UNIVERSITY OF KWAZULU-NATAL

MOTHERS LIVED EXPERIENCES AND COPING RESPONSES TO ADOLESCENTS WITH SUBSTANCE ABUSE PROBLEMS: A PHENOMENOLOGICAL INQUIRY

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Table of Contents

iii

Declaration

Supervisor

As the candidate's Supervisor I agree to the submission of this thesis.

Signed: ………………………………………………….

Student

I Candice Rule Groenewald declare that

(i) The research reported in this thesis, except where otherwise indicated, is my original work.

(ii) This thesis has not been submitted for any degree or examination at any other university.

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1

Abstract

This thesis explored mothers' experiences of living with an adolescent who has a substance abuse problem; an under-researched topic of inquiry globally and especially in South Africa. Specifically, I was interested in 1) the stresses that the mothers faced as a result of the adolescents' substance abuse behaviours; 2) how the mothers' subjective wellbeing was impacted by these stresses; and 3) how the mothers coped with these stresses. To explore these issues, I adopted a qualitative phenomenological approach where five mother-adolescent pairs were invited to participate in 1:1 in-depth interviews using the life-grid (LG) interview approach. The mother-adolescent pairs were recruited from two adolescent substance abuse treatment facilities in KwaZulu-Natal, South Africa and were interviewed separately. Interpretative phenomenological analysis (IPA) was conducted on the data using Atlas ti software (versions 5.0 & 7.5.0). This thesis is presented in the form of five research papers. Paper 1 discusses the LG methodology that was used in this study. Paper 2 is concerned with the methodological challenges I encountered in using research diaries as a data gathering approach. Papers 3 and 4 each discusses the primary codes that emerged in my analysis. The mothers' 'experiences' code is discussed in Paper 3 which revealed the several stressful life events that the mothers endured as a result of the adolescents' substance abuse. These included adolescent misconduct and pilfering, family conflict, financial burdens and feelings of hopelessness, worry, self-blame guilt, shame and signs of depression. The 'coping' codes are discussed in Paper 4 which showed that mothers' used problem-focused and emotion-focused coping in varying combinations of withdrawing, tolerating and engaged coping responses. Understanding the stresses that mothers face and how mothers respond to adolescent substance abuse is imperative for the development of tailored support interventions for mothers required to cope with adolescent substance abuse. This study also evaluated how affected families are represented in three South African policy documents using the Family Impact Lens framework where it was found that these South African policies did not adequately support affected families. These findings are presented in Paper 5. Further implications and recommendations for policy makers, practitioners and researchers are discussed in each of the research papers and in Chapter 4 of this thesis.

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Chapter one: Background

Introduction

Adolescent substance misuse and abuse are complex public health concerns that are escalating worldwide (Schafer, 2011; Smith & Estefan, 2014). Although many adolescents do not move beyond experimentation (Usher, Jackson & O'Brien, 2005), surveillance data from the South African Community Epidemiology Network on Drug Use (SACENDU) shows that 20% (N=4485) of all patients admitted to treatment centres for substance abuse and addiction in 2014 alone were under the age of 20 in South Africa (Dada, 2015). Unlike adults, substance abusing adolescents turn to parents for continued support in dealing with the effects of substance abuse. In turn, the filial relationship demands that parents respond by helping and supporting the adolescent, regardless of the circumstances that they may have to confront in providing this assistance. It is in the nature of this symbiotic relationship that multiple complexities arise in relation to how parents manage and deal with the substance abusing adolescent.

This thesis is concerned with the lived experiences and coping responses of mothers of adolescent substance abusers, a topic that is currently under-researched globally and especially in South Africa. In this introductory chapter, I provide a statement of the rationale and aims of the study and discuss the literature related to mothers' experiences and coping responses to adolescent substance abuse.

Rationale: My focus on mothers

A large body of knowledge currently exists on the role of parenting in the development of adolescents (Henry & Kloep, 2012; Moretti, 2004; Moretti & Peled, 2004;) as well as the importance of certain parental styles and behaviours in the prevention and intervention of adolescent risk behaviours like substance misuse (Ackard et al., 2006; Baumrind, 1991; Gottfredson & Hussong, 2011; Luk et al., 2010; Martins et al., 2008; Miller-Day & Kam, 2010). Despite advances in our understanding of parenting and its influence on adolescent risk behaviours, we know little about how parents' lives are affected by adolescent substance abuse. There is limited insight into the lived experiences of affected parents[1], how they cope with the adolescent substance abuse and related behaviours and the support needs of affect parents (Usher et al., 2007).

While the initial focus of the study was on the experiences and perspectives of both mothers and fathers, only mothers expressed a willingness to participate in this study. Further, the family

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[1] Parents affected by adolescent substance abuse

circumstances of those willing to participate revealed a range of spousal arrangements which in itself may be significant in relation to the willingness of male partners to participate in the study and even the adolescent substance abuse, though these aspects did not form a focus of this study. While the mother-centred focus was thus not intentional, it was considered a significant finding as it reinforced the common gendered discourses which ascribe child-caring roles to women and holds mothers accountable when children behave badly (Butler & Bauld, 2005; Smith & Estefan, 2014).

Mothers are depicted as central figures in the wellbeing and functioning of the family (Smith & Estefan, 2014). The specific responsibility of child-rearing that is generally ascribed to women (Jackson & Mannix, 2004; Smith & Estefan, 2014) often becomes an intrinsic part of women's personal and social identities (Smith & Estefan, 2014). Thus when children behave badly, mothers are held accountable, principally by themselves and other family members, as the child's behaviour is judged according to a societal expectation of what is a 'good' mother or parenting approach and how a 'good' mother's child should behave (Liamputtong, 2006; also see Bhopal, 1998). In addition to the blame that many mothers experience, they are also required to cope with the negative sequelae associated with the adolescents' substance abuse (Jackson, Usher & O'Brien, 2007; Usher et al., 2005). This social blame and isolation lead mothers to suffer in silence and wear what Maushart (2006) refers to as the "mask of motherhood" to disguise the parenting difficulties they contend with. Given the socially ascribed role of ensuring the health and wellbeing of their offspring (Jackson & Mannix, 2004), this accountability weighs heavily on mothers and, for many, is the basis for non-disclosure when struggling with substance using adolescents (Butler & Bauld; Smith & Estefan, 2014). Non-disclosure certainly compromises the kind of support that mothers have available to them to help them cope with the psychosocial strain they experience as a result of the adolescent's substance abuse. Understanding the experiences and coping behaviours of mothers is therefore of utmost importance in promoting supportive interventions.

