

**ADOLESCENT SUBSTANCE ABUSE: PARENTS' EXPERIENCES**

by

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## Declaration

I declare that '*Adolescent substance abuse: Parents' experiences*' is my own work and that all the sources I have used or quoted have been indicated and duly acknowledged as complete references.

Aluta Ngantweni

Signature.....

Date: .....

## **Dedication**

I dedicate this mini-dissertation to all the caregivers who are struggling with their children who use/abuse psychoactive substances. Thank you.

## Acknowledgements

**To my supervisor**, Prof. Makhubela, thank you for supporting me through this journey, and for your excellent guidance, and supervision throughout this process. Lastly, thank you for instilling a good work ethic in me.

**To my mother, father, aunts, siblings and cousins**, thank you for your motivation and support. Thank you for unconditional love and for supporting me in following my dreams. Thank you for all the sacrifices and your belief in me.

**To all the participants**. It was a privilege to be able to capture your difficult experiences. Without you, this mini-dissertation would not have been possible. Thank you so much.

## **Abstract**

Adolescent substance abuse is not only a significant burden on the abusing individuals, but also on their families, particularly their parents. The study explored the experiences of parents of substance-abusing adolescents. A descriptive phenomenological research design was employed. Six female participants from low socio-economic communities in Pretoria participated in the study. In-depth interviews were used by the researcher to gather data by means of a semi-structured questionnaire. The research elicited themes and sub-themes through thematic analysis of the six transcripts of interviews with the participants. The findings of the study were consistent with both international and local studies, even though the contexts differed. The results of the study revealed that parents experienced difficulty in accessing support for themselves and their child or children; consequently they often sought solace in spirituality. Parents reported a great deal of stress and psychological strain due to their children's psychoactive substance use. Adolescent psychoactive substance abuse strained the family's finances and resulted in strained relationships with parents, siblings, and community members. Despite these challenges, many parents felt obliged to help their children and never gave up on them.

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## **Chapter 1: Overview of the study**

### **1 General introduction**

#### **1.1 Background information**

Adolescent psychoactive substances use and abuse is a major public health problem worldwide (Gore et al., 2011; Whiteford et al., 2013). A psychoactive substance can generally be defined as any substance that alters the state of consciousness or emotions when consumed (UK Parliament, Psychoactive Substance Bill, 2015). However, in the current study, psychoactive substances will also be defined as illicit and licit drugs, and alcohol in a sense that they violate existing social norms (Saunders & Young, 2002).

The negative impact of psychoactive substance use is evident in many domains of the youth's lives, including intra-personal, peer, parental and environmental relationships (Morojele & Brooks, 2006; Watt et al., 2014). It also plays a significant role in the development of neuropsychological disorders (Medina et al., 2008), correlated with disturbances in psychological well-being and unwanted sexual experiences (Hayhurst, 2007), as well as victimisation (Morojele & Brooks, 2006; Wechsberg, Luseno, Lam, Parry, & Morojele, 2006). The negative impact of psychoactive substance use is also known to result in addiction and substance abuse disorders (Feinstein, Richter & Foster, 2012). There is compelling evidence that psychoactive substance (ab)use is co-morbid with other mental disorders, particularly anxiety and depressive disorders in adolescents (Saraceno, Munafó, Heron, Craddock, & Van den Bree, 2009). Literature shows that adolescent males are more likely to abuse psychoactive substances than girls (Morojele, Parry, Brook, & Kekwaletswe, 2012), and boys are more likely to continue psychoactive substance use if their peers also use psychoactive substances (Osgood, Ragan, Wallace, Gest, Feinberg, & Moody, 2013).

The social context and society's prevailing norms play a significant role in adolescent psychoactive substance use, or abuse, in South Africa (Onya, Tessera, Myers, Flisher, & Flisher, 2012). The extent of adolescent substance use seems to also correlate positively with otherwise at-risk communities, as well as ethnic demographics (Watt et al., 2014).

Community socio-economic status predicts the extent and preference of use (Mokwena & Morojele, 2014), and poor communities have been found to be affected the most (Myers, Carney, & Wechsberg, 2016). Although there is no significant discrepancy between Black and White ethnic groups in terms of psychoactive substance use (Hayhurst, 2007), most adverse consequences have been noted amongst Black adolescents' (Coloureds and Black Africans) (Watt et al., 2014). Black adolescents tended to gravitate to the abuse of illicit drugs more than Whites (Reddy, Resnicow, Omardien, & Kambaran, 2007). Furthermore, the impoverished Black African population forms most the population, and mostly abuse cheap drugs such as *Nyaope* (Mokwena, & Huma, 2014; Dada et al., 2016; 2015).

Although most of the problems related to adolescent substance abuse have an impact on family members, particularly parents, little is actually known about the experience of those impacted. Parents shoulder the responsibility, and burden of managing this behaviour (Usher, Jackson, & O'Brien, 2005), and it is therefore important to understand the experiences of parents of adolescents using and abusing psychoactive drugs.

## **1.2 Problem statement**

The adolescent stage is one of the most challenging developmental stages in human development. During this stage, the youth experiment significantly, and it is inevitable that some will experiment with drugs and alcohol. Consequently, the use and abuse of psychoactive substance is one of the major health problems facing adolescents in South Africa.

Research reports high rates of psychoactive substance abuse by adolescents in South Africa (Morojele, et al., 2013; Reddy et al., 2010; Routledge, 2005). Peltzer and Ramlagan's (2009) meta-analytic study of research from 1993 to 2006, revealed disturbing rates in the increase of alcohol use from 21.5% to 61%, binge drinking from 14% to 40%, while 19% of those researched were found to use dangerous drugs. Patric et al. (2008) reported an elevated life-time use (72%) of psychoactive substances by adolescents in the Western Cape. Boys are reported to abuse more psychoactive drugs than girls and the illegal dosage of psychoactive drugs has also been found to increase with age. Substance abuse is reported to be a major cause of many of the social problems among adolescents in South Africa (Morejele et al., 2012). These problems include violence and crime, sexual risk

behaviours, earlier sexual debut, academic problems and mental health problems (Brook, Morojele, Brook, & Rosen, 2005; Degenhardt & Hall, 2006; Flisher, Townsend, Chikobvu, Lombard, & King, 2010; McGrath, Nyirenda, Hosegood, & Newell, 2009; Mpofu, Flisher, Bility, Onya, & Lombard, 2005; Plüddemann, Flisher, Mathews, Carney, & Lombard, 2008a; Townsend, Flisher, & King, 2007; Yen & Chong, 2006).

The high prevalence of adolescent psychoactive substance use in South Africa highlights the significance of the problem. Although there is no significant statistical difference between Black and White ethnic groups (Hayurst, 2005), Black adolescents tend to use more addictive and debilitating psychoactive substances (Reddy, Resnicow, Omardien & Kambaran, 2007; Watt et al., 2014). It is a matter of concern, in terms of demographics, that there are few Black African youth who seek formal treatment for psychoactive substance use and related problems (Dada et al., 2016; 2015). Consequently, it is the family, especially the parents, who must shoulder the responsibility of caring for adolescents who use and abuse psychoactive substances (Usher et al., 2007). Thus, it is important to explore the personal experiences of Black parents of adolescents who abuse psychoactive substances.

### **1.3 Aim of the study**

The aim of the study is to understand South African parents' experience and response to adolescent substance abuse.

### **1.4. Objectives of the study**

The objectives are:

- 1.4.1 To understand parents' experience to adolescent substance abuse;
- 1.4.2 To explore how parents respond to their adolescents drug abuse; and
- 1.4.3 To explore parents' relationship with their adolescent who abuse psychoactive substances.

### **1.5 Research questions**

How do parents experience and respond to adolescents' substance-abusing behaviour?

## 1.6 Significance of the study

Adolescent health-risk behaviour is a major public health issue in South Africa, especially when considering that 36.5% to 53.3% of adolescents engage in binge drinking, while 25% smoke marijuana (Bailey, 2012). The consequences of adolescent substance abuse is not limited to the primary user (Smith & Estefan, 2014), the family is always a victim of a person who abuses psychoactive substances (Rice, 2008). Family members of adolescents abusing psychoactive substances endure physiological and psychological distress, including, anxiety, depression, guilt, insomnia, and trauma (Smith & Estefan, 2014).

The consequences of psychoactive drug abuse by adolescents in South Africa are on the rise in educational, social, family, and cultural contexts (Seggie, 2012). Seemingly, most researchers tend to focus on people who directly abuse drugs, not the people who are affected by the use of the psychoactive drugs. According to Choate (2015), parents are the ones who are affected the most by adolescents who abuse psychoactive drugs. Choate states that the use of psychoactive drugs by adolescents affects schools, communities and especially the parents who take care of the adolescents. It is against this background that this study is undertaken to offer the perspectives of parents that live with adolescents who abuse psychoactive Pretoria.

Despite the fact that information is available in the literature regarding adolescents who abuse substances, little information exists that focuses on parents' personal experience in dealing with this problem. Not many researchers actually interviewed parents, and those who did (Himmelstein & Saul, 2015; Karavalaki & Shumker, 2016; Shek, 1998); focused on parents' observations of their adolescents or their view of treatment success. Moreover, most existing literature has tended to see such parents in terms of their deficits in parenting, even when advocating the importance of including them in the treatment process (Gillum, 2007).

A quantitative study by Stadtherr (2011) shows that there is a significant discrepancy between parents' perceptions regarding the use of psychoactive substances by adolescents and adolescents' actual use of psychoactive substances. When parents were asked about the use of psychoactive substances by their adolescent children, the majority (87%) of

parents thought that their adolescent children were not abusing psychoactive substances. By contrast, adolescents revealed that their close friends (22%) and their peers (43.5%) had abused psychoactive substances. The abovementioned results show that parents are often unaware of the use of psychoactive substances by their adolescent children. Similarly, Fernandez-Hermida et al. (2013) found discrepancies between parents' and adolescents' self-reporting, especially on the use of illicit drugs that are debilitating.

Only one study (Masombuka, 2013) in Pretoria was done to explore parents' perspectives of taking care of their adolescent children who abuse psychoactive substances. Masombuka's study focused on one psychoactive substance; Nyaope. Furthermore, the above-mentioned researcher's study used Tesch's data analysis. The current study focuses on a wider spectrum of psychoactive substances and uses a different data analysis method. Seemingly, no research was done in Pretoria to study parents' perspective about raising/living with adolescents who abuse a wide range of psychoactive substances.

## **1.7 Operational definition of terms**

### *1.7.1 Adolescents*

Adolescence will be defined in this present study as a period between 10 and 19 years of age (World Health Organization, 2013).

### *1.7.2 Psychoactive substances*

Psychoactive substances are drugs that can alter the consciousness, mood and thought of those who use them (e.g., tobacco, alcohol, amphetamines, ecstasy, cocaine, and heroin) (Julien, 2001).

### *1.7.3 Substance abuse*

For this study, substance abuse is defined as the use of drugs or alcohol in such a way that it disrupts the prevailing social norms (Usher et al., 2007).

## **1.8 Conclusion**

The present chapter focused on an introduction to the burden of psychoactive substance use and its impact on various levels, particularly the impact of adolescent psychoactive substance use on parents. This chapter demonstrated the need for research that will allow parents to tell their own story regarding taking care of their children who abuse psychoactive substances. Even though international research and local research seem to be parallel, caution should be exercised in relying on international research since the social context plays a significant role in South Africa, particularly socio-economic status as well as ethnicity. The following chapter will focus on the available literature and the theoretical perspective.

## Chapter 2: Literature review and theoretical perspective

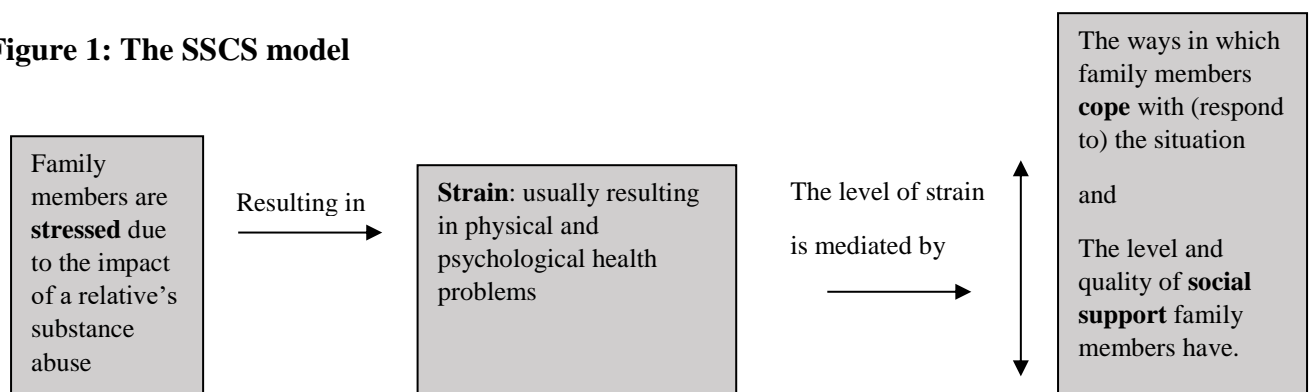
### 2 Introduction

In this section a brief discussion of adolescents abusing psychoactive substances, and the experiences of parents who live with adolescents abusing psychoactive substances, is provided.

