondents 2,5 percent felt that friends had no influence in persuading them to drink again. In these cases, personality problems appeared to have been a factor which caused the respondents to succumb to drinking again.

#### 6.5. JOB EXPERIENCE AND THE PROBLEM OF RELAPSE BEHAVIOUR

Particulars related to job performance are important indicators in any study which involves behaviour in alcoholics. Generally, lowered job efficiency, absenteeism and poor employee relationship on the job are some of the strong indicators related to alcoholism in the job situation (Starker, 1986).

Research has indicated that alcoholism is a serious problem in the working situation. Starker (1986) states that:

*"it has been estimated that between 10-12 percent of a work-force have serious problems, over half of which are related to alcohol and drug dependence ..."*

This has serious problems not only for job performance but for safety at the work place. Table 6.12. illustrates this.

.5.1. Drinking behaviour and job performance

TABLE 6.12.

JOB PERFORMANCE AND DRINKING

PERFORMANCE FACTOR	NUMBER	PERCENTAGE
Bad	72	90
Good	8	10
TOTAL	80	100

N=80

The largest majority of the respondents 90 percent (72) were, surprisingly aware that their job performance was affected by excessive intake of alcohol. The investigation revealed that many of these respondents drank too much the day or night before they went to work. They suffered from hangovers commonly known as "IBHABHALAZI". Some of these respondents were on the point of losing their jobs after a series of warnings. Breckon (1978) also cites drinking during lunch time as affecting job performance.

The remainder of respondents 10 percent (8) felt that their job performance was not affected by their continued excessive intake of alcohol. In this group a factor, lack of motivation, appeared to have exercised some influence in their behaviour. Unrealistic assessment of their situation and, behaviour were observed in this group.

5.5.2. Losing a job as a factor in the problem of relapse

Working is one of the important factors in making ends meet in life. Due to urbanisation and industrialisation, Zulu people have been moving in increasing numbers from rural to urban areas for formal employment purposes (cf Houghton, 1980). Some do find work and others do not. In the urban and industrial areas they live away from the traditional community support structures. They tend to suffer from problems which lead to excessive drinking (Gumede, 1986). These are aggravated when a person is either unemployed or loses his job. Table 6.13. presents this.

TABLE 6.13.

UNEMPLOYMENT AS A CONTRIBUTORY FACTOR IN RELAPSE BEHAVIOUR

WORK STATUS OF RESPONDENTS	NUMBER	PERCENTAGE
Out of employment	72	90
Still in employment	8	10
TOTAL	80	100

N=80

The huge majority of the respondents 90 percent (72) stated that they had lost their jobs through excessive intake of alcohol. Interviews with these respondents, however, showed that they had family problems as well

which had been a contributory factor in their continually relapsing to drinking and eventual loss of a job. These family problems have been reported earlier in this report.

The remaining respondents 10 percent (8) stated that despite their excessive drinking they did not lose their jobs. This group did not see alcohol as the problem per se, although they had personality problems which led to compulsive drinking. They showed a strong defence mechanism.

#### 6.5.3. The Job Aspect in the Problem of Relapse

Because of their problems associated with compulsive drinking they often lost their jobs. This factor was investigated for the impact it had as an (indication) to the deterioration in the behaviour of a compulsive drinker. Certain behaviour indicators become typical as illustrative of this behaviour. These are well illustrated by Starker (1986), as quoted in Chapter Two, and are not repeated here.

From the many indicators of unsatisfactory behaviour in the work situation these are now taken for comment and are indicated in Table 6.14.

TABLE 6.14.

## BEHAVIOUR IN THE JOB SITUATION

UNSATISFACTORY BEHAVIOUR	NUMBER	PERCENTAGE
Absenteeism	34	42,5
Coming late to work	32	40,0
Fighting with employer	14	17,5
TOTAL	80	100,0

N=80

Among the unsatisfactory behaviour habits absenteeism was the highest representing 42,5 percent (34) of the respondents who had lost their jobs because of this behaviour. Because of week-end behaviour when large quantities of liquor were consumed these respondents failed to turn up for work on a Monday.

However, the second category of respondents 40 percent (32) stated that they lost their jobs through coming late. Drinking the day or night before did not give these respondents time to prepare for the following day. They only realised in the morning that it was after all a working day. About 18 percent (14) of the respondents lost their jobs because of fighting with their employers or immediate supervisors. These respondents informed the writer that the misunderstanding of instructions, erratic work

performance and frequent visits to the cloak room were the reasons why they lost their jobs. Thus, they use alcohol as an escape mechanism (Starker, 1986).

6.6. ISSUES IN PROFESSIONAL HELP FOR PATIENT/CLIENTS WITH RELAPSING BEHAVIOUR

The investigation also endeavoured to establish the effectiveness of the professional help offered to the African alcoholics. It can be clearly stated that African alcoholics are people who had been treated by social workers and other professionals such as medical doctors. In cases of serious drinking problems, they had been institutionalised to remove them from an environment that made access to alcohol easier.

6.6.1. Voluntary or involuntary treatment and relapse behaviour

The family of the alcoholics and sometimes the employer and the welfare organisations are usually in a position to detect the early stages of symptomatic drinking. When a person shows prodromal symptoms (he becomes visible) and these "agencies" might want to help by referring him to a treatment centre. Accepting the fact that he has to receive treatment is usually a difficult decision for an alcoholic. Some do still opt for it voluntarily while others are compelled. Table 6.15. examines this problem.

TABLE 6.15.