To provide a coherent perspective in describing and understanding affected mothers' experiences, the Stress-Strain-Coping-Support (SSCS) model developed by Orford Orford, Rigby, Tod, Miller, Bennett and Velleman (1992) in relation to understanding parental experiences of adolescent substance abuse was used. Given the evidence-base developed around this model and its usefulness in unpacking family members' experiences related to the stress and strain of a relative's substance use, it was adopted as an explanatory model to understand the mothers' experiences of adolescent substance abuse. The following section provides an overview of the SSCS literature pertaining to affected mothers' experiences. The aim of this section is to provide a conceptual understanding of how

mothers' lives are impacted by adolescent substance abuse as well as a prelude to the following chapters (papers).

Conceptual framework and literature

The Stress-Strain-Coping-Support (SSCS) model was developed and refined by Orford and colleagues over the last two decades (Orford et al., 1992; Orford et al., 1998; Orford et al., 2001; Orford et al., 2010a; Orford et al., 2013). In contrast to a pathology paradigm that views family members as causative agents, the SSCS model is sensitive to the severely stressful nature of a relative's (in this case the adolescent's) substance abuse and avoids placing blame on family members (in this case mothers) (Orford et al., 2013). Informed by traditional stress-coping models (such as Lazarus & Folkman, 1984), the SSCS model asserts that people may adopt different coping responses to stressful conditions, some of which may be more effective and have better health and wellbeing outcomes than others (Orford, Copello, Velleman, & Templeton, 2010). The model thus incorporates the notion of "being active in the face of adversity, of effective problem-solving, of being an agent in one's own destiny, of *not* being powerless" (Orford et al., 2010).

Elements of the SSCS model

The SSCS model recognises that the impact of a relative's substance abuse on the family is complex and intrinsically linked to the ways in which the affected family member (hereafter AFM) understands and copes with the relative's substance abuse (Orford et al., 2013). There are four elements to this model which describes the experiences of AFMs, namely: stress and strain (usually considered together), coping responses and social support. For the purposes of this thesis, each of these elements has been explored in relation to the existing literature on *affected mothers'* experiences and coping responses to adolescent substance use. Further descriptions of these elements are provided in the respective research papers. For example, research paper 3 specifically focuses on the concepts of stress and strain, while research paper 4 is concerned with coping and support.

Stress and strain

Research shows that experiences of stress and strain are inevitable for AFMs (Orford et al., 2013). Stress is experienced as a direct consequence of the relative's substance abuse and manifests in cognitive, emotional, physical, relational and economic strain. Local and international research highlights that mothers are required to deal with several challenges as a result of the adolescent's misconduct. These include victimisation and intimidation from the adolescent (Jackson & Mannix, 2003), disrupted parent-adolescent relationships (Hoeck & Van Hal, 2012; Jackson & Mannix, 2003; Usher et al., 2007), stressed family relationships (Choate, 2011; Jackson & Mannix, 2003; Jackson et

al., 2007; Usher et al., 2007) and financial strain due to the adolescent's pilfering and destruction of personal property as well as costs associated with the adolescents rehabilitation and related medical visits (Abrahams, 2009; Jackson & Mannix, 2003; Jackson et al., 2007; Mabusela, 1996; Masombuka, 2013; Usher et al., 2007). Given the central role played by mothers in caring for their children, it is not surprising that they often report feelings of hopelessness, worry, self-blame, humiliation, guilt, shame and signs of depression (Abrahams, 2009; Butler & Bauld, 2005; Jackson et al., 2007; Orford et al., 2013; Usher et al., 2007).

While local research on affected families' experiences is limited, the few studies show that South African families report heightened experiences of verbal and physical violence both as victims and perpetrators. One example is dramatically captured (Abrahams, 2009; Thesnaar, 2011) in the case of Ellen Pakkies, a South African mother who had murdered her drug-addicted son in response to the verbal and physical abuse she had experienced at the hands of her son (Thesnaar, 2011). The act of strangulation was the last resort for Ellen who reported that she had made several attempts to obtain protection from police and support from within her community but that the availability of support services was non-existent. Sadly, the anger, hopelessness, isolation and devastation that Ellen felt is not unique but resonates with the experiences of the mothers in the current study and other South African studies (Abrahams, 2009; Mabusela, 1996; Masombuka, 2013; Rebello, 2015; Fouten, Groenewald & Abrahams, *unpublished*). In their paper on parents experience of living with an adolescent drug abuser, Fouten et al., (*unpublished*) found that the parents had experienced different forms of emotional and physical intimidation and victimisation from their adolescents (Fouten et al., *unpublished*) which left them feeling hopeless and angry. In response to their hopelessness, many of the parents indicated that they had responded with aggression to their children while others consistently threatened to hurt the adolescent if s/he continues to use drugs (also see Abrahams, 2009).

Coping responses
The stresses that AFMs endure as a result of the relative's substance abuse prompt them to find appropriate ways to cope (Orford, Natera, Velleman, Copello, Bowie, Bradbury, et al., 2001; Orford et al., 2013). To allow appropriate comparisons to be made between the findings of this study and the literature, the complex nature of coping responses as well the focus on multiple coping strategies, Orford et al's definition of coping was adopted. Coping in this study, therefore, refers to the ways that the mothers responded to, or dealt with, the adolescents' substance abuse behaviours (Orford et al., 1992; Orford et al., 1998; Orford et al., 2001).

Orford et al. (2010a) indicate that coping in the context of substance abuse is an iterative process in which family members draw on several coping strategies in a trial and error fashion. In relation to parents specifically, research shows that they embrace more than one coping response to adolescent substance abuse (Butler & Bauld, 2005; Jackson & Mannix, 2003; Jackson et al., 2007; Usher et al., 2007). Usher et al. (2007) found that parents used multiple coping strategies such as observing the adolescent's behaviours, talking to the adolescent about his/her drug abuse and setting rules and punishments to limit the adolescent's drug abuse. As a last and desperate attempt to cope, the parents also indicated that they had become withdrawn from the adolescent which was also reported by Jackson et al. (2007) in their study on parents' experiences of adolescent substance abuse.