#### 2.1 Theoretical perspective: Stress-strain-coping-support model (SSCS)

This study draws on Orford *et al.*'s typology that explains how family members (i.e., parents) generally experience and respond to a relative's substance abuse (Orford et al., 1992; Orford, Copello, Velleman, & Templeton, 2010). According to the SSCS model, living with a family member with a substance-abuse problem constitutes an often long-standing stressful life circumstance, which places affected family members at risk of experiencing physical and psychological strain (see figure 1). Family members would typically worry about the users' health and safety, and often have to bear the brunt of the abusers' aggression and violence, their disruption of the family and the impact of their behaviour on the family's finances. The model also shows that affected family members typically respond iteratively by repeatedly either tolerating or 'putting up' with unacceptable behaviour, engaging or 'standing up' to it, or simply withdrawing from any form of engagement (maintaining physical or emotional distance from the abusive relative) (Groenewald & Bhana, 2017; Orford et al., 1992, 2001, 2013).

**Figure 1: The SSCS model**





## **2.2 Literature review**

### *2.2.1 The global burden of psychoactive substance abuse*

The United Nations Office on Drugs and Crime (UNODC) estimates that one in twenty people abused psychoactive substances in 2014. Twelve per cent of people who abuse psychoactive substances are considered as problem users and suffer from drug-related problems. Most drug users tend to be polydrug users – they abuse more than one drug. Cannabis continues to be the most popular drug with 128 million users, and amphetamines are the second most used drugs. Cannabis is also the most trafficked psychoactive substance globally.

The abuse of psychoactive substances has adverse consequences – especially for those who use injections (11.4%) to get drugs into their system and those who use stimulants (UNODC, 2014). Furthermore, users are at a higher risk of being infected by communicable diseases such as HIV, hepatitis C and tuberculosis. The 2010 global burden of disease study found that psychoactive substance use and related disorders accounted for at least 86.1% of premature deaths, and 20.5% of lives affected by disabilities (Whiteford et al. 2013).

A disturbing tendency is that drug overdose has increased worldwide. According to Martins, Sampson, Cerda, and Galea (2015), drug overdose has increased over the past ten years. The number of people witnessing drug overdose has increased, ranging from an average of 50% to a high of 90%. Martins and colleagues also found that personal experiences of non-fatal drug abuse are also problematic, ranging from 16.6% to 68%. Drug-related deaths have increased and are problematic, both in rural and urban areas. The crude overdose death rates ranged from 0.04 to 46.6, with rural and impoverished communities recording the most deaths (Martins et al., 2015).

Globally, alcohol intake poses a major health risk (Rehm et al., 2009). The above-mentioned researchers identified disease and injuries that are exclusively because of alcohol abuse, such as alcohol use disorder, alcohol-related liver disease and alcohol induced pancreatitis. The adverse effects of the harmful use of alcohol accounts for more than 200 health problems (WHO, 2014), of note cancer (45.5%), neuropsychiatric disorders (11.1%),

cardiovascular diseases (40.8%), cirrhosis of the liver (31.7%), unintentional injuries (52.1%), and intentional injuries (20.4%) (Rehm et al., 2009). Alcohol-related harm is determined by the volume of consumption and the pattern of drinking. For example, men (6.3%) have a higher mortality rate than females (1.1%), because males typically consume larger volumes and are more likely to engage in heavy drinking than females (Rehm *et al.*, 2009). However, recent trends show that alcohol consumption by females has been on the rise. In 2014, WHO found higher mortality rates for females (4.0%) than males (3.7%).

Although adverse effects are mostly noted in mid-adulthood, alcohol abuse affects people from all phases of human development, from infants (0.3%) to elderly people (3.7%) (Rehm et al., 2009). Similarly, WHO (2014) found that children, the elderly and adolescent, are more vulnerable. Furthermore, health and related alcohol problems are more pronounced on the poor and those that are marginalised (Rehm et al., 2009). Additionally, every community that consumes alcohol develops related health and social problems (Rehm et al., 2009; WHO, 2014). Thus, developing countries experience more health-related problems than developed countries, even though they (developing countries) consume smaller amounts of alcohol (WHO, 2014). In society, the impact of alcohol abuse is not attributed only to health problems, but includes criminality and other social ills.

### *2.2.2 Psychoactive substance abuse in South Africa*

The use of psychoactive substance use is a major problem in South Africa. A review by Peltzer, Ramalagan, Johnson and Phaswana-Mafuya (2010) shows that, when compared to the rest of sub-Saharan Africa, South Africa is the most attractive market for illegal drugs. This is in part due to increased globalisation, continuous trade with Europe, Asia and North America, and the easy access to South Africa air and sea travel (Peltzer et al., 2010). As a result, drug trafficking and psychoactive substance use/abuse has increased significantly since the Apartheid era. Furthermore, ineffective law enforcement adds to the predicament. South African law enforcement agencies are more likely to spend their resources in tackling major syndicates and major 'drug busts' than ordinary drug dealers and consumers on the street (Peltzer et al., 2010).

In the South African context, the extent of consumption and abuse of psychoactive substances tends to be influenced by factors such as age, gender, socio-economic status,

ethnicity, region, and societal influences (Dada et al., 2016; Peltzer et al., 2010, Peltzer, Davids, & Njuho, 2011). For example, alcohol is a prominent psychoactive substance in the Eastern Cape (30%), while cannabis is frequently used in Gauteng (38%) and in KwaZulu-Natal (39%). While cannabis is the drug of choice in Africa, and also in South Africa, its use by adolescents is significantly greater than that of adults (Dada et al., 2015, 2016). The explanation for cannabis being the drug of choice is in part due to the fact that South Africa is the largest producer of cannabis in the world and cannabis is readily available to the general population. In terms of ethnic demographics, the White, generally privileged, population significantly abuse alcohol, while Black Africans and Coloureds are more likely to abuse illicit drugs (Peltzer et al., 2011). The majority of impoverished Black Africans are the ones hardest hit by the harmful consequences of psychoactive substance use. Furthermore, people in urban areas abuse more psychoactive substances than those in rural areas. Regardless of the extent of psychoactive substance use, devastating outcomes are noted in those who are economically disadvantaged.

Many South Africans consume large amounts of alcohol. In 2003, 33% of the sample indicated psychoactive substance use during some time in their lives (49% for males and 22% for females), 28% admitted that they used alcohol in a period of 12 months (39% being males and 16% females), and 18% consumed alcohol over a week's period (30% males and 10% females) (Department of Health, Medical Research Council, 2007 as cited in the National Drug Masterplan 2013-2017, p. 34). Similarly, in 2008, 28% of participants used alcohol in a month prior the study (Peltzer et al., 2011). South Africans consume alcohol more than any other psychoactive substance. According to the National Drug Master Plan (2013–2017), South Africans consume large amounts of alcohol in a harmful manner on weekends. Several South African adults are involved in heavy drinking episodes (WHO, 2011); characterised by binge drinking (10%) and 32% having engaged in dangerous drinking patterns (Peltzer et al., 2011).

There are noticeable differences in the types and degrees of psychoactive substance use/abuse; for example, a noticeable proportion of South Africans use more than one drug at a time. The use of more than one substance is a major problem, with participants from the Northern region (24%) and Eastern Cape (50%) admitting being poly-substance users (NDMP, 2013-2017). Also, heroin is a secondary drug that is more likely to be used than any other substance, with 27% in the Central Region, 16% in the Northern Region and 14%

in KwaZulu-Natal admitting to using heroin as both a primary and/or a secondary psychoactive substance.

### *2.2.3 Impact of psychoactive substance use on the family*

Psychoactive substance abuse does not only impact directly on the user, but also affects non-users, including the family and significant others. Most of the local and international research that documents the widespread use of psychoactive substance (NDMP, 2013-2017), tends to explore the impact of psychoactive substance use on the family of the substance abuser, such as the financial, social and psychological consequences, the impact on health and interpersonal relationships, and the effects of violence. Socially, the impact of the psychoactive substance user's behaviour on the family is profound and may lead to affected family members withdrawing and isolating themselves from social interaction including relationships with close friends due to the negative behaviour of the substance abuser (McCann, Lubman, Boardman, & Flood, 2017). Similarly, Orford, Velleman, Copello, Templeton and Ibanga (2010) found that affected family members preferred to isolate themselves because of fears of criticism and the stigma of being labelled 'a bad parent' due to the condition of the substance-abusing member. Furthermore, Orford and colleagues reported that in some instances, the substance-abusing member would threaten the family member to abstain from seeking external help. Family members also felt cut-off from professionals treating the substance abuser, who refuse to give them information that would help them due to their ethical dilemma arising from their duty to protect client's confidentiality (Oxford et al., 2010).

The financial toll imposed on the family because of the substance-abusing member has been well documented. The substance-using family member exerts extensive financial pressure on the family (Moriarty, Stubbe, Bradford, Tapper, & Lim, 2011). Benishek et al. (2011) found that financial problems are a significant challenge facing family members taking care of a substance-abusing family member. Similarly, family members experience heightened conflict not only owing to the pressure on the family's overall financial position, but also as a result of the financial conflict between the substance-abusing member and the rest of the family (Orford, Velleman, Natera, Templeton, & Copello, 2013). Almost all family members of the psychoactive substance-abusing member incur psychological problems. Benishek and colleagues (2011) acknowledged that all family members experience

emotional problems – Orford et al. (2013) found that family members experience symptoms of depression and anxiety and negative feelings directed at themselves or other family members. Psychological problems may include sleeping difficulties, headaches, fear, low self-esteem, guilt, and anger. The degree of poor psychological health correlates with the impact that the substance user has on the family.

Violent and aggressive behaviour by the substance user is a common phenomenon experienced by families living with, or taking care of, a substance-abusing person. An international study by McCann and colleagues (2017) found that 70% of families coping with a substance-abusing family member, experience aggression and or violence toward them. The same research group also found that these families have significant difficulties in their attempts to curb the aggression and violence and coping with the strain caused by this behaviour. The violence and aggression typically include emotional screaming of abuse, negative criticism, swearing and physical violence – including destruction of property, fighting, and threats of using weapons (McCann et al., 2017). In extreme cases, family members would seek law enforcement assistance to deal with the violence and aggression.

Much of the literature on the impact of adolescent substance abuse on the family focus on treatment success (Hock et al., 2015). Regrettably, there is limited literature on the experiences and the effects of adolescent psychoactive substance use in the absence of successful treatment strategies. Usher et al. (2005) reported on broken family relationships in a study on helping families who are taking care of adolescents who abuse psychoactive substance. These families were found to use ineffective coping mechanisms, such as withdrawing from the substance-abusing adolescent, which might actually escalate the problem (Usher et al., 2005).

#### *2.2.4 Adolescent psychoactive substance use*

Adolescence is a critical developmental stage that is characterised by experimentation, including but not limited to psychoactive substance use. At this stage, young people are highly vulnerable to psychoactive substances. In most cases, adolescents usually first experiment with tobacco and alcohol, after which they proceed to use illicit drugs (Degenhardt, Stockings, Patton, Hall, & Lynskey, 2016). An international study on psychoactive substance use found that the typical onset age of psychoactive substance use

is between 16 and 19. However, the onset of illicit psychoactive substance abuse was slightly higher by 12 months, between 18 and 19 (Degenhardt et al., 2016). Another study on the global burden of disease among adolescents related to psychoactive substance use found that psychoactive substance-related disorders begins in late adolescence (Erskine, Moffitt, Capeland, & Costello, 2015). By contrast, a USA study found that psychoactive substance use in the United States typically begins in early adolescence and peaks in late adolescence (Botvin & Griffin, 2007). In addition, a European study of youth (15 to 24) consulting a family doctor discovered that the majority of adolescents had drunk alcohol (75%), smoked cannabis (10%) and used other illicit psychoactive substance (3%) in the past month (Haller et al., 2015).

Adolescence is a stage of high risk and as a result psychoactive substance use by the youth presents major mental health challenges. At this developmental stage, some adolescents experiment with various psychoactive substances for various reasons. Many adolescents use psychoactive substances due to peer pressure, as a means of enjoyment, to fit in with certain groups, to cope with distress and for medicinal purposes (Montesh, Sibanda, Basdeo, & Lekubu, 2015). Botvin and Griffin (2007) also found that psychoactive-substance abuse occurred in peer groups, such as among friends and acquaintances. Many adolescents who abuse psychoactive substances have friends who also abuse psychoactive substances, and one can therefore speculate that the role of peer influence in psychoactive substance use and abuse is significant. In addition, Atwoli, Munjla, Ndungu, Kinoti and Ogot (2011) found that 75% of college students who were using/abusing psychoactive substances were introduced to such substances by their friends. Furthermore, Hayhurst (2007) found that adolescents are more likely to socialise with peers who use and abuse psychoactive substances. Some adolescents use psychoactive substances for recreational and medicinal use (Wen, Hockenberry, & Cummings, 2015). An American study found that cannabis use increased in the age groups of 12 to 20 after the introduction of new medical marijuana laws (Wen et al., 2015). Lastly, the relationship between stress and the use of psychoactive substances is vast (Sinha, 2008).