TYPE OF CLIENT INVOLVEMENT IN TREATMENT

TYPE OF TREATMENT	NUMBER	PERCENTAGE
Voluntary	56	70
Involuntary	24	30
TOTAL	80	100

A majority of the respondents 70 percent (56) stated that they went voluntarily to the treatment centre. In terms of the Drug Abuse Act 41 of 1971 these are the cases which fall under Section 44 as elaborated in Chapter Four. However, the validity of their voluntary behaviour was not tested experimentally. Yalom (1975) says some problem drinkers use treatment centres as an excuse from their responsibilities. Investigation regarding treatment of these voluntary patients at institutions or treatment centres indicates that they come out before having had adequate time to confront themselves with their problem, hence their subsequent relapse behaviour.

The second category of the respondents comprised 30 percent (24). In this group, it was stated that they had been forced to go for treatment. In terms of Drug Act (1971) these were the cases which fell under

Section 30. This suggested a deeper problem the individual had in that drinking had got the better of him.

6.6.2. The Supportive Role of the Social Worker in Relapse Behaviour

The concepts of social support is an important element in the practice of social work in the team approach which involves other professionals such as medical doctors. The client is treated and handed over. But the social worker has to provide supportive services during the process of treatment and rehabilitation (Compton and Galloway, 1975). These authors elaborate on the use of the supportive method.

In this research respondents were asked to indicate how they felt about the role of the social worker in the helping process. The following table presents their respondents:

TABLE 6.16.

SOCIAL WORK TREATMENT AND SUPPORTIVE SERVICES

VIEW OF SOCIAL WORK SERVICES	NUMBER	PERCENTAGE
Supportive	78	97,5
Not supportive	2	2,5
TOTAL	80	100,0

N=80

In terms of Table 6.16. almost all of the respondents, 97,5 percent (78) felt that the professional relationship they had with the social worker had been supportive. These respondents stated that the social worker helped them to realise that their problem was treatable.

Two respondents (2,5 percent) felt that the social worker had been non-supportive. These respondents had hoped, according to their view, that the social worker would be able to deal with all their problems, and they were consequently disappointed that some of these were outside the ambit of the social worker's job.

#### 6.6.3. Encouragement of Alternative Behaviour to Drinking

When an alcoholic is admitted to a treatment centre, the professional staff, including the social worker encourage, during the treatment and rehabilitation process, the problem drinker to develop alternative behaviour besides indulging in liquor. The view here is that such an alternative will help the client in not using liquor as a helping (leaning) crutch. But to find something to engage him that requires effort in dealing with the problem.

Table 6.17. illustrates this.

TABLE 6.17.

## HELPING THE CLIENT IN SEEKING THE ALTERNATIVE BEHAVIOUR

SUGGESTIVE ENCOURAGEMENT	NUMBER	PERCENTAGE
Those feeling encouraged	78	97,5
Those not feeling encouraged	2	2,5
TOTAL	80	100,0

N=80

Almost all the respondents 97,5 percent (78) felt that they had been encouraged to seek alternative behaviour rather than engaging in drinking as a solution to their problems. This should help them in their drinking behaviour in prospective. As it transpired during the investigation the respondents cited problems such as loss of job.

The remaining respondents 2,5 percent (2) stated that they were not encouraged to seek alternatives. A deeper probe revealed indulgence in defence mechanisms by these respondents. As it has been observed in clients with similar behaviour characteristics there were usually other problems which formed a web-like structure and resulted in this type of behaviour.

In terms of this table, the information suggests the positive role of encouraging clients to seek alternative forms of behaviour to help the respondent in dealing with the problem.

Behaviour modification which focuses, among others, on skills development is important in helping the client develop other forms of alternative behaviour. As already indicated in Chapter Two, coping skills training is the strategy most clearly aligned with cognitive behaviour therapy.

According to Pearlman and Schooler (1978) coping is a behaviour that protects people from being psychologically harmed by problematic social experience. Coping is a behaviour which mediates the impact that the environment has on the person. Coping-skill training therefore provides the patient with a means whereby he may achieve a better degree of "fit" with his environment. The patient becomes an independent change agent.

#### 6.6.4. Employment as a Factor in Dealing with Respondents Behaviour

In this analysis, the factor of employment and the problem of relapse behaviour is discussed. Because of relapse behaviour and drinking the clients had been unable to keep their employment. However, during the treatment and rehabilitation process, they had been encouraged to seek employment with the view of finding something that would discipline the life of the client.

All the respondents admitted that they had been encouraged to seek employment as a form of behaviour that would regulate their life in a more positive and constructive manner.

6.6.5. Compulsory detoxification procedure and the respondents behaviour

During the treatment process some had undergone compulsory detoxification to help them to deal with the problem of drinking. Medically such a procedure is resorted to in order to help the patient reduce the amount of toxins in the body that resulted from heavy intake of alcohol. It is a short term process and a precursor to the actual psycho-social treatment. The respondents were asked whether or not they had gone through the process. Table 6.18. deals with this aspect.

TABLE 6.18.

THE ADMINISTRATION OF COMPULSORY DETOXIFICATION

TREATMENT ADMINISTRATION	NUMBER	PERCENTAGE
Compulsory detoxification	76	95
No compulsory detoxification	4	5
TOTAL	80	100

N=80

The largest majority of the respondents 95 percent (76) stated that they had been subjected to a compulsory detoxification procedure. During the investigation, it was discovered that the behaviour of the clients had in one way or another interfered with this treatment process. Some respondents informed the writer that they drank cooking oil to minimise the effect of the detoxification drugs administered during the treatment process.

The information about the behaviour of the respondents was contradictory to what could have been seen as a form of positive behaviour by the respondents. It was difficult to understand why the respondents engaged in behaviour that interfered with their treatment. Perhaps the explanation lies in the compulsive behaviour that such people go through, or that characterises relapse behaviour.

Only five percent of the respondents (4) stated that they did not go through the detoxification process. In this group social pressure was blamed as a factor in receiving such treatment.

Strictly speaking the respondents had been put through a programme to receive medical treatment which would have dealt with any medical problems they had. However they had through "dirty tricks", interfered with the treatment process.