Earlier work by Butler and Bauld (2005) found that some parents initially went through a period of denial when they first became aware that their child was using drugs. However, they eventually sought assistance from support agencies to help them cope with the challenges they had been facing. Similarly, Jackson and Mannix's (2003) research shows that mothers initially struggled to accept that their child has a substance abuse problem. However once they moved through the denial period, they made use of other coping strategies such as restricting the child's freedom and strictly monitoring the child's personal environment (Jackson & Mannix, 2003).

Social support

Affected family members require good social support networks to help them cope with the stresses they face (Orford et al., 2010a; Orford et al., 2010b; Orford et al., 2013). In the SSCS model, social support comprises formal and informal networks in the form of emotional and material support as well as the provision of relevant information (Orford et al., 2010a). Reporting on two decades of qualitative work, Orford et al. (2010b) indicate that the quality of social support networks are not premised on the number of people that AFMs have in their social circles, but the kind of coping support that the relative receives from those people. Social support may further be compromised by the AFMs willingness or reluctance to seek support, both from formal structures and informal networks like friends and family. For some this reluctance is strongly related to their feelings of self-blame, shame or fears of being blamed by others (Abrahams, 2009; Butler and Bauld, 2005; Chaote, 2011; Orford et al., 2010b; Usher et al., 2007).

Orford et al. (2010b) found that AFMs value social support from other AFMs given that they are likely to share similar understandings and experiences. Affected family members also appreciate the provision of accurate information about the relative's substance abuse and process of recovery which was often achieved through professional sources (Orford et al., 2010b). Studies focussing specifically

on social support for affected parents have reported similar findings. Butler and Bauld's (2005) research showed that parents appreciated information on the kinds of drugs that their children were using as well as guidance on treatment options for the child. The parents reported that this information assisted them to understand and cope better with the child substance abuse (Butler & Bauld, 2005).

Many barriers to the availability and accessibility of services to support parents continue to exist (Orford et al., 2013). Chaote (2011) found that when parents of substance abusers were not able to obtain information about their child's addiction, they reported feeling "uninformed and helpless" (p. 1361). In some instances, formal support services are available but not easily accessible to parents or vice versa. As pointed out by Jackson and Mannix (2003), the availability of support services may not always translate into the applicability or quality of those services. In their study, the mothers expressed dissatisfaction with support structures they had available to them as some of the specialists responded to them unempathetically and at times experienced blame (Jackson &b Mannix, 2003). Similarly, Chaote (2011) reported that the parents often felt like the therapists minimized the child's substance abuse problems which restricted their ability to identify appropriate interventions (Chaote, 2011). Although limited, South African research presents similar findings. For example Fouten et al. (*unpublished*) found that parents felt unsupported when seeking assistance and protection from police services when their adolescents stole from them or became physically abusive.

In summary, the literature shows that parents and especially mothers experience significant distress when adolescents abuse substances. These stressful circumstances require mothers to find ways to cope, often with limited or no formal support. The aim of this study was thus to explore mothers' lived experiences and coping responses to adolescent substance abuse, an under-researched topic of inquiry in South Africa.

Study aims

The current study explored:

a) The stresses that the mothers faced as a result of the adolescents' substance abuse and the impact of these stresses on the mothers' subjective wellbeing; and

b) The mothers coping responses to the adolescents' substance abuse behaviours.

To meet these aims, I put forth three broad research questions to guide my investigation

a) What stresses and strain are experienced by the mothers in dealing with adolescent substance abuse (personal, cognitive-emotional, physical, filial, social and/or economic etc.)?

b) How do mothers of substance abusing adolescents manage the stresses they experience?

c) What kind of support do the mothers have available to them and what kind of support do they need?

Significance of my study

This study contributes to an under-researched topic of inquiry in South Africa and internationally. The majority of the South African studies have focused on the experiences of affected parents and have neglected to explore, in greater detail, how parents and especially mothers cope with the distress that they experience as a result of the adolescents' behaviours (see for example Abrahams, 2009; Mabusela, 1996; Masombuka, 2013; Rebello, 2015). While it is essential to explore affected mothers lived experience, it is equally important to examine the complexities associated with mothers' approaches to coping with adolescent substance use. This may have utility for both further research into how best to support mothers as well as for practitioners working with mothers in therapeutic contexts. Hence, using an interpretative lens, the current study unpacked, described and interpreted the lived experiences, coping responses and support needs of a purposive sample of South African mothers affected by substance abusing adolescents.

In a context where access to, and availability of, specialist treatment centres for adolescent substance abusers is limited, and the provision of coping support for families remains largely unavailable, parents are often required to cope with their distress on their own. This study seeks to contribute to knowledge production in a number of ways. First, its contextual descriptive and phenomenological depth is likely to contribute to local knowledge on how to better support South African parents to cope with adolescent substance abuse. Theoretically, this study focuses on parents, especially mothers' lived experiences and together with an exploration of the mother-adolescent relationship, seeks to develop a better understanding of the enactments and functions of their coping responses (*see Chapter 3*).

Despite the paucity of research, two South African case studies illustrate the importance of understanding the complexities around how parents cope with adolescent substance abuse. In these studies, researchers show that parents of adolescent substance abusers have used aggressive and highly confrontational coping responses to their children's behaviours (Fouten, Groenewald & Abrahams, *unpublished*; Thesnaar, 2011). This is perhaps best captured in the extreme case of Ellen

Pakkies, a South African mother who had murdered her drug addicted son in response to the verbal and physical abuse she had experienced at the hands of her son (Thesnaar, 2011). She reported that the act of strangulation was a last resort and that she had made several failed attempts to obtain police protection from her son. In her community, the availability of support services was non-existent. In a similar vein, the parents in Fouten et al.'s (*unpublished*) study reported having had used, or considered, physical forms of violence where some also made 'fatal promises' to kill the adolescents if they do not stop using drugs soon. For the parents in their study, as in the case of Ellen Pakkies, different forms of emotional and physical intimidation and victimisation from their adolescents were reported, and it was the parents' feelings of hopelessness and anger that produced these 'fatal promises' (Fouten et al., *unpublished*). What these studies emphasise is the importance of understanding parents (mothers') coping experiences within the complexity of local contexts. Parents who are appropriately supported to deal with their own distress will be able to attend to the needs of their children more effectively. As Gombosi (1998, p. 251) asserts: "I don't think we can speak about what parents need from professionals until we recognize that parents are the most important resource a child has".