According to Hendricks, Savahl and Florence (2015) socio-economic status plays a significant role in the use of psychoactive substances. Adolescents from poor socio-economic communities were found to be more prone to use psychoactive substances. Leisure, boredom, and peer pressure were identified as significant predictors of adolescent substance abuse in many socially disadvantaged areas in South Africa. In adolescence, alcohol use (9.1%), as well as the use of other psychoactive substances (21% to 40%), and delinquency (48%) have been found to increase (Barnes, Hoffman, Welte, Farrell, & Dintcheff, 2006). A study in Pretoria by Hayhurst (2007) investigated the relationship between unwanted sexual experiences, psychological well-being, substance abuse and high-risk sexual behaviour among adolescents. The results of this quantitative study by Hayhurst found that adolescents who abuse psychoactive substances were more likely to engage in risky behaviour that endangers their health. The study revealed that risky sexual activity (25% to 37%) was the highest risk behaviour. In addition, Hayhurst found out that adolescents' substance abuse is likely to prevail because 87% of adolescents are more likely to socialise with peers who abuse alcohol and drugs. The study also found that the abuse of psychoactive substances significantly correlated negatively with psychological well-being, while positively correlated with risky sexual behaviour and unwanted sexual experience. Furthermore, when comparing adolescents according to their ethnic groups, those from the Black (32%) and White (36%) ethnic groups were found to abuse psychoactive substances more than Indians (23%).

#### *2.2.5 Prevalence of adolescent psychoactive substance use*

Globally, adolescent substance use is regarded as a major mental health problem and is on the rise. In their meta-analysis of recent North American trends in adolescents' psychoactive substance use over a 30-day period, Pieper, Ridenour, Hockwalt and Coyne-Beasley (2016) reported a 14% to 22% prevalence rate of cannabis use. They reported that cannabis was the most used illicit substance and had increased from 8.2% in 1991 to 14% in 2015. Another international study in Europe reported that alcohol (74%) was the most used psychoactive substance, while 59.18% used illicit drugs and the number of poly-drug users was a matter for concern, with 18.34% having used at least two substances, and 22.3% using approximately three or more psychoactive substances (Rakic, Rakic, Milošević, & Nedeljkovic, 2014).

Psychoactive substance use amongst adolescents remains prevalent in Africa. Atwoli and colleagues' (2011) study on the prevalence of substance used by college students in Kenya, found an overall 69.8% prevalence rate, with alcohol (51.9%) being the preferred psychoactive substance and relatively low prevalence on illicit psychoactive substances use (2% used cannabis and 0.6% used cocaine). A local study which investigated the prevalence and patterns of alcohol use by adolescents found that over half of adolescents used alcohol at some time in their lives (54%), with the onset of alcohol use between the ages from 15 to 16 (28.6%), while 22.45% started when they were between the ages 13 and 14; and a few started consuming alcohol before they were 13 (14.5%) (Ghuman, Meyer-Weitz, & Knight, 2012). The same study found that 40.8% consumed alcohol a month before the survey (Ghuman et al., 2012). Similarly, another local study by the Youth Research Unit found a higher prevalence of psychoactive substance use; the study shows that cannabis is the most abused illegal psychoactive substance (95.4%), while 79.4% admitted to using alcohol daily, with 66.6% consuming large volumes of alcohol to the extent that it altered their state of consciousness (Montesh et al., 2015).

Psychoactive substance use in South Africa is on the rise (SANCA statistic report, 2016/2017; United Nations Office on Drugs and Crime, World Drug Report, 2016). Recent statistics in South Africa indicated that adolescents and school-going children are the second most admitted in SANCA rehabilitation centres. The number of Black African adolescents admitted to treatment centres for illicit psychoactive substance use is particularly disturbing. The number Black Africans under the age of 20 for illicit drug use, including nyaope and heroin in Guateng, KwaZulu-Natal and the central region ranged from 52% to 98% (SANCEDU, 2016).

#### *2.2.5.1 Cannabis*

Cannabis is the most abused illicit psychoactive substance in Africa, particularly in South Africa (United Nations Office on Drugs and Crime, World Drug Report, 2016). The 2016/2017 SANCA statistical report revealed that admission for treatment due to cannabis abuse increased and most clients admitted to all SANCA's 29 centres were treated for cannabis abuse (37%). Even though the type of preferred psychoactive substance used differs in regions across South Africa, cannabis is the most popular psychoactive substance used by adolescents in the country. In 2016, the primary drug abused by patients under the



age of 20 was cannabis, with higher rates noted in Gauteng (77%), the Western Cape (71%) and KwaZulu-Natal (70%) (Dada et al., 2016a).

However, contrary to the above-mentioned trends (Dada et al., SANCA), much of recent literature suggests that cannabis is the second most widely used psychoactive substance by adolescents in South Africa. Several studies (Moodley, Matjila, & Moosa, 2012; Saban, Flisher, & Distiller, 2010) reported cannabis as a secondary psychoactive substance of choice by school-going adolescent in South Africa, with alcohol being their primary choice.

#### *2.2.5.2 Alcohol*

Adolescent alcohol abuse is well known in South Africa and, in fact, alcohol is currently the most abused psychoactive substance in South Africa (Dada et al., 2016a, 2015). In a study that investigated the psychosocial correlation with other psychoactive substances in South Africa, half (50%) of the adolescents had used alcohol in the past six months (Magidson et al., 2017). Similarly, another local study reported that over half (54%) of adolescents had used alcohol at some time in their lives (Ghuman et al., 2012). Alcohol and cannabis are gateway drugs for adolescents. Generally, adolescent start using alcohol and then proceed to other hardened psychoactive substances (Degenhardt et al., 2016). Early onset is regarded as problematic as it is seen to predict later complications and the risk of developing substance-related disorders.

#### *2.2.5.3 Illicit drug use*

Not many adolescents use or abuse illicit drugs. Haller and colleagues (2015) reported a significantly low number of young people abusing illegal drugs (2.6% of the youth in their study). A local study similarly found illicit psychoactive substance use to be less prevalent than commonly thought with only 5.7% of adolescents admitting using them (Flisher, 2010). Adolescent illicit psychoactive substance use is more commonly associated with older adolescents than younger ones. Magidson and colleagues (2017) found that at age 17, 22% of adolescents in South Africa had already used illicit psychoactive substances.

#### *2.2.6 Parents' awareness of the abuse of psychoactive substances by adolescents*

Parental awareness of adolescent substance use seems to affect their attachment with the substance-abusing adolescents. A quantitative cross-national study in Europe by Fernandez-Hermida et al. (2013) found that parents tend to have an inaccurate awareness about adolescents' substance use. The above-mentioned researchers found that parents who overestimated their adolescents' substance use, tended to have low expectations of their adolescents' prospects and are more likely to withdraw their attachment from the substance-abusing adolescents. On the other hand, parents who underestimated (79.1%), or showed poor awareness of their adolescents' substance use, tended to show positive attachment responses to their adolescents. The above results mean that parents of adolescents who are at high risk and in need of urgent intervention might have an unrealistic awareness of their adolescents' wellbeing. Furthermore, even parents who had correct information regarding their adolescent's substance use, tended to view themselves as inadequate and failures as parents (Williams, McDermitt, Bertrand, & Davis, 2003).

#### *2.2.7 Parents' understanding of psychoactive substances abuse by adolescents*

An international study by Hoeck and Van Hal (2012), which studied the experiences of parents of psychoactive abusing youth attending support groups, found that parents have little knowledge about the phenomenon of psychoactive substance use. The majority of parents thought psychoactive substance use would not affect their families and failed to educate their adolescents about the dangers of use (Hoeck & Van Hal, 2012). Only parents who were from communities where psychoactive substance use was prevalent were knowledgeable about the phenomena associated with psychoactive substance use (Hoeck & Van Hal, 2012).

Initially, parents notice the change of behaviour by the substance-abusing adolescents, including stealing, staying up late, isolation, manipulation, and aggression (Swartbooi, 2013). However, they are not sure about the cause of this behaviour, although many suspect psychoactive substance use. Eventually, after sustained vigilance, parents can confirm their suspicions. Many parents view this change of behaviour in relation to the adolescent's developmental stage. They think that their adolescent's change of behaviour, including psychoactive substance use, is normal and think that their child will outgrow this behaviour. The realisation that an adolescent is abusing psychoactive substance is difficult to bear for parents (Swartbooi, 2013).

The behaviour of substance-abusing adolescents tends to make parents perceive themselves and their parenting as inadequate (Saatcioglu, Erim, & Çakmak, 2006). It is important for parents to understand that there are factors beyond their control or that of their family. These factors that are beyond parental control may include ethnicity, gender, and communities that are at high risk (Green et al., 2011). Furthermore, the substance-abusing adolescent may play an important role in balancing family dysfunctional symptoms (Saatcioglu et al., 2006).

## *2.2. 8 Experiences of parents of adolescents abusing psychoactive substances*

Swartbooi (2013) studied parents' experiences of their adolescents' substance abuse in low socio-economic communities within the Cape Flats in the Western Cape Province. In Swartbooi's study, parents were found to play a significant role in managing their adolescents' substance addiction. Most parents were found to blame themselves and each other's parenting style for their children's drug abuse behaviour. They also felt helpless, guilty and angry at their failure to curb their children's substance abuse. Furthermore, Swartbooi stated that her results were consistent with previous research (Bancroft, Carty, Cunningham, Burley, & Backett-Milburn, 2002; Barnard, 2005; Butler & Bauld, 2005; Copello, Templeton, & Powell, 2010; Denning, 2010; Orford, Velleman, Copello, Templeton, & Ibanga, 2010; Saatcioglu, Erim, & Çakmak, 2006; Usher et al., 2005; Usher et al., 2007) that found parents endure a great deal of emotional devastation, and physiological, physical, financial, psychological problems when trying to manage their adolescents' substance-abuse behaviour.

### *2.2.8.1 Seeking professional help*

Parents often lack the knowledge and skill to manage their substance-abusing adolescent (Masombuka, 2013; Swartbooi, 2013). During this difficult time, parents require professional help from mental health experts, such as psychologists, doctors, law enforcement agencies, and psychiatrists (Masombuka, 2013). However, it is not generally the case that parents have access to professional help. Many parents experience professionals as unhelpful, particularly their general practitioners (Swartbooi, 2013). When faced with the knowledge that their child is abusing psychoactive substances, for most parents the first professional

contact is their general practitioner (Swartbooi, 2013). Van Hout and Bigha (2012) reported that parents were frustrated at the level of information provided by their general practitioner. In another international study parents felt let down, disappointed and experienced the knowledge of their general practitioner as lacking in depth (Hoeck & Van Hal, 2012). Parents often felt misunderstood. Furthermore, parents were frustrated at the refusal by professionals to disclose confidential information of their children (Hoeck & Van Hal, 2012).

#### *2.2.8.2 Interpersonal impact*

A local qualitative study by Groenewald and Bhana (2015) of mothers' experiences of staying with an adolescent who abuses psychoactive substance, found that parents experience strained relations between themselves and their loved ones, especially their partners. Groenewald and Bhana also observed that parents' relationship with their spouses deteriorated when their adolescent children started using psychoactive substance, and often blame each other's parental capacity. Parents experience great communication difficulties between themselves and the psychoactive substance-abusing adolescent (Hoeck & Van Hal, 2012). Adolescents often isolate themselves and refuse to disclose their problems (Hoeck & Van Hal, 2012). Parents and their adolescent children's relationship significantly deteriorates when parents attempt to gain control of their children's psychoactive substance use (Groenewald & Bhana, 2015). Parents' quality of life decreases because of the psychoactive substance-abusing child.

The psychoactive substance-abusing adolescent takes precedence over parents' lives, to the extent that parents live a life that is not their own. The relationship with other siblings, their marital relationship and other relationships become secondary priorities, even though parents rely on others, other than the substance-abusing adolescent for support (Swartbooi, 2013). During this time parents adjust their lives, including their work schedule, and also sacrifice their own needs (Swartbooi, 2013). Swartbooi (2013) reported that the relationship with the psychoactive substance-abusing adolescent becomes more important than the marital relationship. Masombuka (2013) reaffirms the finding that the marital relationship is threatened by the psychoactive-abusing child. Further, the marital relationship deteriorates more because of conflicting decisions taken by parents in taking care of the psychoactive substance-abusing adolescent (Swartbooi, 2013).

Parents felt that they were held accountable for their adolescent child's problematic behaviour by society, the family and even the psychoactive-abusing adolescent (Usher et al., 2007). Society at large tends to view the parents, particularly mothers, as playing a part in the development of their child's behaviour (Usher et al., 2007). This resulted in shame and blame, especially the stigma associated with being a parent of a psychoactive substance-abusing child (Usher et al., 2007). Rayes and Duchene (2015) also found that, amongst other things, parents often felt unhappy due to the lack of emotional response by the psychoactive substance-abusing adolescents. Consequently, parents felt unloved and would not rely on their substance-abusing children for emotional connection (Rayes & Duchene, 2015).

#### *2.2.8.3 Financial toll*

Parents experience a financial burden when taking care of their psychoactive substance-abusing child. They experience financial barriers when accessing treatment for their adolescents and some even have to pay large sums of money (Van Hout & Bigham, 2012) for treatment. The substance-abusing adolescent's destructive behaviour, which may include theft and destruction of property, further contributes to parent's financial woes (Groenewald & Bhana, 2015). In addition, parents are intimidated by the aggressive behaviour of the substance-abusing adolescent children and feel forced to provide financial support for their addiction (Masebuko, 2013).

#### *2.2.8.4 Coping*

Usher et al. (2007) reported that parents endure great difficulty in controlling their adolescent children's psychoactive substance abuse and destructive behaviour. Usher and colleagues reported that parents engaged in different experimental approaches. Initially, parents became authoritarian but as soon as they noticed that this approach did not work, they tried a softer approach by attempting to connect with their children (Usher et al., 2007). Inevitably, parents would succumb to adolescents' substance use and become disengaged from their children. Furthermore, when parents can no longer tolerate this behaviour, they send their children away as a means to preserve their mental health (Swartbooi, 2013). However, being cut off from their adolescent children resulted in feelings of guilt (Usher et al., 2007).