6.6.6. Co-ordinated Treatment Procedure in Dealing with Relapse Behaviour

As indicated in Chapter Four, the team approach is used in dealing with the problem of alcoholism. The many facets of the problem do easily make the patient susceptible to relapse behaviour if one aspect is neglected. Hence adequate and effective treatment is characterised by co-ordination of services to the client. Table 6.19. examines this.

TABLE 6.19.

CO-ORDINATION OF TREATMENT SERVICES

CO-ORDINATION	NUMBER	PERCENTAGE
Treatment co-ordination	76	95
Treatment without co-ordination	4	5
TOTAL	80	100

N=80

In terms of this table, the majority of the respondents 95 percent (76) stated that treatment services were co-ordinated. In practice, on admission to an institution and or treatment centre, the patients were interviewed by a social worker, and nursing sister to elicit relevant data about their problems. Thereafter, the patient is seen by a medical officer. Also, other professionals such as a minister of religion, a psychologist, were brought in at appropriate periods. The social worker had the

responsibility for co-ordinating all these services in such a way that they offer meaning to the client in dealing with his problem.

The minority of the respondents 5 percent (4) expressed the opinion that the services they received, had not been co-ordinated. The perception by the respondents of the co-ordinated nature of service should have an impact on the respondents. It became apparent, however, that the respondents referred mainly to the structure of the team rather than to the systematic operation. This is a challenge in social work practice, to educate the client to develop and acquire the appropriate meaning of the involvement of the team members and the operation of the holistic approach to treatment.

#### 6.6.7. After-care Services and the Problem of Relapse Behaviour

After-care is an important aspect in the treatment process, whether or not this aspect is handled expertly will determine if the client will continue on the road to rehabilitation after treatment or will suffer more problems and eventually relapse. In social work, home visiting is an essential aspect of the after-care process. In his natural environment the client is helped to deal with the situation and services are co-ordinated with the help of his family or next-of-kin.

In this respect, Verster (1965:149) believes that the best therapeutic results can be obtained if the treatment begins on an in-patient basis, followed by

planned regular and co-ordinated out-patient treatment. The following Table 6.20. illustrates this aspect among the respondents.

TABLE 6.20

ROLE OF AFTER-CARE SERVICES

AFTER-CARE SERVICES	NUMBER	PERCENTAGE
Rendered	58	72,5
Not rendered	22	27,5
TOTAL	80	100,0

N=80

According to the table above almost three quarters of the respondents 72,5 percent (58) were of the opinion that they had received after-care service after being discharged from the institution. A slightly less number 27,5 percent (22) expressed a contrary opinion.

In the theoretical chapter, the role of after-care was indicated. These respondents viewed after-care as visits by the social worker and contact with the service centre and general help with the rehabilitation process, both for the individual and the family.

After-care service needs to be a planned measure involving the respondent in particular forms of behaviour modification and at particular times. Evaluation is an important feature in after-care service by a professional worker. The second category of respondents stated that they had not received any or adequate after-care because of their physical distances away from the service centres.

However, the fact that the majority of the respondents relapsed despite receiving after-care service indicates some problems and or short-comings about the type and quality of after-care rendered.

#### 6.6.8. The Role of Formal Therapy

The major aim of formal therapy is to engage the entire family in the treatment programme. Ziter (1987) states that "all alcoholic families are unhealthy. Their family roles are distorted because excesses of behaviour prohibit the fulfilment of basic social roles that require a flexibility that is unavailable to family members."

Alcoholism severely handicaps families in fulfilling the vital and valued family roles and coping with the demands of their environment. Hence the engagement of the entire family in treatment. Table 6.21. illustrates this:

TABLE 6.21.

## FORMAL FAMILY THERAPY

FAMILY THERAPY	NUMBER	PERCENTAGE
Family therapy conducted	64	80
Family therapy not conducted	16	20
TOTAL	80	100

N=80

The data above indicates that 80 percent (64) of the respondents' families stated that members of their families had been involved in treatment whilst 20 percent (16) stated the opposite. They stated that such a service had not been available to them. In view of what has been said above about the family of alcoholics it becomes imperative for the whole family to be engaged in treatment so as to enhance their coping capacity and help them to deal with the problems of the alcoholic member. Despite this service having been available to almost all the members the relapse behaviour (see Table 6.4.) shown by the respondents clearly indicates that the service had not (i) achieved the desired results; and (ii) that the family members, together with the relapsing person, still needed further intensive therapy and (iii) that perhaps more focussed approaches had to be applied in dealing with this problem.

It is observed from the presentation above that despite the implementation and operation of standard professional measures the problem of relapse behaviour still loomed large. This begs certain questions to be asked in relation to the services themselves, their nature; focus and equipment of the professional dealing with African clients.

Perhaps the observation by Ziter (1987) is applicable here. She states "that Black alcoholic families often need education in the rational process of problem-solving. These families come from and return to an environment that challenges the best problem-solving skills ..., for these reasons the author recommends that orientation to the treatment stage be expanded to structure treatment, more as rational problem-solving to teach by precept as well as by example."

It cannot be over-emphasised that social work is culture bound. It is, therefore, important that the professional service intervention strategies should pay attention also to the cultural context within which the problem emanates. Also, the fact that the changing life-styles of the clients concerned cause them and their families to shoulder burdens far beyond their normal coping capacity.

#### 6.7. PARTICULARS RELATED TO FEELINGS OF THE RESPONDENTS

Every individual, every group, every community has a need to express their feelings. Their right to do so is basic to social work. Emotions are as important as

thoughts or beliefs or knowledge and negative emotions are as important as positive emotions (Piccard, 1979:7).