Second, this study emphasises the importance of national policies that recognise the support needs of affected parents, and families. While policies might not in themselves be appropriate platforms to provide implementation strategies for family-focused interventions, they serve to provide direction about the most effective ways of dealing with adolescent substance use within the context of families. The knowledge that emerges from an analysis of the complex issues related to the experiences and coping responses of parents and adolescents, as well as factors that might enhance treatment outcomes, forms an important part of the objectives of this study.

Third, this study will utilise an innovative methodological approach to the study of sensitive topics. The idiographic, phenomenological epistemology (IP) analyst is concerned with more than the breath of themes but is rather interested in uncovering the depth and complexities of people's experiences. Within this framework, this study will use the novel qualitative methodology of the Lifegrid (LG) in addition to research diaries to explore the mothers' experiences. The LG is especially valuable as it assists in raising sensitive issues within the context of a space-time memory continuum in non-threatening way. This is especially useful in substance use research where events and the associated emotional and cognitive content are lost because of time and the need to not actively revisit periods in time that are especially stressful (for e.g., discovering your son or daughter is abusing substances) (*see Chapter 2*). The use of the LG has not been employed previously in substance use research in South Africa. This study thus highlights the importance of using innovative methodologies when doing

sensitive research that asks participants to discuss personal and painful experiences. It further shows that in doing sensitive research where the phenomenon itself may be rare, the quality of the information provided, through appropriate data collection techniques, helps alleviate the need for enrolling a larger number of participants.

Structure of the thesis

This thesis has been compiled by way of academic research papers as outlined in the table below. Chapter two comprises two research papers discussing the methodological approaches adopted in this study. Paper 1 discusses the lifegrid (LG) methodology that was used in this study. Paper 2 is concerned with the methodological challenges that I encountered in using research diaries as a data gathering approach. Chapter three discusses the findings of my study in the form of two research papers. Paper 3 relates to the impact of adolescent substance abuse on the lives of mothers. Paper 4 presents the mothers' coping responses to adolescent substance abuse. Each paper will discuss the relevant literature and theories that underpin them and will offer research and practice implications. Chapter four presents a discussion of the findings and draws together the theoretical, research and practical implications of the study as a whole where I present the policy implications of this work in the form of a policy review article (Paper 5). Chapter five concludes this thesis with recommendations for further research.

Table 1: Structure of the thesis

Chapters	Paper title	Paper focus	Status
Chapter one	Introduction	Introduction	N/A
Chapter two	Paper 1: Using the Lifegrid in Qualitative Interviews With Parents and Substance Abusing Adolescents	Methodology	Published in: FQS
	Paper 2: "I was so lazy to write": Reflections on using research diaries in 'sensitive' research with mothers and adolescents.		In preparation for: Journal of Qualitative Research

Chapter three	Paper 3: "It was bad; it was bad to see my child doing this": Mothers experiences of living with an adolescent who abuses substances.	Results	Published in: International Journal of Mental Health and Addiction
	Paper 4: Mothers experiences of coping with an adolescent with substance abuse problems.		Under review in: Journal of Child and Family Studies.
Chapter four	Discussion and implications	Study implications	
	Paper 5: Substance abuse and the family: the South African policy context.	Policy analysis	Accepted in: Drugs: education, prevention and policy.
Chapter five	Conclusion	Conclusion and recommendation	N/A

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Chapter 2: Research methodology

Overview

Researchers seeking to explore sensitive topics are required to identify appropriate philosophies and methodologies that will encourage open expression in a non-threatening way and generate information-rich data. This section outlines the qualitative methodology and research tools that I employed to explore the mothers' lived experiences and coping responses to adolescent substance abuse. The interpretative phenomenological approach, data collection and study processes, participant characteristics and data analysis framework will now be presented. This will be followed by the two research papers that describe, in more detail, the study processes and research tools that were used in this study.

Qualitative research paradigm: Interpretative phenomenology

Interpretative phenomenological analysis (IPA) is concerned with the participants' lived experiences, subjective reflections, and perspectives (Reid, Flowers, Larkin, 2005; Smith, 2008; Smith & Osborn, 2007). IPA is underpinned by two theoretical traditions, namely phenomenology and hermeneutics (Houston & Mullan-Jensen, 2011; Smith & Osborn, 2007). Phenomenology is the descriptive study of human experience which emphasises an in-depth exploration of phenomena "from the point of view of the participants" (Smith & Osborn, 2007, p. 53). Hermeneutics, on the other hand, is concerned with interpreting the participants' experiences, behaviours or perspectives by exploring the intentions and meaning attached to of them (Houston & Mullan-Jensen, 2011). Moreover, Houston & Mullan-Jensen (2007) explain that hermeneutic researchers try to understand the connections between "the context of action and its interpretation" (p. 269).

Given that IPA is primarily concerned with making sense of the way people think, feel and talk about certain experiences, it has been closely linked to cognitive psychology (Smith, 2008). However, Smith and Osborn (2007) and Smith (2008) argue that while mainstream cognitive psychology utilise largely quantitative and experimental approaches to exploring phenomena, IPA uses qualitative methodologies to facilitate in-depth exploration. The IPA analyst is, therefore, committed to uncovering the connections between the participant's narrative, emotional state and ways of thinking (Smith & Osborn, 2007). The person's narrative is viewed from a multidimensional perspective, exploring not only cognitive and affective aspects but also the verbal and expressive characteristics of

the narrative (Smith & Osborn, 2007). Exploring these connections is a complex and iterative process especially because people often struggle to express themselves or, for some reason, may hesitate to disclose certain information (Smith & Osborn, 2007). The analysis process, therefore, becomes important as meaning is essential to IPA.

Participant recruitment

The families who participated in this study were recruited from two substance abuse rehabilitation centres that accommodate adolescents in the province of KwaZulu-Natal, South Africa. At the time of the study, the adolescents had been admitted to treatment for no less than four weeks. The adolescents and their mothers were recruited and informed of the study by a child and youth care social worker (CYCW) who worked at the treatment centres. Once the families expressed interest in the study and allowed the CYCW to provide their personal contact details to me, I contacted them to set up an initial meeting to discuss the study and what would be expected of them. After this meeting, they were invited to participate (separately) in a series of qualitative data gathering activities which involved individual interviews, diary keeping, diary interviews, and life-grid interviews.