On the other hand, parents who were religious were found to be somewhat hopeful and did not give up on their psychoactive-using children (Rayes & Duchene, 2015).

Parents experienced great difficulties in coping with, and in attempts to manage, their problematic adolescent children. In Hout and Bigham's (2012) study parents would buy illicit psychoactive substances such as cannabis, in an attempt to lessen withdrawal symptoms when attempting to detoxify children. Caregivers also experienced dilemmas in dealing with the problematic adolescents. Groenewald and Bhana (2015) found that participants were not sure whether to report the problematic child to the law enforcement agencies or to protect their children from them. Similarly, Usher et al. (2007) reported that, when parents were extremely tired of their adolescent children's behaviour, they would consider sending them away – but then they would worry that something bad might happen to their children while they were away. Parents would also provide money to their adolescent children to buy psychoactive substances in the hope that they would not engage in criminal ways to obtain money to pay for psychoactive substances (Hoeck & Van Hal, 2012).

To regain control of the situation, and attempt to keep their children out of danger, parents often feel obliged to help their children (Swartbooi, 2013). Usher and colleagues (2007) described ways in which parents encouraged their children to immunise dangerous use of drugs and promoted a proactive lifestyle. These attempts were aimed at reducing harm. Parents who became overly involved in their children's well-being were often found to feel emotionally defeated (Swartbooi, 2013). Furthermore, overinvested parents tend to rely too much on their emotions, which could result in their making emotional rather than rational decisions, which may not be in the best interest of the family, the substance-abusing adolescent or the parents themselves (Swartbooi, 2013). In some extreme cases, parents would engage in inhumane coping mechanisms to restrain their adolescents, hence infringing their children's right in the process. Swartbooi (2013) reports that some desperate parents physically chained their adolescent children in order to gain control.

#### *2.2.8.5 Psychological well-being*

Adolescent psychoactive substance use has a negative impact on the parents' psychological well-being. For example, most of the studies consulted found that parents often had depressive symptoms (Swartbooi, 2013). As a result of the substance-abusing

adolescent, parents could experience, amongst other symptoms, guilt, shame, suicidal ideation, excessive worry, insomnia and anxiety (Groenewald & Bhana, 2015). In addition, parents could develop a sense of hopelessness and helplessness because of their inability to explain their adolescent children's behaviour and resolve the problem (Groenewald & Bhana, 2015). Furthermore, Groenewald & Bhana (2015) reported cases of para-suicidal parents, who resorted to excessive alcohol use and later attempted to commit suicide in a desperate attempt to escape from a hopeless and helpless situation.

Parents experienced grief at the loss of the child they once knew, the child they understood before the child resorted to psychoactive substance use, and the loss of dreams and aspirations they once had for their child (Usher et al., 2007). In the unfortunate event of an adolescent child dying as a result of psychoactive substance abuse and related complications, parents experience feelings of despair (Usher et al., 2007). In general, parents experience intense feelings of guilt because of their failure to find solutions for their children's problems. However, parents' negative emotional symptoms lessened when they cut off ties with the psychoactive drug-abusing adolescent. Usher et al. (2007) point out that parents felt that they regained their lives when their substance-abusing adolescent children were no longer part of their lives. Furthermore, those parents whose adolescent children died noticed that their negative emotional symptoms disappeared after the death of the substance-abusing adolescent, and they were able to regain their own identities, unattached to their problematic child (Usher et al., 2007).

#### *2.2.8.6 Aggressive behaviour*

Many substance-abusing adolescents are normally aggressive. The aggression (physical and verbal violence) is at times directed toward parents and the entire family. Van Hout and Bigham (2012) describe cases where parents were often frightened of their adolescent children. Parents found themselves in the middle of physical fights between family members other than the substance-abusing adolescent. Parents were found to mediate aggressive behaviour of other family member that were affected by the substance-abusing adolescent (Swartbooi, 2013). One participant reported that the adolescent abusing a psychoactive substance would threaten family members with a weapon, forcing them to 'run for cover' (Van Hout & Bigham, 2012). Usher et al. (2007) also describe a horrific experience, where

the adolescent destroyed property and threatened to attack the parents with a knife. Parents experienced disrespectful conduct and verbal aggression such as swearing and disrespect.

Adolescents' destructive behaviour escalated when they were not given money to support their addiction (Groenewald & Bhana, 2015). Similarly, Swartbooi (2013) reported that adolescents become aggressive when there were financial disagreements with their caregivers. Furthermore, adolescents manipulated their parents for money which resulted in conflict between their parents (Swartbooi, 2013).

## **2.3 Conclusion**

In this chapter the theoretical perspective of the study was discussed in detail, and international and local literature was reviewed. The literature reviewed the problems associated with psychoactive substance use at different levels and in different contexts. The discussion concentrated on the impact on all those affected by the conduct of abusers of psychoactive substances.



## **Chapter 3:**

### **Research methodology**

### **3 Introduction**

The current research followed a qualitative phenomenological method (i.e., descriptive method). Phenomenological research is particularly effective when describing the subjective experiences of people involved in the phenomena under investigation (Smith, 2007).

#### **3.1 Research design**

Qualitative exploratory research provides an understanding of the phenomenon being studied by establishing the opinions, reasons, and motivation of people experiencing the phenomenon (Creswell, 2014). The researcher finds meaning by exploring subjective experience from the perspective of what is being studied. Qualitative research designs are influenced by culture, historical background and social contexts in understanding common patterns of behaviour (Gwyther & Possamai-Inesedy, 2009). The design is chosen according to the nature of the topic to be researched. Qualitative phenomenological research is used when enquiring about lived experiences (Smith, 2007). Phenomenology is a form of enquiry of unique human experiences (Kafle, 2011).

##### *3.1.1 Phenomenology*

Phenomenology originated as a philosophy in the twentieth century in Europe (Dowling & Cooney, 2012). The term 'phenomenology' first appeared in philosophical texts in the 19th century. Phenomenology as a philosophical movement was introduced by scholars such as Kant, and Hegel (Moran, 2000). For example, Kant saw phenomenology as a science that concerns itself with how things appear in the observer's perspective. Hegel played a prominent role in the movement of phenomenological science, although his work was only recognised later. In his work on the phenomenology of spirit, Hegel made the most prominent use of the term 'phenomenology', but later his work lost its significance. It was only during the 1920s and 1930s, after Edmund Husserl (1859 – 1938) introduced the phenomenological movement that other scholars started to see Hegel's role as central to the foundation of phenomenological methods (Moran, 2000).

Edmund Husserl is credited as the founder of phenomenology. Husserl introduced phenomenology in his paper *Logical Investigations* (German: *Logische Untersuchungen*) published in two volumes in 1900 and 1901. In this paper, he attempted to discuss a far-reaching theory of knowledge and was particularly interested in the phenomenology of the experiences of thinking and knowing (Moran, 2000). Although Husserl is credited with conceptualising phenomenology, much of his work was based on the foundations laid by his teacher Franz Brentano. Husserl was influenced by the idea of intentional structures of consciousness that originated from his teacher Brentano. Furthermore, Husserl modified Brentano's thinking and came up with the assumption that intentionality was guided by consciousness (Lopez & Willis, 2004). This thinking led Husserl to attempt to empirically study intentionality. This gave rise to phenomenological methods, which focused on investigating the phenomena through the structures of consciousness (Koch, 1995). The main objective of Husserl's work was to find the true meaning of the phenomena by describing the given information (Dowling, 2007). For Husserl, phenomenology meant to study experiences that are not empirically perceived and treated as actual facts in the usual sense, but as human experiences that are *perceived* to be facts by the observer (Moran, 2000). Furthermore, the emphasis is on the meanings of experiences people attach to their daily living, which is not rooted in social reality.

Husserl postulated that subjective information is essential for a scientific investigation that intends to understand human motivation, because human beings are influenced by what is considered real by them in a given context and time (Husserl, 1970). Hence he proposed that phenomenology should describe pure expressions and essential concepts that are governed by essence. The aim of phenomenology is to define things as they are. Phenomenology is seen in the meaningfulness one attributes to his/her own affections, emotions, and imaginative life. The focus is on one's own preoccupations, one's own self-satisfaction and one's own demands (Moran, 2000). One's own experiences represent direct engagement with the world. The phenomenological movement is a comprehensive, anti-traditional form of philosophy, which aims to discover truth, in whatever manner it appears, as it manifests itself to the consciousness of the observer. Often it will discover meanings that are taken for granted or considered as 'common sense'. It is anti-traditional because it rejects prior knowledge, previous experiences, religious or cultural traditions,

everyday common sense, and history (Moran, 2000). In essence, it is free from dominant traditions and lines of enquiry.

Van Manen (1989) (as cited by Lavery, 2003) defines phenomenology as 'essentially the study of lived experiences' (p. 22). The purpose of phenomenology was to return to things themselves and to discover meaning and experiences as perceived by people themselves (Smith, 2007). The thrust is on how people see the world in which they live in and the meaning they attach to it (Kafle, 2011), and to return to pure rich lived human experiences. It intends to study the commonly shared human experiences and perception of objects in the world (Lavery, 2003). Central to the study of phenomenology is the nature and meaning of phenomena (Kafle, 2011). According to Lester (1999), the purpose of the phenomenological approach is also to describe the idiosyncratic aspects of phenomena as they are perceived in a certain situation. Therefore, it rejects all accounts of knowledge as absurd. The central question that phenomenological enquiry aims to uncover concerns itself with 'what is the experience'? In an attempt to uncover meanings of everyday living, the lifeworld is critical. The lifeworld is known as unprocessed experiences, including; pre-reflective experiences, free of categorisation, taxonomy or conceptualisation.

Phenomenology is a diverse philosophical movement and research method to explore experiences. There are many scholars with vastly diverse perspectives who have contributed to this field. Amongst the most influential are Edmund Husserl and Martin Heidegger. The latter conceptualised his phenomenological movement as *interpretive phenomenology* while the former introduced *descriptive phenomenology*. To date phenomenology is closely associated with these school.

### 3.1.1.1 *Descriptive phenomenology*

Descriptive phenomenology was first conceptualised by Husserl. Descriptive phenomenology is based on the assumption that understanding human experiences is central to discovering reality. The aim of this school is to unearth and describe 'lived experiences' (Kafle, 2011). The characteristics of descriptive phenomenology include description, reduction or bracketing, essence and intentionality. Descriptive phenomenology aims to discover the true meaning of phenomena. In order to achieve this, the researcher has to make use of reduction or bracketing in order to ensure neutrality. Bracketing

(German: Einklammerung; also called epoché, or phenomenological reduction) is a term in the philosophical movement of phenomenology describing the act of suspending judgment about the natural world to instead focus on analysis of experience. Husserl believed that it is possible to eliminate personal bias in an attempt to arrive to a state of pure consciousness by bracketing. Through bracketing, the researcher must be able to eliminate personal opinions in order to arrive at a single, essential and descriptive presentation of a phenomenon. The researcher has to open himself to the task at hand in order to see things as they are. Therefore, this school concentrates on phenomenological attitudes rather than natural attitudes that may be influenced by social background.

The central question in descriptive phenomenology is ‘What do we know?’ Intentionality and consciousness become of critical value when attempting to answer this question. Intentionality is a procedure where the mind is focused on the subject of study. On the other hand, intentionality is guided by conscious awareness. Conscious awareness is the point of departure in the realisation of one’s knowledge of reality. By intentional directed focus, one is able to describe his/her reality.

### *3.1.1.2 Interpretive phenomenology*

The interpretive phenomenology school of thought was initiated by Martin Heidegger because he rejected Husserl’s notion of reduction. Heidegger believed that it is impossible to get rid of personal attitudes, ideas and biases (Reiners, 2012). Heidegger believed that consciousness is the result of the individual’s background and history. He was of the assumption that a person’s background enables him/her to understand what is real. Furthermore, he believed that historical understanding is not something one can ignore, and he saw historical understanding as part of people’s make-up. Instead of bracketing, Heidegger’s emphasis was on awareness. For him, the individual has to be aware as much as possible in order to account for interpretive influences rooted in the individual’s culture. Furthermore, he believed that personal awareness of individuals’ attitudes and biases is essential in phenomenological research (Reiners, 2012).

The central question interpretive phenomenology concerns itself with is ‘*what is being?*’ Furthermore, interpretive phenomenology is concerned with the question ‘*how do people make meaning of their experience?*’ Interpretation is critical in answering these questions.

Heidegger's assumption was that the individual and the world constantly influence and shape one another, and he aimed to interpret this interaction. Heidegger claimed that human beings are interpretive and stressed that every encounter involves interpretation influenced by an individual's background or history. Interpretations focus on historical meanings of experiences and their development and cumulative effect on both the individual and the social level. The essence of interpretive phenomenology is understanding our everyday world as derived from our interpretations. To uncover meanings rooted in everyday lives interpretive phenomenology goes further than a mere description of experience (Reiners, 2012). While descriptive phenomenology focuses on understanding phenomena, interpretive phenomenology focuses on the meaning of being human in the world. The focus is on understanding basic human existence, not in the way we understand the world, but in how we are in the world.

A descriptive phenomenological approach will serve as a lens through which the research problem will be viewed. This paradigm is appropriate to the aim of the study, which is to describe the subjective lived experiences of parents of adolescents who abuse psychoactive substances.