This clearly indicates that attention has to be paid to feelings; when the helpee can no longer handle feelings appropriately this causes a problem in that the individual's behaviour is affected negatively. Marlatt, Kosturn and Lange (1975) pay attention to this aspect. Some support for the hypothesis that feelings of anger may initiate drinking behaviour comes from an analysis of incidence leading to relapses experienced by alcoholics who had undergone treatment for their drinking problem. They further state that an examination of relapse data for 48 alcoholics who had participated in an in-patient treatment programme revealed that 29 percent of the patients took their first drink in situations in which they reported feeling frustrated or angry. Individuals across a wide spectrum express and handle feelings differently. In terms of their psychological make up even minor states such as boredom and loneliness can cause an individual negative reactions.

6.7.1. The Feelings of Boredom and Loneliness as an Aspect in Relapse Behaviour

Modern living conditions, which for African people in particular, have resulted in a movement from rural to urban situations have impacted variously on their lives. Even for people who have lived almost for decades under urban conditions, the changes in culture and life-style are becoming very visible. Under the new conditions in which many African people live, the

supportive structure of the kinship system has decreased in influence. Green (1982:101) states it this way:

*"... the complex kinship networks assured that the physical necessities of daily life as well as moral support in times of crisis will always be available."*

When this is no longer the case, problems will result. The feelings of boredom and loneliness have become problematic to many individuals especially when they are away from their "natural" supportive network system (Family relations, friends and family social environment). Such individuals might not know how to make use of their free time in the absence of culturally defined and known patterns of living. As a consequence they seek solace in drinking liquor.

Information from the respondents indicated that they suffered both from the stress factors associated with loneliness and boredom. They did not have adequate coping skills to lessen the stress factors. Sight is not lost of the complex nature of human life and the different impact each stress has on an individual person.

#### 6.7.2. Leisure time activity and relapse behaviour

Further to what has been said above, the investigation sought to establish how the respondents engaged themselves in leisure time activity. The ability to handle leisure time (activity is one of the major activities that are attended to in a rehabilitation programme. In the process of recovery the respondent

is assisted and re-socialised in this aspect. Table 6.22. presents the picture regarding the leisure time behaviour of the respondents.

TABLE 6.22.

LEISURE TIME ACTIVITIES OF THE RESPONDENTS

LEISURE TIME ENGAGEMENT	NUMBER	PERCENTAGE
Reading newspaper	34	52,5
Listening to the radio	30	37,5
Playing games	10	12,5
Drinking alcoholic beverages	6	7,5
TOTAL	80	100,0

N=80

The information above shows that only 7,5 percent (6) of the respondents admitted to drinking alcoholic beverages as a past time activity. While 80 percent involved themselves in listening to the radio and reading the newspapers, a mere 12,5 percent involved themselves in games.

The vast majority of the respondents involved themselves in sedentary types of leisure-time activities which unfortunately indicated a type of behaviour where the individual need not necessarily engage in interaction with other people. The spectre of loneliness and boredom hovers around such behaviour.

This behaviour can best be seen in perspective with reference to the previous data on the educational level of the respondents.

Such type of behaviour for the majority of respondents meant that there was nothing consciously planned by the person himself for his engagement. But in most cases it is simply having or looking for something to do. This might account for the subsequent behaviour of the respondents in relapsing.

### 6.7.3. Self-evaluation and the problem of relapse

In the process of rehabilitation, the social worker helps the client to be part of the evaluation of the situation. It is important how a person sees himself vis-a-vis the problem situation. It is this self-evaluation that clarifies to the individual his situation and whether he has the chance of redeeming himself or being redeemed. In this case we say, therefore, it is important that a person has a view of himself as a person with a drinking problem. An alcoholic is the acceptance of drinking as a problem and the role that the individual as a person plays in this drama. Table 6.23. presents the perceptual views of the respondents.

TABLE 6.23.

## RESPONDENTS' VIEW OF THEMSELVES AND THE DRINKING PROBLEM

RESPONDENTS VIEWS	NUMBER	PERCENTAGE
Sees himself as not responsible	66	82,5
Sees himself as responsible	14	17,5
TOTAL	80	100,0

N=80

A large majority of the respondents 82,5 percent (66) saw themselves as not being responsible for their drinking behaviour while 17,5 percent (14) of the respondents saw themselves as being partly responsible for the problem.

However, this latter group's perception of themselves lacked realism in that they could not explain clearly how they were responsible. The former group merely saw themselves as victims of circumstances and their relationship to their social circumstances was nebulous. Some tried to rationalise their behaviour in terms of cultural practices which, however, they could not explain. This problem with self-concept was found to be related with loss of status, to be discussed below.

6.7.4. Loss of status

In Zulu society, drinking was allowed but drunkenness was not tolerated (Gumede, 1986:18). For instance, the traditional idiom for a drunkard was "UKUHLULWA UKUDLA" (cannot control himself with the intake of alcohol). Such a person lost status in his peer group and even generally in the community. Currently it is observed that people of status who are affected by drinking tend to accommodate themselves to lower status groups where their behaviour was not frowned upon. Table 6.24. looks at this aspect:

TABLE 6.24.

DRINKING AND STATUS POSITION OF THE RESPONDENTS

POSITION	NUMBER	PERCENTAGE
Status lowered	76	95
Status not lowered	4	5
TOTAL	80	100

N=80

According to Table 6.24., 95 percent (76) of the respondents still indicated that they had lost status because of their drinking behaviour. While 5 percent (4) of the respondents thought otherwise. Those who felt that they had lost status associated this with their image, which they felt had been tarnished in the

eyes of their peers and associates and that in the community they were regarded as failures (cf Burr, 1982:79).

Associated with this, was the fact that these people saw themselves as good for nothing. Drinking for its own sake became a way of life.

#### 6.7.5. The View of the Community Toward Relapsers

The respondents were asked how they thought and felt the community saw them as people with a drinking problem. In Zulu society, like other societies, some people will earn certain "nicknames" describing their behaviour. Perhaps it might be sad to say "GIVE A DOG A BAD NAME AND HANG IT," but it has been observed that at times this becomes the lot of people with a drinking problem. Table 6.25. presents some of the community's perceptions.