Five mother-adolescent pairs were recruited for this study. While I was specifically interested in the mothers' experiences, the adolescents were also interviewed about their substance abuse behaviours to provide the context in which the mothers' experiences and coping responses should be understood in relation to the adolescent's substance abuse and rehabilitation. The adolescent participants included four boys and one girl. The adolescents were asked about the development of their substance abuse problems and how they ended up in the treatment centre. The information gathered from these adolescents are summarised in Table 2 below. This section does not include any of the findings pertaining to the mothers' experiences and coping responses. Rather it shapes the context. Pseudonyms are used throughout this thesis and all identifiable information has been anonymised, including the names of the treatment centres and places mentioned by the adolescents. The mothers were required to complete consent forms for themselves and the adolescents. Once the mothers provided consent for the adolescents to participate in the study, the adolescents completed assent forms. The participants were also informed that the information will be used in study reports and research papers but that personal or any identifying information will be anonymised using pseudonyms and thus remains confidential. Furthermore, the participants were also required to provide consent for the interviews to be audio recorded. Ethical clearance was provided by the Humanities & Social Sciences Research Ethics Committee of the University of KwaZulu-Natal (protocol reference number: HSS/0980/13D). Study clearance was also obtained from both the treatment centres that participated in the study.

It is important to note here that participant recruitment in this study was extremely challenging. Like Hoeck and van Hal (2012, p. 2), I found that "family members of drug-abusing young people were difficult to reach and to persuade to participate" in the study. The recruitment difficulties I faced were largely influenced by the sensitive and traumatic nature of the research topic, especially because many of the families who were seeking treatment for the adolescent had not been able to process their experiences and were thus not ready or willing to participate. My recruitment was also constrained by the treatment centres' confidentiality regulations. The families were recruited by the child and youth care workers (CYCWs) and I only had access to the families once they had provided written consent to CYCWs to give their contact details to me. A total of nine families initially provided consent to the CYCWs for me to contact them. However once I had contacted the families, four were not able or willing to participate.

For two of the families, their participation had been compromised by the adolescents leaving the treatment centres prior to the completion of the treatment program which made it difficult to get hold of them as they ended up ignoring my calls. Although two of the mothers initially expressed interest in participating in the study, we were unable to establish a meeting time (given that they live and/or work outside of Durban). The mothers had also seemed to have lost interest in participating in the study. Based on the details provided to me by the CYCWs, all of the adolescents in these families were males between 16 and 17 years of age. Two of the boys were admitted for whoonga abuse and the other two for cannabis abuse. Furthermore, as is evident in my research, the fathers' voices of the adolescents who participated in this study are not represented in this thesis. Some of the main reasons for this were that the fathers' were either not involved in the adolescents' lives, were not interested in participating in the study or were deceased.

Adol. aliases and gender (M/F)	Mothers' aliases	Age of adol[2]	Adol. residing with mother (current)	Adol. academic profile	Adol. substances of choice	Duration of adol. substance abuse	Quantity of substance used in last year by adol.	Adol. methods to finance own substance abuse	Rehabilitation history of adol.	Adol. reason for seeking treatment
Terrance (M)	Ursula	15	Yes	Repeated grade 7 and spent first quarter of grade 9 in rehab. He has also been expelled from school for possession of drugs and alcohol	Whoonga[3] and cannabis	Approximately 4 years	Smoked whoonga daily and between 40 and 60 joints a day, depending on how much money he has available.	Stealing parents' personal goods and money Robbing people and break-ins	Readmitted four times	"I have seen that I am putting my life in a risk because anything now can happen to me. Because I have seen one of my friends got= he, he died. And one of my friends… when my parents came to visit me the first time they told me that my friend got shot with five bullets. Ay I've seen that, because that, that friend I was going with him, it was like we were brothers! Everywhere I was with him and everywhere he was with me. And he got shot with five bullets (.) Ay, and I've seen that there was something like telling me now… like no I have to stop doing this thing now!"

[2] At time of interview

[3] A highly addictive powder that is mixed with cannabis and smoked in the form of a joint. It consists of low grade heroine and other additives like rat poison (http://www.kznhealth.gov.za/mental/Whoonga.pdf).

Winston (M)	Jacky	17	Yes	Repeated grade 8 and grade 10.	Cannabis	Approximately 2 years	Smoked cannabis daily and at least 5 joints a day	Combining friends' money Use allowance Working on taxi's	First time in treatment	Caught by police for possession of illicit drugs and ordered to complete a rehabilitation programme by the courts
Clint (M)	Erica	15	Yes	Repeated grade 8 twice and dropped out of school. He has also been expelled from school for possession of illicit drugs and alcohol	Whoonga and cannabis	Approximately 3 years	Smoked whoonga daily and between 30 and 80 joints a day, depending on how much money he has available.	Robberies and house break-ins Stealing families' personal goods and money	First time in treatment	"Because I see that if I was still using I'll become jailed and I'll never go back to school and I'll [have a] bad future. Yeah, and I want to change! Yeah, I want to live yeah I want to live, yes!"
Brandon (M)	Anne	15	Yes	Failed some subjects in the previous semester. Often skipped school and was writing exams	Cannabis [and possibly whoonga[4]]	Approximately 2 years	Smoked at least three days in the school week and two joints a day.	Used allowance Used money that was meant for school related activities	First time in treatment	Mother found out that he was using cannabis through blood tests and enrolled him into the rehabilitation programme.

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[4] Adolescent not sure about what he was smoking.

				during his rehabilitation				Combining money with friends'		
Abigail (F)	Margaret	16	Yes	Has not repeated a grade. However has been expelled from school for drinking alcohol at school.	Alcohol	About 1 year	Was not drinking daily, but binge drinking weekends	Stole money from mothers employer Alcohol was often free available at social gatherings/parties	First time in treatment	Ordered to complete a rehabilitation programme by school in order to be able to write final exams.

Data collection

Given the sparse literature around the experiences of affected mothers and the need to take account of disclosure of painful and personal experiences by them, I was prompted to think about information gathering tools that will accommodate and bring to the fore the complexity of the mothers' experiences and at the same time facilitate discussions in a non-threatening and sensitive way. I further recognised that my ability to obtain data that is information rich was intrinsically dependent on the participants' abilities and willingness to tell their stories. For these reasons, it was decided to incorporate two information gathering tools to facilitate discussions: the Lifegrid (LG) (Berney & Blane, 1997; Parry, Thomson & Fowkes, 1999) which extended this study beyond the traditional individual interview and research diaries (Alaszewski, 2006). The rationale behind choosing these tools was to engage the participants and encourage them to tell their stories in novel and sensitive ways.