### **3.2 Sampling**

The population for the study is parents of adolescents who abuse psychoactive substances. Hycner (1999) (as cited by Groenewald, 2004) states that 'the phenomenon dictates the method (not vice-versa) including even the type of participants' (p. 156). The researcher employed purposive sampling (Marshall, 1996) to recruited six participants (aged 36 to 64) residing in Pretoria townships. Participants were contacted or recruited with the help of the Community Oriented Substance Use Programme (COSUP). With the assistance of the organisation, an open invitation (with information about the nature of the study) was sent by COSUP to their clients' database (i.e. parents who are aware of their child's psychoactive substance use, in other words all the potential participants). The letters were distributed in three COSUP districts – Mamelodi, Atteridgeville and Eersterus. Those who indicated interest, and volunteered to participate in the research, provided their contact details to COSUP; the researcher contacted them and they were then included in the study.

The interviews were held either at the University of Pretoria (Itsoseng Clinic, Mamelodi Campus) in an appropriate room for interviews, or at the participants' homes. The location was determined according to the place that was deemed more comfortable for the participants. According to Englander (2012), phenomenological research demands a small sample that allows participants to speak for themselves regarding their lived experiences.

### **3.3 Inclusion criteria**

The type and extent of psychoactive substance abuse in South Africa is positively closely correlated with socio-economic status. The impoverished Black African population forms the majority of the population, and mostly abuse cheap drugs such as Nyaope, which is a psychoactive substance used in low socio-economic communities (Mokwena & Huma, 2014). The current study focused on a broad spectrum of Black parents – one Coloured parent and five Black African parents who were aware of their child's psychoactive substance use. The researcher recruited participants from only mothers of the substance-abusing adolescents. Three of the six mothers were biological parents of their adolescent children, and two were foster parents working in a children's home, while the other surrogate parent was a grandmother. All six participants were living with, taking care of, and responsible for adolescents whose ages were between 10 and 18, and were abusing psychoactive substances. Lastly, the parents, or guardians, and their children were residing in Pretoria. The majority of parents five (5) were from Mamelodi and the other parent lived in Eersterus.

### **3.4 Data collection procedure**

The interview is the main method of data collection in qualitative research. In phenomenological research, interviews are reflective, in other words, participants' descriptions can be explored, illuminated and probed using reflection, clarification, requests for examples, and descriptions, and listening techniques. The researcher should start with a general plan about the direction the conversation will take. The interview should establish the context of the interviewee's experience, the construction of the experience, and reflection on the meaning it holds (Flood, 2010).

The researcher conducted semi-structured interviews in an agreed upon venue with the parents. Two interviews were conducted at the University of Pretoria at the Itsoseng clinic. The other four interviews were conducted at the participants' homes in Mamelodi and Eersterus. The interviews were audio-recorded (each took approximately 50 minutes) and conducted following the interview schedule provided in Appendix C. During data collection, the researcher *bracketed* to avoid research bias, and prior influence. Hamill and Sinclair (2010) state that when bracketing, the researcher should be self-critical and self-aware, curious, and inquiring, insightful and willing to admit to being wrong when gathering information. Furthermore, *bracketing* means that the researcher should be open, organised, articulate, honest, and transparent.

### **3.5 Data preparation and analysis**

Thematic analysis was employed to analyse the data. Thematic analysis is a flexible method that can be used in a variety of qualitative methods. Furthermore, thematic analysis is a method that is independent of any theory or epistemology and can be applied in various theoretical and epistemological contexts (Braun & Clarke, 2006). Braun and Clarke define thematic analysis as a method of identifying, analysing and reporting of themes. In essence, it is a method to identify repeated patterns of data. However, thematic analysis goes further to identify and interpret aspects of the research questions.

Before conducting thematic analysis, the researcher may need to make four key decisions.

1. The first question the researcher has to answer is '*what constitutes a theme?*' The researcher has to define prevalence, that is, the patterns that are repeated or patterns that are important in answering the research question (Braun & Clark, 2006). In this research, themes were chosen because they appeared repeatedly across all six the transcripts of interviews.
2. The second decision the researcher has to make is choosing between a rich description of the entire data set or providing rich details of a particular aspect of the data set (Braun & Clark, 2006). In the current research, the researcher analysed data to provide a rich description of the whole data set to highlight significant themes or patterns.

3. Thirdly, the researcher has to decide between inductive and theoretical thematic analysis (Braun & Clark, 2006). According to Braun and Clark (2006) the inductive approach means that the themes are more likely to be representative of the raw data, while theoretical thematic analysis means that the data will be representative of the researcher's interest or theoretical framework. An inductive approach was chosen because it aligns well with the research question and the theoretical research framework.
4. A fourth important decision is whether to report data at a semantic or latent level. The researcher employed a semantic style to report on the observable patterns or only what the research subjects reported (Braun & Clark, 2006). On the other hand, the latent approach goes further than what the participant has reported and searches for detailed features such as the underlying reasoning (Braun & Clark, 2006). The semantic approach was utilised in this research to provide a rich description of what the participants reported.

Braun and Clarke (2006) identified six phases of conducting a thematic analysis.

1. The first phase involves the researchers familiarising themselves with the research data, the transcription of verbal interviews into a written form and identifying initial codes (Braun & Clark, 2006). The researcher initially familiarised himself with the data by listening to the audio tapes of the verbal interviews.
2. Thereafter, the researcher transcribed verbatim the audio tapes as accurately as possible from the original audio tapes. Thereafter the researcher read the transcripts several times until he was familiar with the depth and breadth of the data. This enabled the researcher to get a sense of initial codes and enabled him to write some notes about prospective codes and themes. While reading the transcripts, the researcher could identify prominent themes and dominant patterns. In the second phase, the researcher manually gathered initial codes that appeared to be interesting regarding the phenomena under study (Braun & Clark, 2006). The initial codes involved coding almost the entire data set. In trying to make sense of what is in the entire data set, the researcher wrote notes on the text. Thereafter, the researcher



was able to gather meaningful information by generating initial codes of the entire data set. The initial codes at this stage either represented concealed meanings and meanings derived directly from the text.

3. The third phase involved the researcher analysing the codes by sorting them into potential themes (Braun & Clark, 2006). The researcher sorted the themes into different levels and collected all the necessary data to form broad themes and the researcher was able to identify relevant ('candidate') broader overwhelming themes, and sub-themes. The above-mentioned procedure was done by initially sorting themes in each of the six transcripts and then combining the transcripts. Further, the researcher used a mind map to organise themes.
4. The fourth stage of analysis involved reviewing and refining candidate themes in two levels (Braun & Clark, 2006). Data were reviewed initially in the level-one phase by re-reading extracts themes, checking whether they were coherent and whether they captured the essence of the themes. Further, the researcher read all the information relevant to a particular theme and was certain that the data within the particular themes were coherent. Secondly, Level 2 data were validated through the review of the entire data set to check whether candidate themes were exact representations of the entire data set. The researcher was convinced that the data was coherent with the themes and that the themes were clearly differentiated.
5. The fifth stage involved the researcher defining and naming satisfactory themes (Braun & Clark, 2006). In the fifth stage the researcher identified the essence of what is represented by the data by identifying what was interesting about them. Further, the researcher wrote a detailed narrative on each theme in an attempt to describe how each theme fitted the broader story and how it related to the research question.
6. Lastly, the researcher included candidate themes. In the sixth and final stage, the researcher needed to write up a comprehensive report of all the themes. A written write-up of all the themes was provided by the researcher. The write-up or report included data extracts and vivid examples.

### **3.6 Ethical considerations in phenomenological research**

The research information that forms part of the consent form was presented in a language that the participants could reasonably understand. The informed consent form contained all ethical aspects involved in the study. The informed consent form provided clear information on the procedure to be followed on participating in the study. The researcher ensured that the participants' human rights and dignity were respected. Participation in the study was voluntary; the participants were made aware that they could withdraw at any time and such action would not impact them negatively. The researcher received ethical clearance from the Ethics Committee in both the faculties of Humanities and Health Sciences at the University of Pretoria.

Before data collection, the researcher explained the aim of the study and the duration of the interview, and the participants were given an opportunity to ask questions to clarify the procedure, and when satisfied they signed the consent forms indicating that they agreed to be involved in the study. Because the interviews were face-to-face, anonymity could not be protected, but pseudonyms were used in the final dissertation to protect the rights and identity of the participants. Research material and audio data will be stored in the Department of Psychology for 15 years (office HSB 11-24) for reuse and archiving. During this period other approved researchers may also have access to the data for further use.

### *3.6.1 Beneficence and non-maleficence*

The participants were made aware that there was no material benefit (to them) for participating in the study. However, the participants were informed that their participation could aid in gaining insight into the phenomena in question and could aid in future interventions. The participants were assured that they could not be harmed by the research process. The research participants were made aware of the sensitive nature of the research questions. Therefore, the researcher made contingency plans to reduce harm to participants. Such interventions included referring the participants to mental health experts (Walker, 2007). In the case of the proposed study, affected participants were made aware that they could be referred to the University of Pretoria's Itsoseng Psychology Clinic for debriefing at no cost to them. However, no participant was negatively affected by the sensitive nature of the interview and there was no need to refer.

### 3.6.2 Trustworthiness

The terms *reliability* and *validity* are replaced by the terms *trustworthiness* in qualitative research. To ensure trustworthiness or rigour in qualitative research, the researcher should ensure that the research findings are credible, dependable and confirmable (Thomas & Magilvy, 2011). The researcher achieved trustworthiness by consistent supervision. Throughout the research process, the researcher received intensive supervision and feedback. Furthermore, the researcher was responsible, flexible and adapted to a changing research environment. For example, the researcher went to the participants' homes when they were unable to go to the University. The researcher also provided extensive descriptions, was sensible, and clarified and summarised research findings (Denzin & Lincoln, 2011). Lastly, the researcher acted responsibly; the research method was congruent with the theoretical framework and the sampling was adequate. The researcher maintained an active stance and analysed data till saturation was reached. If the researcher has achieved the above conditions for trustworthiness then the researcher's findings should be transferable, credible, dependable and confirmable (Morse, Barrett, Mayan, Olson, & Spiers, 2002).

### 3.7 Conclusion

This chapter focused on the methodology and methods of the research. Qualitative research was utilised to explore the phenomenon under investigation. Within qualitative research methods, descriptive phenomenology was chosen as it aligned well with the aims and objectives of the study.

## **Chapter 4:**

### **Results**

#### **4 Introduction**

The present chapter presents the results of the study. A detailed analysis and exploration of the main findings elicited from all six transcripts of interviews will be offered. This analysis discovered many themes. As a result, these themes could subsequently be grouped into main themes and subordinate themes, reflecting parental experiences of taking care of adolescents who abuse psychoactive substances.

#### **4.1 Demographic Information**

##### *4.1.1 Characteristics of the adolescents whose parents were interviewed*

Five of the adolescents were Black African residing in Mamelodi, while one was Coloured who lived in Eersterus. Also, five adolescents were male while one was female. All the adolescents were living with their parents and or caregivers. The age range of the adolescents varied, with the youngest being 14-years-old and the oldest 19-years-old. The age of onset of psychoactive substance use also varied, with most adolescents being initiated to psychoactive substances from mid to late adolescence (four started when they were between 15 and 18 years old, while two initiated psychoactive substance use early – between 11 and 13 years old). The duration of psychoactive substance use also varied (three adolescents had abused psychoactive substances for three years, two adolescents for two years and one adolescent for a year). None of the adolescents had a criminal record or charges against them. However, two of the adolescents were not studying because they were expelled from school due to conduct problems.

##### *4.1.2 Characteristics of the interviewed parents*

All the participants were Black females, five Black African and one Coloured. Three of the participants were unemployed, one was an auxiliary nurse and two worked as caregivers in a children's home. Five of the parents' highest level of education was grade 12, with one parent having a diploma. All the parents were from low socio-economic communities in

Pretoria, five from Mamelodi and one parent from Eersterus. Five parents were single parents, and only one parent was married.

## **4.2 Main results: themes and sub-themes**

The following themes and subthemes emerged from the data and are presented using representative excerpts from the mothers' accounts to illustrate analyses and interpretations.

### **4.2.1 Adolescents' changed behaviour due to psychoactive substance use**

The researcher will discuss themes that are related to the parents' experience of their adolescents' changed behaviour as a result of their children's psychoactive substance use.

These themes include the following:

- a) worry about safety,
- b) concerns about adolescents' future,
- c) lack of communication,
- d) loss of the adolescent, and
- e) Conduct problems.

#### *4.2.1.1 Worry about safety*

Adolescents' changed behaviour included not being at home for a number of days, going out at night and stealing from the community. As a result of this problematic behaviour, parents worry about their psychoactive substance-abusing adolescent children. Parents whose children stole from the community displayed a significant degree of anxiety. They were worried because they feared that community members would harm their children. These extracts demonstrate this point:

*P6: "I'm afraid that they will kill him, beat him".*

*P1: "if they use it, sometimes they become sick. Sometimes they, they have fight. Sometimes people can kill him because they don't know themselves".*

*P5: "Because I know that there are some Nigerians who are taking children and join prostitution, you see. So, I've seen that she is not safe when is around township. It's*

*much better to go there because when she is there it's like a jail. No matter I know that they won't abuse her, they won't abuse her but because she is a girl".*

These interviews are consistent with Masombuka (2013) who also found that parents worry about their children's safety when they are on the streets. Further, the above-mentioned researcher found that this worry at times manifested in parents being tearful, feeling depressed and melancholy. These findings are consistent with Swartbooi (2013) who found that parents worry about the safety of the adolescent. In her study, she described a horrific incident where an adolescent was assaulted due to the failure of the adolescent to pay for psychoactive substance that the adolescent owes. At times, the worry for safety extends beyond the adolescent, wherein parents also worry about their own safety because of their adolescents' habits. One parent felt unsafe around her adolescent and also from the community members. This extract reveals this point:

*P6: "He has that anger and I cannot manage that anger. I am afraid to myself that one day he can do bad things, beat me. I sorry to say that. Even the rape he can do because he more, he is too much now. He is too much. He is violent".*

*P6: "I'm scared of that worse drugs because when someone use drugs his life is in danger. That means my life is in danger too because it's my child".*

These findings are consistent with Swartbooi (2013) who found that some parents felt unsafe because of their adolescent's associates. Further, Swartbooi also noted that the concern for safety also extends to the entire family.