TABLE 6.25. PERCEPTION OF RELAPERS BY THE COMMUNITY

COMMUNITY PERCEPTION	NUMBER	PERCENTAGE
Drunkard	38	47,5
Not responsible	16	20,0
Hopeless	14	17,5
Failures	12	15,0
TOTAL	80	100,0

N=80

Table 6.25. presents the derogatory terms which the respondents expressed were used by the community in describing them. From the observation made these respondents were not pleased with such references as they felt they were seen as failures. The significance of this was that they were not encouraged to break away from this type of life, and made to feel outcasts. In the following chapter, the conclusion and recommendations will be dealt with.

6.8.

#### SUMMARY

The foregoing presentation and analysis of data covered a fairly wide spectrum with regard to the respondents of the study. Their life-style, behaviour, as individuals and as members of families and community was analysed with a view as to how they were helping to deal with their problem, and how lack of help and support contributed to relapse behaviour.

## CHAPTER SEVEN

### 7. CONCLUSIONS AND RECOMMENDATIONS

#### 7.1. INTRODUCTION

In this chapter, it is important to recapitulate and give an overview of the study, with a view to formulating conclusions and, make recommendations which might serve as a guideline for further scientific enquiry into the subject investigated. In Chapter Five, it was stated that this was an exploratory - descriptive study, and the reason for the choice of this research approach was given. Before making the general and specific conclusions about the study, it is important to restate the purpose of the study as well as the problem under investigation.

#### 7.2. RESTATEMENT OF THE PURPOSE OF THE STUDY

The major purpose of the investigation was to study the problem of alcohol abuse and in particular the phenomenon of relapse behaviour among a group of Zulu speaking patients/clients who had been dealt with by a South African National Council on Alcoholism (SANCA) Agency at Empangeni. The following were looked into:

- Firstly, the nature and circumstances related to alcohol abuse and specifically relapse behaviour among some Zulu speaking alcoholics.

- secondly, the factors associated with this problem, as stated above, and the typical relapsing client.
- thirdly, the range of treatment services available, as well as the treatment methods and techniques employed in dealing with such clients, and how these were co-ordinated for effective service delivery.
- lastly, on the basis of the investigation and findings, to make recommendations that might help in dealing with such a category of clients.

In this study, mention was made, in addition to the work of the agency, of the KwaSimama Out-patient Clinic at Kwa-Mashu, Madadeni Rehabilitation Centre (Newcastle) and Themba Rehabilitation Centre (Wakkerstroom).

### 7.3.

#### RESTATEMENT OF THE PROBLEM

As indicated in the first chapter, the escalating cost of social welfare services was generally high. Hence, the government was, for instance, proposing measures such as privatisation of certain services to ease the burden of financial services on the government. Alcohol treatment services in particular, are very costly financially, and also in terms of the suffering inflicted on the alcoholic, his immediate family and social environment. While it is the concern of the helping professions that the scope of the services should increase in extent and quality, financial constraints tended to make this unattainable.

In Black society, in particular, the cataclysmic effects of social change and attended disruptive influences on persons and social organisations and institutions, tended to assault the value systems as well, leaving the individuals without an understandable frame of reference in their lives. The result was the increase in the type of behaviour characterised by frustration, confusion and hopelessness.

As indicated alcohol becomes a catalyst in this negative development. Dependence on alcohol becomes too high, often sweeping individuals off their feet and making them slaves of the drinking process. This, to the writer was an added conceptual view of the investigation undertaken in order to understand the problem of recurrent drinking and relapse behaviour. Specific aspects to be investigated were the following:

- alcohol abuse and subsequent relapse behaviour.
- treatment services for African alcoholics and their effectiveness in relationship to this problem while taking into account the specific needs of these clients and their social environment.

#### 7.4. ANALYTICAL VIEW OF THE SITUATION

In this regard, an attempt was made to give a theoretical exposition of relapse behaviour in general, and the circumstances related to this behaviour. The investigation attempted to develop a specific understanding of the type of alcoholics the African people tend to be, taking into account the

circumstances of their lives. In this investigation an attempt was also made to describe the factors that lead to relapse behaviour. These were listed as effective behavioural, cognitive, environmental as well as treatment related factors. The common misleading beliefs about relapse behaviour were also looked at. A fair amount of literature in the form of books, journals and research reports was reviewed for background and also for analytical information of the study.

#### 7.5. SCOPE AND METHODOLOGY

The study was conducted as an exploratory/descriptive design using the empirical approach in the research methodology. Alcohol abusers and relapsers were used in the sample. The procedure used in obtaining the sample is described in Chapter Five. Because of the nature of the study, both the interview guide and interview schedule were used to elicit as much information as possible from the respondents.

#### 7.6. GENERAL RESUME

Chapter Two provided review of literature which formed the background to the study and analysed the problem of relapse among alcohol abusers, and what factors were associated with it. From a literature point of view, it appeared that the problem of relapse was symptomatic of a complex behaviour problem that the abuser was facing.

The intake of alcohol, per se, no matter how large the amount was , could not singly be a factor in relapse behaviour. Aspects in the individuals like functioning of his personality, the stress tolerance level, his view of life on the one hand, and the pressure of psycho-socio-economical problems as experienced in the environment on the other hand were also factors of the individuals involved in this complex problem.

There was also an aspect associated with the methods applied in terms of theory applicability and appropriateness in dealing with clients in different social and cultural background. Ziter, (1987) discussed this fact in respect of Black clients in America.

The role of the practitioner and method used seemed to be crucial factors in working with relapse behaviour. According to the investigation it came out that the treatment procedures and methods used were of general nature while the special focus on African alcoholics as such did not seem to come out clearly. This was seen as a draw back and inadequacy of these treatment procedures for them to have the desired impact.