Three of the adolescents were interviewed at the treatment centres while two adolescents were interviewed at their homes, as per their request. Three of the mothers were interviewed at their homes and two of the mothers were initially interviewed at the treatment centres. Follow-up interviews with one of these mothers were conducted at the school that the mother had been teaching at.

The next sections overview the two data collection tools I used in this study namely the lifegrid and research diaries.

Overview of the LG approach

The LG is a chart tool used to collect information about selected aspects (significant life events) of participants' lives (Richardson, Ong, Sim, & Corbett, 2009). These aspects are closely related to the research questions of the study and can include topics such as family life, friends and social relationships, place of residence, occupation and so forth. In my study, these significant life events were associated with the development of the adolescents' substance abuse, the impact of the adolescents' substance abuse on the mother and mother-adolescent relationship, and the mothers' coping responses to the adolescents' substance abuse behaviours. The LG interview was also facilitated by a semi-structured interview guide (see Appendix B) that asked questions related to the significant life events mentioned earlier. Separate interview schedules were developed for the mothers and adolescents, although questions pertaining to the development of the adolescent's substance abuse and the adolescents' behaviour during substance abuse formed part of both the interview schedules. Specifically, the adolescents' interview guide focussed on the development of the adolescents' substance abuse, the adolescents' substance abuse behaviours, the impact of the adolescents'

substance abuse on the mother-adolescent relationship, and reasons for seeking treatment. The mothers' questions were directed at their experiences of living with an adolescent with a substance abuse problem, dealing with the adolescents' behaviours, coping with the challenges that they faced as a result of the adolescents' substance abuse and their own support needs.

The completed LG allowed me to determine how and when the mothers' lives had been affected by the adolescents' substance abuse and to unpack how the mothers managed these challenges. A detailed discussion on the utility of the LG is provided in paper 1 (Groenewald & Bhana, 2015).

Overview of research diaries

Diaries can be used as the primary source of research data or as adjunct to interviews (Bray, 2007; Nicholl, 2010). In my study, research diaries were proposed to compliment and enrich the information that was collected during the LG interviews. The aim of the diary was for the participants (mothers and adolescents) to have a space to reflect on any experiences or changes that might have occurred between our meeting dates which we would have discussed during the interviews. I was also aware that the sensitivity of some of the research topics (such as how the adolescent's substance abuse affected their daily lives) could unlock emotions and cognitions that the mothers might not be ready to discuss during the interviews. Thus, where needed, some of the participants were asked to write about these difficult issues and informed that we will discuss these (should they be comfortable to do so) in the next interview. The mothers were also asked to write about the ways they had coped with (responded to) the adolescents' substance abuse behaviours as a way to 'prepare' for upcoming discussions. I thus adopted an unstructured diary approach using prompts to encourage the participants' inputs and reflections (Nicholl, 2010). The participants were asked to keep the diaries for about three to four weeks; depending on their availability for subsequent interviews where we intended to discuss their contributions and the diaries were collected. In this study, only two of the mothers used their diaries while none of the adolescents used their diaries. The reader is referred to paper 2 for more detail on the role of research diaries in this study.

Data analysis

Complementary to the interpretative phenomenological epistemology of this study, an ideographic interpretative phenomenological analytic (IPA) approach was adopted (Smith & Osborn, 2007; Smith, 2008). This means that each of the mothers' interviews was treated as unique cases and thus initially analysed individually until I achieved "some degree of closure or gestalt" (Smith, 2008, p. 41). This was done in order to acquire a detailed and subjective understanding of each of the mothers'

experiences and to avoid a generic comparison of the themes. Following this, I conducted a cross-case analysis of the themes where I was interested in the convergences and divergences of the emergent themes using Atlas ti software (5.0 and 7.5.0) (Smith, 2008; Smith & Osborn, 2007). The IPA processes (Smith and Osborn, 2007) that were followed in this study is explained below.

Stage one: Getting to know the transcripts and identifying themes
All of the audios were transcribed verbatim. The transcripts were read and reread one at a time and a free textual analysis (Smith and Osborn, 2007) was conducted. The aim of this step was to become familiar with the mothers' accounts and to start commenting on some of the initial extracts and themes that emerged. Once I was familiar with the transcripts, I started the analysis process using Atlas ti software. The aim of this step was to analyse each transcript independently and develop an initial set of emerging themes.

Stage two: Developing clusters and code lists
This step involved searching for connections between the initial emerging themes by developing clusters of themes (codes) (Smith & Osborn, 2007). This part of the analysis was iterative and involved a back and forth process of checking and rechecking whether the codes adequately summarise the participants' accounts (Smith & Osborn, 2007). Case-specific themes or code lists were then developed using Atlas ti software. Smith and Osborn (2007, p. 72) argue that during this phase, "certain themes may be dropped: those which neither fit well in the emerging structure nor are very rich in evidence within the transcript". The intention was to compile a cluster of subthemes that best describes the codes and to either drop the themes that were repetitive and at times unnecessary, or merge themes. For example in my study, I identified a theme of 'friends and family' when a mother made reference to these persons. However, in the current study was not interested in *whether* the mothers had friends but rather the mother's social support structure. The 'friends and family' theme, that referred to the availability of friends, was dropped and a new theme was created under social support.

Stage three: Reviewing other cases
Once I developed a table of themes for the first case, I followed the same processes for each of the other cases in my study. Although I could have used the table of themes I developed during the analysis of the first case to direct the analysis of the subsequent cases, Smith (2008) suggests that it is important for PhD candidates to conduct a detailed analysis of each of the cases. In my study, where experience is understood as subjective and embedded within past and present life events, the idiographic approach becomes important.

Stage four: Reviewing other cases and tabulating superordinate themes (code families)
Steps 1-3 were followed for all of the cases. Once the transcripts of all the cases had been through the interpretative process described above, code families (superordinate themes) were developed (Smith & Osborn, 2007). The code families in this study were: "Family background", "Adolescents' substance abuse", "Mothers' experiences", and "Coping responses".

The next part of this chapter presents two research papers which describe, in more detail, the data collection tools (LG approach and research diaries) that formed part of this study.

Research papers citations

Groenewald, C. & Bhana, A. (2015). Using the Lifegrid in Qualitative Interviews With Parents and Substance Abusing Adolescents. *FQS* 16(3).