#### **4.2.1.2 Concerns about adolescents' future**

The use of psychoactive substances was associated with adolescent problematic school behaviour. As a result of this behaviour adolescents' performances declined at school and at worse they were expelled from school. These extracts demonstrate this point:

*P1: "He goes twice a week but now and the not going to school I didn't see him going there anymore".*

*P3: "Like now he is not at school. For this whole year because why. Because of the substance... It's just when they tested him it stopped positive and they don't want it".*

Because of the above-mentioned problematic behaviour, parents lost hope of the future they anticipated for their adolescent and they had to adjust the dreams that they had for their children. Parents were worried that they had to take care of their adolescents. For some, this was difficult because they had relatives who were negatively affected by psychoactive substance use. As a result, they saw their adolescents' future as bleak. These extracts reveal these findings:

*P6: "He must finish the school. He must be educated and be what he wants to be. That can make me happy".*

*P4: "The knowledge that I have is that a person who is using these substances has no bright future... She won't have a bright future.... They don't get a profession like other people".*

*P3 "he is 14 years but remember he has to grow up and he must have his own family. You know? So, what's going to happen? It's not nice".*

These findings are consistent with Usher et al. (2007), who found that parents experience loss because of broken dreams they had for their children. Furthermore, parents were distressed because they had to change their expectations of the adult they imagined their adolescent would be.

#### **4.2.1.3 Lack of communication**

Parents experienced a significant barrier in communication, especially when it came to adolescents using psychoactive substances. Their children generally did not want to speak about their psychoactive substance use. Parents' attempts were normally met with silence. These extracts demonstrate this point:

*P5: "So, I tried to sit them, to sit him down and ask him but he couldn't say anything".*

*P3: "He just doesn't speak. If you ask him something (personating by mumbling). He won't. He will answer you if it's a question. But like this substance thing he won't answer me because I think he is guilty".*

On the contrary, the psychoactive substance-abusing adolescents would speak at a later stage about their substance use, perhaps after few days and when the parent is no longer upset with the adolescent. Those adolescents who did communicate, were experienced as rude. Parents would engage in intense arguments which would not end well. These arguments were characterised by the adolescent lying and denying substance use. These extracts demonstrate this point:

*P3: "All the questions that I have asked he didn't answer me in just maybe 2 or 3 days he will come back and then he will talk about it".*

*P6: "Maja, he keep quiet, doesn't answer. I'm starting talking to him; what is the problem? No mama I'm fine. No, you are not fine. And you will end up fighting because I want to know Maja what is the problem, no leave me alone... like arguing with mouth to mouth. Maja please tell me, you are in trouble? Did you beat someone? Did you attack somebody? I don't know what is your problem. You make me, I'm scared now. What's the problem? They are chasing you? Did you done something? No, mama I can't do that. I'm not doing these thing. it's just your imagination. I'm not doing these things. Yes, I'm smoking. Ok fine I'm smoking. Oh, you're smoking, what? No, the cigarette. Only the cigarette. Maja, ma, what is the problem? Tell me do you smoke? Do you use the drugs? No. you see now ma, you are starting now. You are starting".*

These findings are consistent with those of Reyes (2015), who found that parents were hurt because of the lack of communication with their children. The above-mentioned researcher noticed that parents felt disrespected and, at times, wished they could terminate their relationship with the substance-using child.

#### **4.2.1.4 Loss of the adolescent that parents knew**

Parents experience a significant change in their adolescent children when using/abusing psychoactive substances. They experience their child as different from the child they were used to. To make things worse, the changes in the adolescent are experienced as negative. These changes present difficult challenges for parents in the process of caring for their adolescent child. Thus, parents experience loss of the child they knew and face difficulty of dealing with a changed adolescent. These extracts reveal this point:



*P5: "I experienced my boy last year he was using this substance and I didn't expect that from him because he was such an oh, I can say obedient or someone who listen in the houses but suddenly the behaviour changed. He will be coming home late. He'll not be, he didn't want to do anything in the house. He'll be back charting at me".*

*P1: "This person is not the one you know".*

*P6: "You are not Madisha anymore. I don't know who you are anymore".*

*P2: "Since he was smoking this there is something that has changed. I don't know what it is. But I see he is not acting like before".*

These findings are similar to those of Usher et al. (2007). They found that parents grieved/longed for the person their child was before using/abusing psychoactive substances. Worse, they found that some parents experienced loss because of death. However, none of the participants in the current study experienced the death of their substance-using child. Reyes (2015) confirms these finding that parents often experience negative histrionic changes in their adolescent children. Furthermore, these behavioural changes are experienced as hurtful by the caregivers.

#### **4.2.1.5 Conduct problems**

Parents experience a wide range of conduct problems when their children use/abuse psychoactive substances. This is a challenging time as adolescents become delinquent. These conduct problems included truancy, back chatting, stealing, beating siblings, and lying. With that said, the most challenging conduct problem that parents were faced with was their adolescent missing from home or coming home late. This was particularly distressing for parents. Some parents could not sleep at night when their adolescent child was missing. These extracts prove this point:

*P1: "Usually they are coming at the half-past 5 but sometimes himself they come eleven o'clock in the midnight...That's why I said when they come at night, sometimes I don't sleep. Ja, I'm waiting for anything".*

*P5: "He will be coming home late. He'll not be, he didn't want to do anything in the house. He'll be back chatting at me... he just swearing at me. When I try to discipline him by grounding him he refused flatly. He tell me that I won't do it".*

*P6: "when I say Madisha don't do this he just agree but he is going to do".*

These findings are consistent with Groenewald and Bhana (2015, 2017). Groenewald and Bhana found that psychoactive substance-abusing adolescents present with challenging behaviours.

#### **4.2.2 The impact of adolescent psychoactive substance use on the parents, family and the community**

The researcher will discuss themes that are related to the impact of their adolescent children's psychoactive substance use on the family, community and at a parental level. The themes that will be covered in this section include: loss of trust, embarrassment and breaking down of relationships, and the role the substance-abusing adolescents play in their parent's romantic relationships.

##### **4.2.2.1 Loss of trust**

The psychoactive substance using/abusing adolescent becomes less reliable and as a result loses the trust of significant others. Caregivers and siblings feel that they can no longer rely on or trust the psychoactive substance-using/abusing adolescent. This is precipitated in particular by stealing. This results in parents and siblings having to guard their belongings. When they are away from their home, they have to make sure that the house is locked. On the other hand, when the psychoactive substance-abusing adolescent is around, they become hypervigilant. These extracts demonstrate this point:

*P2: "They don't trust anymore... him because they know sometimes when you go with the place he just took the other people's stuff".*

*P6: "I can tell you now we cannot leave our phones like this. You see there are the changes. We have to take this phone and put inside my pocket or here, some in my breast or take with my hands. I cannot leave my money like the way I used to do like I put R10 there. I will find that R10 gone. So, there is some changes and then*

*even though we put the bread inside ... we have to take it safe and put it in the place so that we can share because if he can come here he will take that bread and eat without asking”.*

Watt et al. (2014) confirm these findings. They found that family members lost trust and families were no longer united due to the debilitating behaviour directed toward the family members. Similarly, Velleman et al. (2010) found that parents do not trust their children with finances because of their habits.

#### **4.2.2.2 Embarrassment and breakdown of relationships**

Psychoactive substance-using/abusing adolescents' behaviour resulted in strained relationships with their caregivers and other members of the family. They had conflict-laden relationships with siblings, their extended family and the community as a whole. Further, the impact of this relationship also had a negative impact on the caregiver's relationships with others, particularly family members. Caregivers would find themselves in the middle of this conflict. They found themselves in positions where they had to mediate. These extracts reveal this point:

*P6: “Yes, because there's some few people that are crying with Thabo. Thabo do this to our kids. Thabo do that. I didn't expect him to do that to the community, especially people I live with them. I live with those people. even I don't have anything I have to go there and ask; makhi you don't have this kind of thing? his helping me. Those people he is going there and do bad things to them... They just come and put that complain, Maja do this and I'm trying to talk to them that give me a chance. Ask my child. I will speak to him... Because he doesn't greet me like the way I used to know him. We used to wait outside there; hi makhi, how are you? How was the morning, what what and talk about the water? This place, sometimes there is no water. He doesn't do those kind of things anymore because of Maja”.*

*P4: “My son said I don't care about her because I told her that she must leave this things... So, now there is not relation, good relationship between her, my sister's daughter and my younger sister. They don't have that good relationship”.*

*P3: “Because as I said it was his best friend. It was his right arm. It was the apple of his eyes and he failed him somewhere somehow. So I have to talk to him and tell*

*him this is still our child. It doesn't matter what he is doing. We can't give him to the wolves outside. He have to stay here. If you feel you want to put him out, I am going with him".*

These extracts describe how the behaviour of the psychoactive substance-abusing adolescents has led to poor relationships with family members and community members. These findings are consistent with those of Swartbooi (2013), who found that family members endure strained relationships as a result of the psychoactive difficulties. More specifically, family members had to adjust their lifestyle and adapt to the adolescent's problematic behaviour. Watt et al. (2014) further validate the above-mentioned extracts. Their results reveal that psychoactive substance use leads to a strained relationship between the community and the family of the psychoactive substance-abusing adolescent.

#### **4.2.3 Parents' view of support**

The researcher will discuss themes that are related to the parents' view of support. Themes that will be covered include: viewing adolescent assistance as their own support and spiritual support.

##### **4.2.3.1 View adolescent assistance as their own help.**

Parents had difficulty in distinguishing between their own support and support for their children. Parents were asked; what support do you have in dealing with your child's behaviour? Their responses indicated that they viewed help for their children as a way of helping themselves. In other words, they viewed interventions directed toward their children's problematic behaviour as interventions for themselves. These extracts advocate for this point:

*P1: "I just get help to the social workers. Maybe when I talk to Thabo they don't listen, then I tell the social workers they come and talk to him but even if the social workers they help me to talk to Thabo, Thabo is not going there. Even if the social workers mmm help me to find the support groups".*

*P5: "Did call other mother like our mother rep, mother representative and he assistant because they were in the child co-ordinator team (CYTD) to come and intervene and talk sense into him. They usually come and talk to him about his behaviour".*

These extracts highlight that parents view interventions for themselves as interventions that help them deal with their children's behaviour. These findings are similar to those of Hoeck and Van Hal (2012), who found that parents' initial response was getting help directed at the substance abuser and in the process neglecting their own support needs. Further, in their study, Hoeck and Van Hal (2012) found that parents learned to separate their physical and emotional needs from those of the psychoactive substance-abusing adolescent to focus on their own needs. However, it is important to note that the parents in the above-mentioned study were attending a support group.

#### **4.2.3.2 Relying on spiritual help**

Most of the parents reported that they relied on spiritual assistance to cope with the challenges of having a child who abuses substances. This gave them hope in difficult circumstances. These extracts reveal this point:

*P4: "that God gives me strength and also gives me strength to survive this".*

*P3: "The only thing that really helped him, I prayed because he wasn't getting better".*

These findings are similar to those of Masombuka (2013) who found that parents found solace and comfort in their faith and religion. This is despite the fact that most churches and religious organisations harbour a negative attitude towards psychoactive substance use. The church, in particular, views psychoactive substance use as dishonourable and sinful. Nonetheless, participants were inclined to seek spiritual help in dealing with their children's behaviour.

#### **4.2.3.3 Professional support**

Much of the professional support parents sought was for their psychoactive substance-abusing adolescents. The first contact they have when seeking professional help was usually from social workers. These extracts indicate this point:

*P3: "then we went to the clinic, Jane (COSUP social worker)".*

*P1: "I just get help to the social worker".*

*P5: "in our situation we have to have contact with social workers".*

*P6: "Ja since I met Mr Senzo (social worker), he tried about Senzo even though he suffer because he doesn't find Senzo the way he want".*

These findings contradict the findings of Hoeck and Van Hal (2012). In their study they found that parents first contact their general practitioner (GP) when faced with a psychoactive substance-abusing adolescent.