In the investigation it appeared that the specific points mentioned by Burling et al (1989) for consideration for workable treatment with African clients as well were not given attention. Those adapted for the study are presented as follows:

- a) A clear perspective on the meaning of the African experience.

- b) The isolation of behavioural components among African people that had fostered their survival.
- c) The implication of the treatment methods as applied in dual-cultural perspective society. The impression was gained that routine application of treatment procedures was used without such sensitive application.

In interviewing respondents some reasoned that mystical powers were involved in their drinking behaviour and the relapse that ensued. These were interpreted cosmologically in the world view of the respondents. Ngubane (1977) discussed this perception at great length in her book wherein she explains how an African patient sees illness not only as a physiological fact but also as having a cultural and other mystical dimensions. These discoveries indicate to us that relapse behaviour among Africans does not subscribe to the phenomenon of cause-relationship effectively. The theoretical implication involved is the understanding of the psyche of the relapsee, his world view and his relationship to the problem.

#### 7.7.

#### SPECIFIC CONCLUSIONS

The writer now wishes to restate specific conclusions relating to the analysis of empirical data. This presentation has its format on the restatement of the broad categories without repeating them.

7.7.1. Sex of the respondents

According to the data, men drank more than women. Generally, and in Zulu society in particular there is a cultural sanction in drinking by women. This, inadvertently had a positive effect. However, female Zulu alcoholics were now on the increase (cf Chapter One).

7.7.2. Age Factor

In the presentation and analysis of data, it was revealed that the highest number of respondents fell in the category of 36-40 years. This situation indicated that respondents started drinking heavily at younger ages; if it is taken into account that complex deterioration of behaviour usually indicates itself most obviously after a period of 10 years or so of indulgence.

The dangerous indication here was that people who should be at the prime of their lives were drinking heavily as a result of alcohol abuse. This would have other implications in their life circumstances.

7.7.3. Education Level

The overall impression created was that people with primary school education and lower accounted for sixty two (62) percent of the respondents. The explanation is that it can be assumed that these people suffered as persons in the employment field because of their education, and generally lack of preparation. The fifteen (15) percent of the respondents with standard

ten and higher education level were people who had a poor self-image of themselves. In all of the respondents the factors mentioned in Chapter Two as contributing to the type of relapse behaviour were applicable to these respondents as well.

#### 7.7.4. Marital Status of Respondents

The high number of respondents both males and females sixty four (64) percent were married. This is a clear indication of the extent of the problems and the people affected as indicated earlier. It was revealed that marital relations might have been a contributing factor in the relapse behaviour of these clients. However, the investigation did not employ any instrument to test the quality of behaviour relationships as a valid assertion by the respondents related to this behaviour. It can also be concluded that the marital relationship did not benefit the respondent as such. Reportedly, the respondents concerned were experiencing problems without the support of the structure of the Zulu extended family system. Equally they were not tuned to utilise other facilities now available in the community.

#### 7.7.5. Attitudes of the Family Towards the Relapsing Person

From the data available, it becomes clear that the family members appeared to have negative attitudes towards the problem of the respondents. The respondents stated that their family members bombarded them with citations of negative behaviour associated with their problem, such as separation and divorce and not being well looked after. Such type of behaviour

indicated social work intervention with the family in order to help the respondents not to suffer increased indignities at the hands of his own family.

In Zulu idiom, a relapsing alcoholic patient is termed, 'ISAHLULEKI SOTSHWALA" (a person who is unable to control his drinking). Because of the group-oriented nature in the Zulu extended family relationship, a type of behaviour that might have an effect of negating the individual status and relationship in the group usually had disastrous effects on the person. He was sanctioned not to degrade the group's image and name.

#### 7.7.6. Relapse Behaviour and Work

Formal engagement in work activity is understood as an essential part of an adult responsibility. The majority of the respondents (100 percent) felt that their job performance had been negatively affected by their behaviour as alcoholics.

Despite the fact that the previous employer had helped the respondent to deal with the problem of alcohol abuse, repeated lapses into drinking behaviour and the fact that this was having on the work situation had finally caused loss of employment for the respondents. The negative outcome of the cycle of developments had been the compounding and multiplicative nature of the circumstances of the respondents with the problem.

7.7.7. Professional Help in Dealing with Relapse Behaviour

While a large number of respondents (97,5 percent) had felt that their problem was treatable, however, they had not shown a distinct possibility of this. They admitted that social workers and other professionals had assisted them to understand the nature of their problem and to seek alternative ways rather than abusing liquor. However, it also became apparent that for one reason or another treatment lacked co-ordination and effective coverage for the respondents' nature of problems.

7.8. SUMMARY

In summary, the investigation tried to highlight the existence of the problem of relapse among African clients. Lack of adequate empirical data did not make it possible to devise a model for treatment. However, it is highly recommended that there should be a re-assessment of the existing treatment approaches and models. Professional social workers and rehabilitation officials should take heed of the writers who argue for sensitivity in the application of treatment to African clients - some social workers dealing with these clients should not deceive themselves in that sharing ethnicity with the client assures proper communication. Professional communication is a specific process and the acquisition and possession of appropriate skills is a factor in ensuring competency.

In this study it has been indicated that lack of co-ordination hampers successful treatment and rehabilitation.

The service delivery system should create a clear picture in the mind of the client as to the treatment process he is undergoing. The work with the immediate social environment of the client, especially the family is important. Supportive behaviour is essential in assisting the client on the road to recovery. Because social workers are in short supply the training of lay workers at community level is advocated. These will serve as a continuous link with the entire service delivery system. Their nearness to the client and, perhaps, understanding the idiom of the client's communication will enhance the treatment process. The client should be seen and dealt with as a total person, taking into account his cultural background also.