Groenewald, C. "I was so lazy to write": Reflections on using research diaries in 'sensitive' research with mothers and adolescents. (In preparation for the Journal of Qualitative Research)

Paper 1 (published)

Using the Lifegrid in Qualitative Interviews With Parents and Substance Abusing Adolescents

Candice Groenewald & Arvin Bhana

Abstract

This article describes the usability of a retrospective data collection tool called the lifegrid (LG) in exploring adolescent substance abuse from the perspective of mothers and their substance abusing adolescent. We found the LG approach useful in building researcher-participant rapport, enhancing participants' depth and range of recall, and cross-referencing and comparing of events between participant accounts. These advantages are discussed in detail in this article while we also unpack some of the challenges we faced in using the LG approach in our qualitative study.

Keywords: retrospective study; qualitative; lifegrid; adolescents; substance abuse

Introduction

In qualitative studies, researchers often rely on retrospective data collection methodologies to investigate people's experiences. When the inquiry involves sensitive issues and requires participants to voice descriptive and emotional stories, the use of appropriately sensitive data gathering methodologies is imperative (Guenette & Marshall, 2009). In this article, we describe the utility of using a retrospective data collection tool called the lifegrid (LG) in exploring adolescent substance abuse from the perspective of mothers and their substance abusing adolescent children (hereafter referred to adolescents).

We decided to use the LG approach to complement the case-study research methodology as it has proved useful in previous studies in engaging with participants, supporting them to talk about their experiences and collecting retrospective information (Wilson, Cunningham-Burley, Bancroft, Backett-Milburn & Masters, 2007). In addition, parents' lives and parent-adolescent relationships are profoundly impacted by adolescent substance abuse given the various psychosocial and economic stresses associated with adolescent substance abuse (see for example Jackson & Mannix, 2003; Jackson, Usher & O'Brien, 2007; Usher, Jackson & O'Brien, 2007; Wegner, Arend, Bassadien, Bismath & Cros, 2014). In light of this, we surmised that the trauma that adolescents and parents may have experienced could influence the kind of information they are willing to recall. In order to facilitate recall of these events, we thought to use a data collection tool that will lend itself to recall and discussion of sensitive events.

In the following sections, we provide an overview of the LG and the methodology of our study. We will then discuss our findings in relation to the usefulness of the LG. Finally, we outline some of the practical challenges we faced in using the LG and provide some ideas on how to overcome these challenges.

About the Lifegrid

The LG is a tool used to construct a visual chronological framework of a person's life (Richardson, Ong, Sim & Corbett, 2009; Wilson et al., 2007). It generally takes a chart-like structure with several rows and columns, where the rows usually represent the person's life in years (each row is a particular year) and the columns represent significant life events (Wilson et al., 2007). The significant life events are selected aspects of the participants' lives that the researcher wishes to explore. These aspects are closely related to the research questions of the study and can include topics such as family life, friends and social relationships, place of residence, occupation and so forth. For example, the LG was used to explore the life course of cancer patients using selected aspects such as "personal life events," "education, lifestyle," "residence," "occupation" and "other" (Novogradec, 2009, p.2). A completed LG then allows the researcher to assess how the participant's life has changed over a certain period of time and when these changes occurred. When the LG is used to facilitate qualitative data gathering, it further allows the researchers to unpack how the participants experienced and managed these changes. [4]

The lifegrid tool was developed to address research concerns related to participant recall and validity in retrospective medical studies (Bell, 2005). It has traditionally been used to collect quantitative data on the development of illnesses, pain and health behaviors (Berney & Blane, 1997; Parry, Thomson & Fowkes, 1999; Richardson et al., 2009). The core focus of the earlier studies (see Berney & Blane, 1997; Blane, 1996) was to use the LG to improve the accuracy of the recalled information (Bell, 2005). Berney and Blane's (1997) study assessed the accuracy of older participants' recall of events that stretched over 50 years prior to the interview. The events they focused on were "external" events like wars and strikes, "family" events such as births and marriages, residential events and occupational events (Berney & Blane, 1997). When compared to the historical records of the participants, the findings indicated that residential and occupational information, like fathers' occupation or residential address, was recalled with more accuracy than detailed information on childhood illnesses and dietary requirements (Berney & Blane, 1997).

Recent studies suggest that the potential of the LG extends beyond collecting quantitative data and improving recall accuracy. Research by Bell (2005), Harrison, Veeck and Gentry (2011), Novogradec (2009) and Wilson et al. (2007) show the usefulness of the LG to facilitate participant engagement in qualitative interviews. Bell (2005, p.53) however warns that while the LG may improve the quality of

the data collected, it could also restrict "the extent to which interviewees feel able to discuss events not covered by the life-grid." In our study, the LG was therefore used to compliment the semi-structured individual interviews conducted with the participants and support them to talk about their experiences.

Methodology

Summary of formative work

The LG approach was piloted on one mother and her adolescent son who had been admitted to a substance abuse treatment center for cannabis abuse (n=2). The aim of the pilot was to determine how, and in what time sequence, we needed to conduct the LG interview with the study participants. Additionally, we were interested in identifying some of the initial significant life event categories that we could include on the LG table for the overall study. Once identified, these categories were included on the LG table as examples of significant events and additional category options were provided should the participants identify other significant events.

Both the mother and the adolescent were interviewed at their home on three occasions over a period of one month. The first interview was structured to build rapport between the researcher and the participant and included questions about the participant's family, school or work background, social relationships and relationship with each other (parent-child relationship). Given that we wanted to use the LG during the second interview, we also included questions that focused on when certain experiences occurred and when relationships changed. For example, we asked the mother: "When do you think your son started using drugs?" and "When did you start noticing a change in your relationship with your son?"

Pilot interview with mother participant: Outcomes

Following the first interview with the mother, the interviewer (first author) partially filled in the LG with some of the information that was gathered during the first interview. The partially completed LG was then co-completed during the second interview. In this case, the mother indicated that she would like the interviewer to continue filling in the grid on her behalf as she did not want to do the actual writing but was comfortable to do the activity.

The second interview with the mother commenced with a recap of the LG. This helped ensure that the mother was primed to discuss her experiences in greater depth using the partially completed LG as a guide. The LG approach proved to be useful during this interview both as a means to document information chronologically, and facilitating the recall of events and experiences. It is our experience

that the LG was well received, appeared to be easily understood by the mother, and allowed us to ask sensitive questions (described in the findings).