#### **4.2.4 Parents' experience of caring for the psychoactive substance-abusing adolescent child**

Parents were adamant that they were the only ones who could take care of their psychoactive substance-abusing adolescent child and felt that they needed to shoulder the responsibility of caring for their children who use/abuse psychoactive substances. All these parents were mothers, and they felt that it was their responsibility to take care of their children. These parents had to fight for their children against other siblings and against their romantic partners. At times, parents would take the side of the psychoactive substance-abusing adolescent. They protected them. These parents never gave up on their children despite having feelings of helplessness and a sense of 'being stuck'. Some continued to seek help even though they thought it was too late for their children to stop using psychoactive substances because of addiction. Other parents never gave in despite their adolescents refusing interventions for their problematic behaviour. These extracts reveal that parent feel that they should shoulder the responsibility of caring for their psychoactive substance-using/abusing adolescent child:

*P6: "Ja, he doesn't want to be helped. It's what I see about him because I try every day. I talk on one thing. Every day is a session to me that Madisha I want to help you my son. Let's go to the social worker, therapist, whatever they call it so that you can get help and be well, so that we can be together again".*

*P2: “the situations that you must hold on to because other people can’t hold it... I must be strong for them so that they cannot be scattered or feeling that they don’t get help. I must help my son”.*

*P3: “Then I said we have to help him because the people outside can’t help him”.*

These findings are similar to those of Usher et al. (2007), who found that parents shoulder the responsibility of taking care of their children despite the many challenges they face. Further, they revealed that parents continue caring for their children even though they struggle to manage the problematic behaviour and are left with the burden of having to raise their psychoactive substance-abusing adolescent children.

#### **4.2.5 Financial implications**

The majority of parents experience financial difficulties due to their adolescent children’s drug habit. Financial loss included losing money while seeking or receiving treatment by having to pay for the intervention and transport. However, the theme of theft was prominent. In this section, a theme that is related to psychoactive substance use is discussed in detail. The theme that will be discussed is stealing.

##### **4.2.5.1 Stealing**

An overwhelming theme experienced by most parents was financial loss through stealing. Psychoactive substance using/abusing adolescent stole from the community and stole at their households in order to support their habit. These extracts indicate this point:

*P6: “So I’m afraid to leave him in the house. I cannot leave him inside the house, some things TVs, everything, DVDs. Last, I can tell you last week he open the music system. He want to take those speakers and the part of music system out... he want to take those things and go and, his going to sell so that he can smoke”.*

*P3: “they say its him who took the stuff”.*

*P4: “the stealing of money. Yes, he always steal money from me and buy this drugs... I’ve lost of R200, R100, R200, R300. A lot of money which was stolen’*

These findings are confirmed by Swartbooi (2013). She found that psychoactive substance-abusing adolescents often sell their own belongings and steal valuable assets from family members. Masombuka (2013) found similar results. Masombuka identified parents and family members as the most frequent victims of theft. Further, a similar study by Groenewald and Bhana (2015, 2017) further confirmed these findings. They found that parents suffered financial difficulties because of their adolescent children's stealing. Further, in their study, financial difficulties were also due to costs incurred in the process of treating the psychoactive substance-abusing adolescent.

#### **4.2.6 Parents' emotional response to psychoactive substance-abusing adolescents**

Parents of psychoactive substance-abusing adolescents experience a wide range of emotions due to their children's behaviour. In this section, themes related to the caregiver's emotional experiences will be discussed. These themes include: helplessness and guilt.

##### **4.2.6.1 Helplessness**

Parents of substance using or abusing adolescents feel helpless because of the chronic nature of the problem. They find it difficult to get satisfactory interventions. They approach a number of organisations for help, but their adolescent's problematic behaviour does not change. As a consequence they experience overwhelming feelings of helplessness. These extracts indicate this point:

*P1: "I don't know what can I do".*

*P6: "It's difficult because I don't know what to do. I don't know where to go... I'm stressed because eh when a child eh is taking those drugs its difficult to help that child if he doesn't want to help".*

*P3: "It makes me feel helpless, because even though I seek for help, it's like nowhere, everywhere I am going no one can help me. I've been to SANCA. I've been to the clinic. I, I, I have been to Victory Out Reach, but he is still using the substance".*

These findings contradict some of the available literature's results (e.g., Reyes & Duchene, 2015). They found that parents remain hopeful (due to religion) despite having to endure negative emotions.



#### **4.2.6.2 Guilt**

Another prominent emotion that parents experienced is guilt. Parents felt guilty because their children were using/abusing psychoactive substances. This inappropriate guilt is reflected in the following utterances:

*P5: “you feel like what have I done wrong. What did I went wrong? Mmm in raising this child”.*

*P6: “So those kind of this I ask myself maybe I done wrong even by after Maja”*

These findings are consistent with those of Usher et al. (2007), who found that parents often lived with feelings of guilt because they perceived their adolescent child’s psychoactive substance use as a parenting failure. In their study, they found that guilt was also fostered by evicting psychoactive substance-abusing adolescents from home. Furthermore, they found that parents who lost their children experience intense guilt.

#### **4.3 Conclusion**

In this chapter a detailed analysis of the transcripts from the six participants was conducted. Using thematic analysis, each transcript was analysed where themes and sub-themes were documented. The researcher used pseudonyms in order to protect the participants’ right to confidentiality. The researcher used direct words from the participants in order to provide a description of the parents’ experiences. Lastly, the findings of the present study are similar to the majority of both local and international studies.

## **Chapter 5:**

### **Discussion, recommendations and limitations of the study**

#### **5. Introduction**

This chapter focuses on the discussion of the main findings. It also provides recommendations and identifies limitations of the study.

#### **5.1 Parental support**

All the parents experienced difficulties when it came to taking care of their substance-abusing adolescent children. Therefore, they needed support. Most parents found it difficult to access support for themselves. This was in part because of a lack of differentiation between the support they needed, and the support needed by their children. Consequently, parents tended to view support for their psychoactive substance-abusing children as support directed at themselves. These findings are similar to those of Hoeck and Van Hal (2012). Hoeck and Van Hall's (2012) study found that parents neglected their own needs and focused on the interventions directed at the substance abuser. In the present study, parents seemed to lack awareness of their own need for support. Another significant point is that five parents in the present study never received any form of intervention (supportive or therapeutic), whereas in Hoeck and Van Hall's study parents were receiving interventions for their children's challenging behaviour. Consequently, similar to most of the literature, parents found solace in faith and religion.

A significant finding in the study was that parent's first access to professional help for their children, was through social workers. These findings contradict most of the literature, which found that parents' first contact for help was with general practitioners (GP) (Hoeck & Van Hal, 2012; Van Hout & Bingham, 2012). This may be accounted for by the fact that many of the studies were conducted in developed countries where people have access to basic health care. However, that is not the case in South Africa. In the South African context, people do not have access to basic health care, especially in poor socio-economic communities, such Mamelodi and Eersterus. Furthermore, social worker services are mostly available free of charge through NGOs in South Africa. Parents in the present study

accessed social work services through COSUP, which is an NGO and offers free social-work services. Unfortunately, parents found significant difficulties in helping their children. They lacked financial resources to travel as well as to provide finances for interventions. On the other hand, this difficulty was due to the psychoactive substance-abusing adolescent refusing intervention to curb his/her habit.

## **5.2 Parents' emotional reactions**

It became apparent that parenting an adolescent who uses and/or abuses psychoactive substances was significantly stressful. Parents experienced a wide range of emotions due to their children's psychoactive substance use. Of note, in the present study, is that parents experienced guilt and helplessness. They experienced guilt because they thought their adolescent children's challenging behaviour was a result of their own deficiencies in parenting and wished they could have done more. As a result, they blamed themselves. The helplessness was due to the parents not having access to interventions and viewing psychoactive substances as a chronic problem, especially those parents who have relatives who were victims of psychoactive substance use. The reported emotional reactions to psychoactive substance use are consistent with the findings of past studies (e.g., Groenewald & Bhana, 2015, 2017; Masombuka, 2013, Swartbooi, 2013; Reyes & Duchene, 2015; Usher et al., 2007). It is interesting to note that the findings in the present study are consistent with studies in first-world countries (Hoeck & Van Hal, 2012; Reyes & Duchene, 2015; Usher et al., 2007), bearing in mind the role of the context in psychoactive substance use. Similarly, Usher et al. (2007) found that there were no differences between rural and urban participants. Although there is not much detail on the context in previous studies, these findings seem to challenge the idea that the context plays a role in the experience of psychoactive substance use. Furthermore, there seem to be similarities regardless of whether the parents receive or do not receive interventions for their children's problematic behaviour.

## **5.3 Financial loss**

An overwhelming theme consistent with literature was financial loss. All the parents reported that caring and living with their adolescent had financial implications. This was difficult as it brought about further financial difficulties on parents already living in poverty-stricken

communities. The psychoactive substance-abusing adolescent further drained their family and the community of financial resources. Parents were faced with difficult decisions, such as providing transport money for their adolescent in order to seek interventions or to purchase household needs. These findings are similar to those of previous studies (Masombuka, 2013; Swartbooi, 2013; Usher et al., 2007; Van Hout & Bingham, 2012). The financial burden seemed to have had an impact on parents' romantic relationships, especially the mothers who supported their children unconditionally. Some parents argued about money to support their adolescent child and the psychoactive supporting adolescent mother was left to seek financial resources on her own to provide for their children.

Financial loss was also incurred through stealing. Psychoactive substance-abusing adolescents stole household assets, and stole from the community to support their addiction. Parents found themselves in difficult positions when they were confronted by community members because of theft. Community member demand reimbursement of the asserts that the adolescent stole. Furthermore, parents were often fearful of mob justice and thought that the community would eventually harm or kill their adolescent children. In addition, of note, parents in this study tended to downplay stealing of household products. They labelled stealing of household goods as 'taking'.

#### **5.4 Parents' experience of caring for the psychoactive substance-abusing adolescent children**

The burden of taking care of a psychoactive substance-abusing adolescent was well documented in the present study. Parents, especially mothers, were left with the burden of having to raise their drug-abusing children. These parents felt it was their sole responsibility to take care of their children's problematic behaviour. They felt that they were obliged to take care of them and that no one else would be able to care for their children. This is evident by these parents siding with the psychoactive substance-abusing adolescents, protecting them and fighting for their rights in opposition to the community, family, a romantic partner and the siblings. These mothers never gave up on their children despite their children causing significant distress and refusing treatment. These findings are noted by Usher et al. (2007) as well.

#### **5.5. Parents' experience of their adolescents' changed behaviour**

Adolescents who abuse psychoactive substances present with changed behaviour from the behaviour their parents knew. These new behaviours are challenging for parents and they initially struggle to make sense of them. Some parents view the changed behaviour developmentally, in the sense that their children are changing because they are teenagers. However, as soon as they realise that the challenging behaviour is as a result of substance abuse, parents become devastated. Similar results have been reported in the literature (Swartbooi, 2013).

Firstly, parents were worried for the safety of their adolescent children because the adolescents would steal from the community and walk out at night in dangerous neighbourhoods. These parents were especially fearful of mob justice by the community as a response to their adolescents' conduct problems. In addition, parents sometimes worried about their own safety. They feared that the psychoactive substance-abusing adolescent would harm them and the other children in the family. This corroborates findings that report that adolescent psychoactive substance abuse threatens parents' safety and users' own lives (Masombuka, 2013; Swartbooi, 2013).

Psychoactive substance-abusing adolescents normally present with problematic behaviour at school, including truancy, poor school performance, strained relationships with teachers, and risk being caught in possession of illicit psychoactive substances. Worryingly, adolescents who were found in possession of psychoactive substances and those who tested positively with illicit psychoactive substance use were expelled from schools; consequently parents were worried about their children's future. Parents who had expected that their adolescent children would develop to be independent individuals had their hopes dashed. As a result of these behaviours, especially their children's academic performance, parents had to lower their expectations and the hopes they had for their adolescent children. These findings are supported by Usher et al. (2007).

In addition, parents experience a loss of the adolescent they knew and the child they wished to see growing up. Parents were distressed by the changed and problematic behaviour. Consequently, they longed for the child they knew before psychoactive substance use. Swarbooi (2013), also noted similar findings.

All the parents experienced significant barriers in communicating with their psychoactive substance-abusing adolescent children. Parents were frustrated as they could not engage their children, who refused to speak about their psychoactive substance use. This was difficult for parents as they felt shut out and they could not assist their children. In general, psychoactive substance-abusing adolescents were defensive when communicating with their parents. On the contrary, adolescents would speak about psychoactive substance use at a later stage when their parents are no longer upset with them

Lastly, the changed adolescent's challenging behaviour manifested in the form of conduct problems. Parents experienced a wide range of challenging conduct problems, particularly staying out late. Their children would come home later than the time they were allowed to. This presented major rule violations. Thus, this resulted in parents responding emotionally. Parents felt helpless because they could not control their psychoactive substance-abusing adolescent children and their children were pointedly challenging them. These findings were also observed by Groenewald and Bhana (2015, 2017).

## **5.6 The impact of adolescents' psychoactive substance use on interpersonal relationships**

The children's psychoactive substance use normally had a negative impact on their relationships with the community, family, parents and siblings. The challenges that were posed by the psychoactive substance-abusing adolescent caused tension, not only within the family, but also with those associated with the family. Parents had to mediate between other family members and the psychoactive substance-abusing adolescent because of the strained relationships between them. This extended beyond the family to the community. The family of the psychoactive substance-abusing adolescent was devalued in the eyes of the community and the family felt embarrassed. The conduct problems resulted in conflicted relationships between the family of the psychoactive substance-abusing adolescent and the community. Parents' relationship with other community members deteriorated. Consequently, the family of the psychoactive substance-abusing adolescent lost trust in their child. They could not leave their children alone or entrust them with important tasks. Parents and others were found to be hypervigilant and worried about their belongings. The foregoing findings are confirmed by Swartbooi (2013).