Further research on aspects such as communication problems should receive attention of future studies. It is hoped that the study will stimulate further research into preventative programmes to deal more appropriately with the needs of relapsing clients. This will assist in improving the treatment programmes to relate much more meaningfully to the needs and problems of relapsing African clients.

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INTERVIEW SCHEDULE

RELAPSE AMONG BLACK ALCOHOL ABUSERS AND ALCOHOLICS

WITH SPECIAL REFERENCE TO SOCIAL WORK TREATMENT

The study of the relapse among black alcohol abusers and alcoholics with special reference to Social Work treatment offered is conducted by a Masters student in Social Work at the University of Zululand for degree purposes.

Please assist me by completing this questionnaire and answer the following questions by putting an X in the square provided.

-----

IDENTIFYING PARTICULARS

- 1. Sex: .....
- 2. Age: .....
- 3. Education: .....
- 4. Type of employment: .....
- 5. Marital status: .....
- 6. Number of children: .....

A. QUESTIONS RELATED TO THE FAMILY:

- 1. Are you married?  
Yes \_\_\_\_\_  
No \_\_\_\_\_
- 2. How many children do you have?  
1 \_\_\_\_\_  
2 \_\_\_\_\_  
3 \_\_\_\_\_  
None \_\_\_\_\_
- 3. Are you staying with your immediate family?  
Yes \_\_\_\_\_  
No \_\_\_\_\_

4. (a) Are you staying with your relatives?

Yes  
No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(b) If you are staying with your relatives, who are they?

Uncle  
Aunt  
Brother  
Sister  
Granny

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Are your parents still alive?

Yes  
No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. What is the attitude of your family towards you as a person who has a drinking problem?

Negative  
Sympathetic  
Indifferent

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Would you <sup>say</sup> way they are understanding?

Yes  
No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Is their behaviour supportive?

Yes  
No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Do they assist you to realise that you can solve problems without resorting to drinking?

Yes  
No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**B. QUESTIONS RELATED TO THE INFLUENCE OF FRIENDS:**

1. What is the attitude of friends towards your drinking?

Negative  
Positive

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Are they persuading you to drink like a gentleman?

Yes  
No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. QUESTIONS RELATED TO WORK:

1. How is your job performance after drinking?

Good  
Bad

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Were you ever threatened of losing your job because of drinking?

Yes  
No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. What was the reason?

Coming late  
Absenteeism  
Fighting the employer

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

D. QUESTIONS RELATED TO PROFESSIONAL HELP

1. How did you come to the clinic?

Were you forced by someone  
Come voluntarily

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. How did you find the social worker?

Supportive  
Not supportive

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Were you ever encouraged to find alternatives besides drinking?

Yes  
No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Assuming that you are unemployed, were you encouraged to seek employment before finishing your treatment?

Yes  
No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Have any aftercare services been offered to you for when you finish your treatment?

Yes

No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Was compulsory detoxification offered to you?

Yes

No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Do treatment services lack co-ordination?

Yes

No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Is any formal therapy with the family being conducted?

Yes

No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Do treatment services give holistic attention to the factors associated with alcohol abuse?

Yes

No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**E. QUESTIONS RELATED TO FEELINGS**

1. How many times have you had the problem that caused you to be re-admitted?

Once

Twice

Thrice

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. What was the cause of your relapse?

Loneliness

Boredom

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. How do you spend your leisure time?

Reading

Listening to music

Drinking alcohol

Playing games

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. How do you see yourself as a person who has a drinking problem?

Responsible  
Not responsible

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

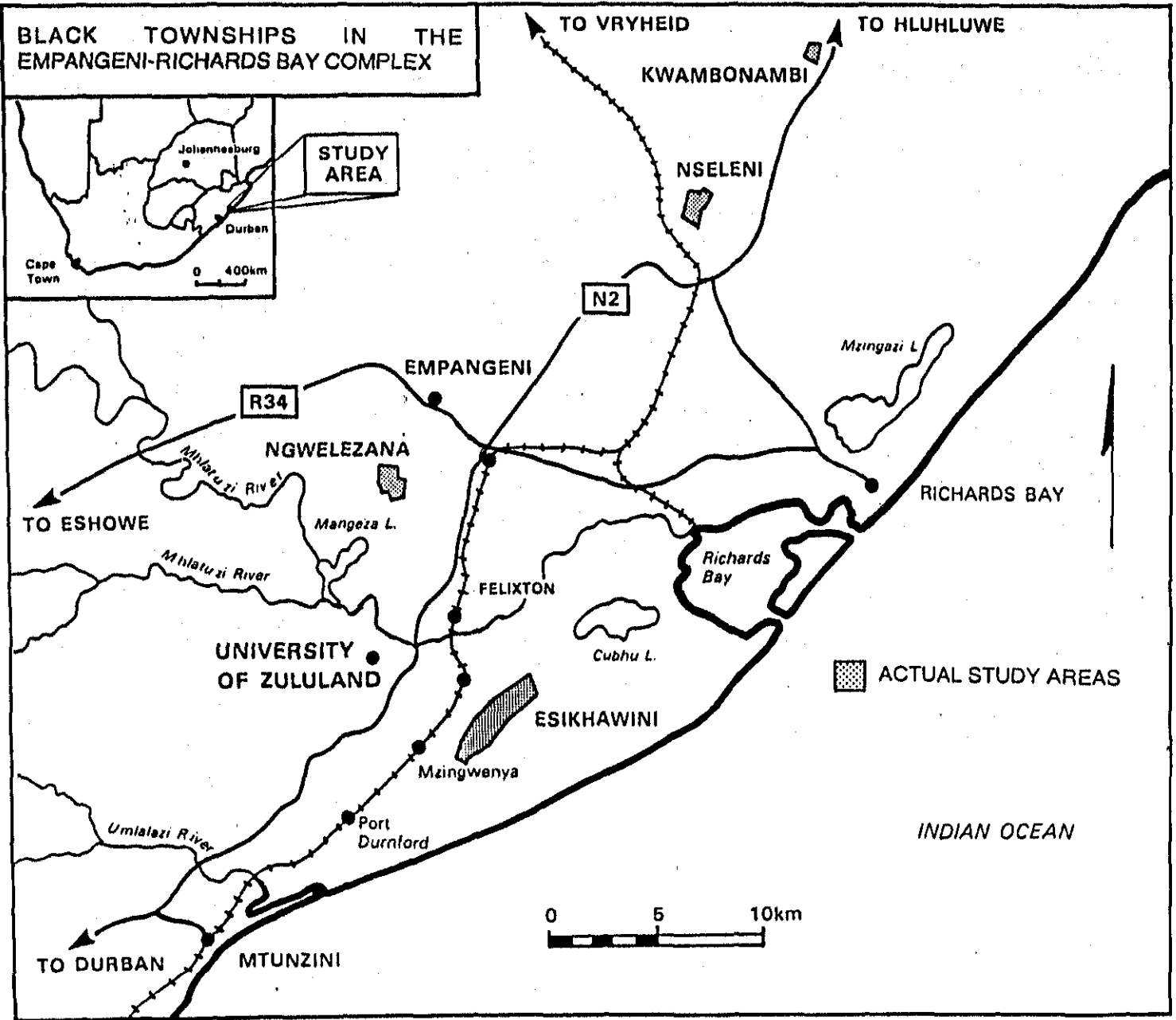
5. As a community member have you felt that relapsing is lowering your status?