## **5.7 Recommendations**

There are few studies in South Africa focusing on those who are affected by adolescent psychoactive substance use. More studies are required in order to get rich information about the impact of adolescent substance abuse on others, including the family, community members, siblings and significant others. Most of the literature on this topic, particularly in South Africa, has focused on mothers. It would be important for future studies to explore fathers' experiences of taking care of psychoactive substance-abusing adolescents. Only female volunteers participated in the present study. It seems there is a difference, particularly in terms of tolerance, between male and female parents, where fathers would easily be frustrated and give up easily on their adolescent children. Fathers often refused to provide financial support for their psychoactive substance-abusing adolescent children. Exploration of this phenomenon would add value to the existing literature.

In terms of context, only one Australian study (Usher et al., 2007) compared results from a different context. In this study, there were no differences in terms of experiences between rural and urban populations. However, the role of the context has been well documented in South Africa. In South Africa, the context plays a major role in the extent and the impact of psychoactive substance use. Therefore, it would be vital to explore experiences of parents from different contexts. It is apparent that adolescent psychoactive substance use/abuse is causing significant distress to parents. Appropriate interventions to support them should be in place. The focus should not only be on those who are directly affected, but also those who are indirectly affected by psychoactive substance use.

## **5.8 Limitations of the study**

The study was based on responses from six participants and was limited to the Pretoria region, more specifically Mamelodi and Eersterus. Furthermore, only female participants, in other words mothers', experiences were explored. This means that the result of the study only applies to female caregivers. The study was also restricted to low-socio-economic communities. One should therefore be mindful of the context when applying the findings of the study.

## **5.9 Conclusion**

Parents report serious psychological and emotional strain due to their children's psychoactive substance use. Parents' experiences and responses were mostly complex, dissimilar and enacted differently by each participant. Parents' coping responses were influenced by personal factors, which were mostly associated with the parents' level of distress and their relationship with their substance-abusing adolescent children. Parents displayed a range of coping responses, i.e., engagement, tolerance and withdrawal (Orford *et al.*, 2010) and these were also deployed in divergent ways.

Overall, the findings of the present study corroborate the extant literature which shows that parents and families respond, and are affected by adolescent substance abuse, in diverse ways (Butler & Bauld, 2005; Groenewald & Bhana, 2015; 2016, 2017; Jackson *et al.*, 2007; Usher *et al.*, 2007). Adolescent psychoactive substance use tended to result in negative personal relationships with other family members and the community at large. The parents and extended family members are disempowered (i.e., financially, materially, emotionally and socially) by the substance abusers' behaviour (Groenewald & Bhana, 2017; Orford *et al.*, 2013).



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## 7. Appendices

### 7.1 Appendix 1: Interview schedule

1. What is your experience of being a parent of an adolescent who is abusing psychoactive substances?

*Probe:*

What age is your child?

How is it like to live with an adolescent who is abusing drugs/substances?

How has the behaviour of using or abusing substance by your adolescent impacted you?

Are there changes in the family as a result of this behaviour?

What support or help do you have in dealing with your child's behaviour?

2. What psychoactive substances or drug does your child use or abuse?

*Probe:*

At what age did your child use substances (alcohol and/or drugs)?

What knowledge do you have regarding the substance (s)/drug(s) that your child use or abuse?

How do you understand substance/drug abuse?



## 7.2 Appendix 2: Informed consent letter



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**Faculty of humanities**

**Department of psychology**

### **Dear participant**

You are kindly invited to participate in the study whose title is **Adolescent substance abuse: Experiences of parents**. The study is done as a fulfilment of Masters in Clinical Psychology. The study is conducted by Aluta Ngantweni under the supervision of Dr M. Makhubela. The aim of the research is to better understand the experiences of parents whose adolescents abuse psychoactive drugs. The outcome of the study may help in developing programs that can help parents whose adolescents are abusing psychoactive substances. Furthermore, research data may be useful for future research.

**Possible risks and discomforts:** The interview questions of the study are sensitive. You may stop answering questions if it happens that during the interview session you feel uncomfortable and continue when you want. If you feel that you need additional help with the discomforts caused during the interview; you will be referred to professionals who will help you.

**Benefits:** You will not be given any reward for participating in the study. However, the results of the study might help to better understand the experiences of adolescents who abuse psychoactive substances. Furthermore, in future, the results might help in programs designed for parents whose adolescents abuse psychoactive substances.

**Voluntary participation:** Your participation in the study is voluntary. You may leave anytime and no questions will be asked if you feel that you no longer want to participate in the study. Nothing will negatively impact on you if you decide to do so.

**Confidentiality:** The information gathered is confidential and your identity will remain anonymous. Your name in this informed consent is for the purpose of making you aware of your rights. Furthermore, pseudonym will be used so that your name will not be linked to the interview and results. The research information will be stored in a locked cabinet in the Department.

**Consent form**

The study has been described in a language that I can understand and I freely volunteer to participate. I understand that my identity will be kept anonymous. I had an opportunity to ask questions about the study and they have been answered. I understand that I may withdraw from the study without giving any reason and that this will not impact negatively to me in any way. I understand that the research material and audio data will be stored in the department of psychology for 15 years (office HSB 11-24) for reuse and archiving. During this period other researchers may also have access to the data for further use.

**Participants name** .....

**Participants signature**.....

**Date** .....

### 7.3 Appendix 3: Parent or guardian information and informed consent document

PICD 3

#### PARENT OR GUARDIAN INFORMATION & INFORMED CONSENT DOCUMENT

##### **Consent and assent:**

If there are children younger than 7 years in your study, the parents give consent on their behalf and you will need to adapt the information leaflet by substituting 'you' with 'your child'.

For children between 7 and 18 years, parents give consent for their child to participate in the study and the child gives assent. Adapt the form below for that purpose too. Both information leaflets and the consent /assent form have to be included with your application.

**TITLE OF STUDY:** Sub-study of 83/2017: Adolescent substance abuse: Parent's experiences

Dear Parent,

#### 1) INTRODUCTION

We invite you to participate in a research study. This information leaflet will help you to decide if you want to participate. Before you agree to take part you should fully understand what is involved. If you have any questions that this leaflet does not fully explain, please do not hesitate to ask the investigator or interviewer.

## **2) THE NATURE AND PURPOSE OF THIS STUDY**

The aim of this study is to determine shared experiences of parents who are taking care of adolescents who abuse psychoactive substance.

## **3) EXPLANATION OF PROCEDURES TO BE FOLLOWED**

This study involves interviews that will be audio recorded as part of the study of the personal experiences of parents who provide care to adolescents who abuse psychoactive substances. The interview will be held either at the University of Pretoria (Department of Psychology) in an appropriate room or at a place convenient to you. I will ask you questions about your personal experiences of taking care of an adolescent/s who abuses psychoactive substance/s. The one-on-one interview will be for approximately an hour.

## **4) RISK AND DISCOMFORT INVOLVED**

The content that the research intends to elicit is anticipated to be sensitive in nature. Consequently, you may stop answering if it happens that you are uncomfortable during the interview process and continue when you are comfortable. In the event that you are affected, you will be referred to the University of Pretoria's Itsoseng psychology clinic for debriefing.

**5) POSSIBLE BENEFITS OF THIS STUDY**

You will not be given any reward for participating in the study. However, the results of the study might help to better understand the personal experiences of parents of adolescents who abuse psychoactive substances.

**6) WHAT ARE YOUR RIGHTS AS A PARTICIPANT?**

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the interview without giving any reason. Your withdrawal will not affect you negatively in any way.

**7) HAS THE STUDY RECEIVED ETHICAL APPROVAL?**

This study has received written approval from the Research Ethics Committee of the Faculty of Humanities at the University of Pretoria [Reference number: 16280726 (GW20170706HS)], (012 420 4853) The study has also been approved by the University of Pretoria's Faculty of Health Sciences Research Ethics Committee (012 356 3085). The Ethics committee's task is to ensure that research participants are protected from harm.

**8) INFORMATION AND CONTACT PERSON**

The contact person for the study is Aluta Ngantweni. If you have any questions about the study please contact him on the following telephone numbers 073 4535626. Alternatively, you may contact my supervisor at following telephone numbers 012 420 2830.

## **9 COMPENSATION**

Your participation is voluntary. No compensation will be provided.

## **10 CONFIDENTIALITY**

All information that you give will be kept strictly confidential. Once we have analysed the information no one will be able to identify you. Because the interviews will be face-to-face, anonymity cannot be protected, as such pseudonyms will be used in the final dissertation to protect your rights and identity. Research reports and articles in scientific journals will not include any information that may identify you.

### **CONSENT TO PARTICIPATE IN THIS STUDY**

I confirm that the person asking my consent to take part in this study has told me about nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect me negatively in any way.

I have received a signed copy of this informed consent agreement.

Participant's name .....(Please print)

Participant's signature: ..... Date.....

Investigator's name .....(Please print)

Investigator's signature ..... Date.....

Witness's Name .....(Please print)

Witness's signature ..... Date.....

**VERBAL INFORMED CONSENT**

I, the undersigned, have read and have fully explained the participant information leaflet, which explains the nature, process, risks, discomforts and benefits of the study to the participant whom I have asked to participate in the study.

The participant indicates that s/he understands that the results of the study, including personal details regarding the interview will be anonymously processed into a research report. The participant indicates that s/he has had time to ask questions and has no objection to participate in the interview. S/he understands that there is no penalty should s/he wish to discontinue with the study. I hereby certify that the client has agreed to participate in this study.

Participant's Name .....(Please print)

Person seeking consent .....(Please print)

Signature .....Date.....

Witness's name.....(Please print)

Signature .....Date.....

**7.4 Appendix 4: Informed consent information for audio tapes**





**Faculty of Humanities**

**Department of Psychology**

An audio recording will be used during the interview in the study. Your identity will not be associated with the audio recording or transcript. The audio recording will be transcribed in order to get the accuracy of the information. The transcript of your audio recording may be produced as whole or part on the results of the study. Your identity will be kept anonymous in writing or presenting the results of the study by using pseudonyms.

The researcher has explained the term of use of the audio recording. By signing the consent form I am allowing the researcher to audio record the interview on this study and that other researchers may also have access to the data for further use.

**Participants name** .....

**Participants signature**.....

**Date** .....

I Aluta Ngantweni have explained this study to the participants and have sought his/her understanding of informed consent.

**Date**.....

**Place**.....

**Researcher's signature**.....

**Witness' name.....**

**Witness's signature.....**

**Date.....**

**7.5 Appendix 5: letter of invitation for participation**



UNIVERSITEIT VAN PRETORIA  
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**University of Pretoria**  
**Department of Psychology**

## **INVITATION TO PARTICIPATE IN A RESEARCH PROJECT**

Dear Madam/Sir

My name is Aluta Ngantweni, I am conducting a research as a requirement in completing Master's degree in Clinical Psychology. My research aims to describe person experience of parents' who take care of adolescents' who abuse psychoactive substances. I hereby invite you to participate in the study.

### *Purpose and the procedure of the study*

The research intends to determine and describe personal experiences of parents taking care of adolescents who abuse psychoactive substances. The research will conduct interviews as part of the study the personal experiences of parents who provide care to adolescents who abuse psychoactive substances. The interviews will be held either at the University of Pretoria (Department of psychology) in an appropriate room for interviews or at the participant's home if the participants invite the researcher. Findings from the study could provide valuable information and understanding about the experiences of parents whose adolescents abuse psychoactive substances.

### **Participation**

The following will be required from you should you choose to participate:

- If you are willing to participate please contact the researcher and suggest a time and a place convenient to you.
- You will be asked to give consent to participate in the study.
- You will be asked to participate in a one-on-one interview with the researcher for approximately an hour. The interview will be audio recorded.

### **Possible risks and discomforts**

The content that the research intends to elicit is anticipated to be sensitive in nature. Consequently, participants may stop answering if it happens that they are uncomfortable during the interview and continue when you are comfortable. In the case of the proposed study affected participants will be referred to the University of Pretoria's Itsoseng psychology clinic for debriefing at no cost to them. All the information gathered will be used for future research and will be safely stored for future research. Because the interviews will be face-to-face, anonymity cannot be protected, as such pseudonyms will be used in the final dissertation to protect the rights and identity of the participants. You will not be given any reward for participating in the study. However, the results of the study might help to better understand the experiences of adolescents who abuse psychoactive substances.

Please make use of the following contact details should you wish to participate in the study:

#### **Researcher**

Mr Aluta Ngantweni

University of Pretoria

Call: 073 453 5626

Email: alutangantweni@gmail.com

#### **Supervisor**

Dr M. Makhubela

University of Pretoria

Tell: 012 420 2830

Email: silas.makhubela@up.ac.za

## **7.6 Appendix 5: Ethics letter**

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 22 May 2002 and Expires 03/20/2022.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 03/14/2020.



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Faculty of Health Sciences Research Ethics Committee

10/10/2017

**Approval Certificate  
New Application**

**Ethics Reference No: 396/2017**

**Title:** Sub-study of 83/2017: Adolescent substance abuse: Parents' experiences

Dear Mr Aluta Ngantweni

The **New Application** as supported by documents specified in your cover letter dated 29/09/2017 for your research received on the 9/10/2017, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 10/10/2017.

Please note the following about your ethics approval:

- Ethics Approval is valid for 2 years
- Please remember to use your protocol number (**396/2017**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

**Ethics approval is subject to the following:**

- The ethics approval is conditional on the receipt of **6 monthly written Progress Reports**, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

A handwritten signature in black ink, appearing to read 'R Sommers'.

**Dr R Sommers**; MBChB; MMed (Int); MPharm, PhD  
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

*The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health).*

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