Yes  
No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Indicate how you think the community sees you as a person with a drinking problem?

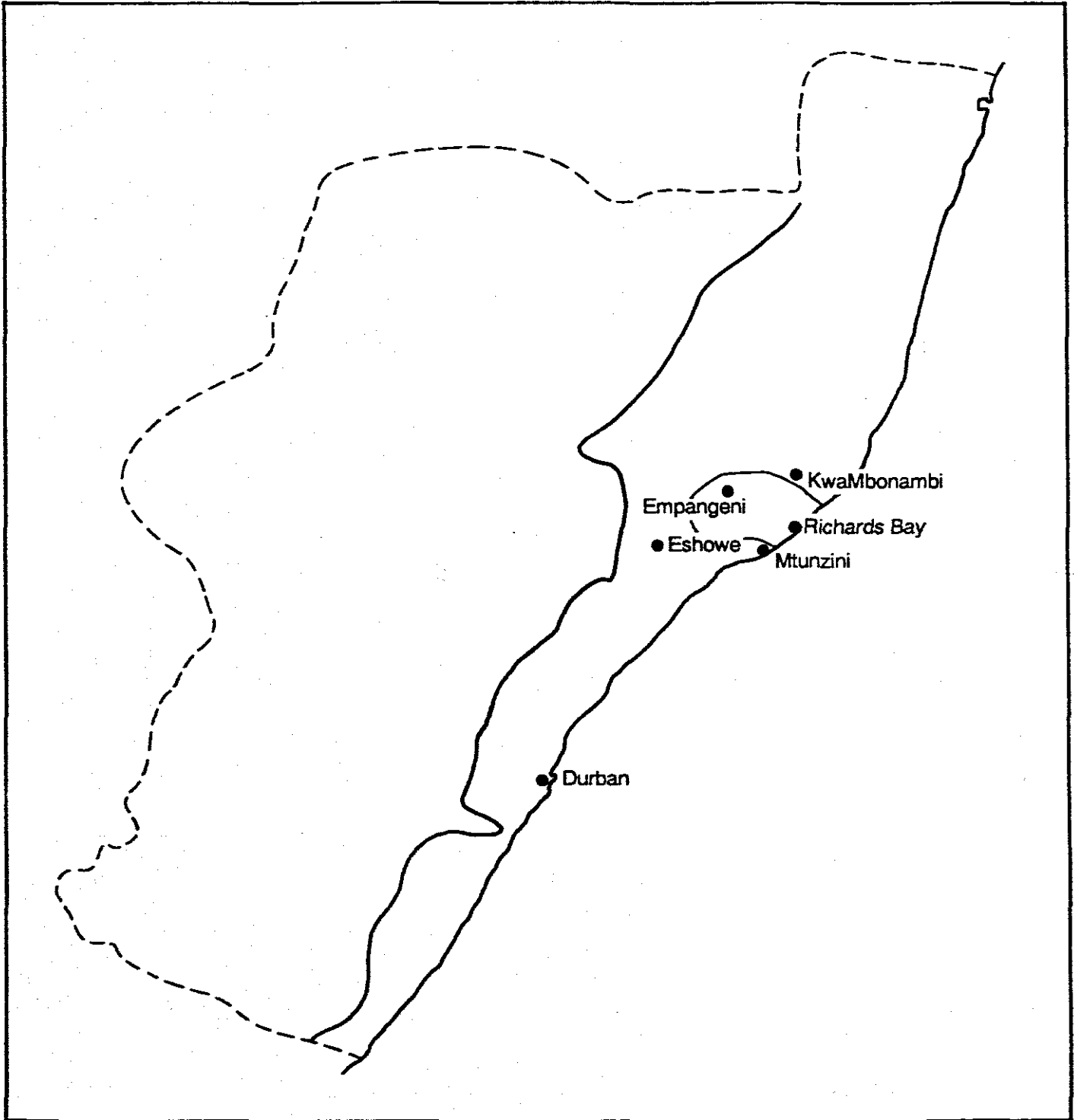
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(SOURCE: MAGI, 1992 - UNIZUL)

ANNEXURE 2

**MAP OF NATAL (INCLUDING KWAZULU AREAS)**



# LOCATION OF LOWER UMFOLOZI REGION