Pilot interview with adolescent participant: Outcomes

The pilot continued with the adolescent participant. Given the favorable outcomes of the interviews with the mother, we decided to incorporate the LG during the first interview with the adolescent to determine how he will respond to a blank LG. The same processes were followed as with the mother: the LG was introduced and explained to the adolescent and was then co-completed. This approach was found to be acceptable because, as in the case of his mother, the LG appeared to have been understood and easy to co-complete. Practically, using the LG in this way also allowed the interviewer to check and therefore capture the information more accurately without having to correct it in a next interview. The findings section of this article will provide a more detailed account of the usefulness of the LG in facilitating participant recall, discussing sensitive topics, and cross checking and validating participant information.

Study participants

Given the various challenges associated with the accuracy of participant recall in retrospective studies, researchers have since argued that the inclusion of collateral informants are useful for increasing confidence (some would say reliability) in subject self-report (Amodeo & Griffin, 2009). We, therefore, interviewed five parent-adolescent pairs, each consisting of one mother and her adolescent who had been admitted to a substance abuse treatment center. Discussions centered on issues pertaining to the development of the adolescent substance abuse, experiences of parenting an adolescent substance abuser and being an adolescent substance abuser (respectively) and the strategies parents employed to cope with the adolescent's substance abuse. We were interested in the participants' current experiences and feelings associated with the adolescent's substance abuse, as well as their recollections of the past and how this might have contributed to the way they currently feel.

Each participant was interviewed once using the LG method and the information gathered during the LG interview was discussed in greater detail. Where needed, each participant's LG was used to facilitate these additional discussions. Scheduling of the interviews was also dependent on the availability of the participants. The mothers and adolescents were interviewed separately and confidentiality was strictly adhered to. This meant that none of the information discussed with the mother was shared with the child and vice versa. Separate interview schedules were developed for the mothers and adolescents, although questions pertaining to the development of the adolescent's

substance abuse, parent-adolescent relationships, and parental coping strategies for the adolescent's substance abuse formed part of both the interview schedules. This data formed the basis of interviews on the second occasion using the LG.

Study processes

Following Bell (2005) and Wilson et al.'s (2007) examples, an A3 landscape sheet of paper to map the interview with the mothers and their adolescents children was used. The adolescents' LG comprised eleven columns by roughly 30 rows, depending on the age of the participant. The mothers' LG was eleven columns by about 50 rows. Extra rows were provided in order to have enough space should there be more than one significant event per year to document. In using the LG we were interested in when significant events occurred and how the participants experienced these significant events. We considered events significant when they provided us with information on the development of the child's substance abuse, the effects of the child's substance abuse on his/her well-being, and the effects of the child's substance abuse on the mother and the family as a whole. For example, one of the questions we asked the mothers was: "when did you first become aware of your child's substance abuse?" with follow-up questions such as "tell me about how you felt when your child told you that he was using drugs?," "when did you start feeling this way," and "how did you deal with it (a particular challenge)?

The participants generally requested that the interviewer completes the LG. Although this was not planned, it ensured that "completing the grid did not interrupt the flow of the interview" (Bell, 2005, p.56). Participants were then able to engage with the questions and provide responses without being concerned about issues such as spelling and whether they are doing it right.

Given that a blank lifegrid could prove to be daunting to participants with complex narratives (Wilson et al., 2007), we decided to introduce the participants to the LG in the first interview indicating that we would return to it during the course of our meetings. The interviewer explained that the LG will be used during the interview to document particular issues as they emerge. It was also made clear that there are no right or wrong answers and that the information that will be written is fully dependent on what will be discussed during the interview. Lastly, it was made clear to participants that their respective LGs will not be shown to one another as to ensure that confidentiality is respected.

Findings

Drawing on extracts from our interviews, this section will discuss our findings on the usefulness of the LG in relation to the following themes: Building rapport, Enhancing depth and range of recall and

Cross-referencing and comparing of events. Each of these themes will be discussed in turn followed by a discussion on some of the challenges that we encountered and how we resolved these.

In this article, our interpretations of the themes are illustrated using extracts. In these quotations, square brackets contain material provided by us for clarification. Ellipsis points "(...)" indicate that the participants' thoughts have trailed off and uppercase letters are used to illustrate emphasis. A pause is illustrated by "(.)" and interruptions are indicated by "=."

Building rapport

We found the LG useful to establish interviewer-participant rapport and "breaking the ice" (Wilson et al., 2007, p.140; see also Harrison et al., 2011, and Parry et al., 1999). Following general introductory questions such as "tell me about yourself," the interviewer used probing questions focusing on where and when the participants were born, where they are currently residing, residential movements, academic performance (for adolescents) and occupation (for adults). The interviewer wrote this information onto the LG and the participant checked to see if it was documented accurately. In line with findings presented by Harrison et al. (2011, p.221) the co-completion of the LG facilitated the interviewer-participant relationship as it could be perceived as "a team working together to complete a common task, much like two strangers collaborating to complete a jigsaw puzzle." Wilson et al. (2007) add that the practical completion of the LG averts the need for continuous eye contact which can further put participants at ease, especially when sensitive issues are discussed (also see Harrison et al., 2011). Additionally, Sheridan, Chamberlain, and Dupuis (2011) indicates that in using graphic elicitation methods like the LG, the interviewer and participant reciprocally engage in the research which could encourage the participant to become aware of his/her own agency (see also Kesby, 2000).

Enhancing depth and range of recall

The LG proved an effective approach in encouraging participants to provide detailed accounts of their experiences. While the LG was initially completed in a chronological fashion using the biographical information, it was flexible enough to allow participants to move between significant events when discussing their experiences.

> "Researcher: Is that when you went to formal school like big school? Cause that's when you went to grade
>
> Interviewee: grade 1.

31

Researcher: Uhm, did anything big happen for you during that time? Did anything happen at home, with your family?

Interviewee: [silence] no. I am confused now. I forget in here that my granny died!

Researcher: Oh the year your granny died?

Interviewee: Yes

Researcher: So your granny died somewhere?

Interviewee: Yeah

Researcher: How old do you think you were?

Interviewee: Eight or nine that time" (Winston, 15 years, cannabis abuser). [20]

Similarly, Abigail, a 16-year-old girl who had been referred to the treatment center for her harmful alcohol use, was able to control the discussion and talk about her experiences as she remembered them. In this way, she was not restricted by a rigidly structured interview approach which may have prevented her from sharing her story as openly as she has. In telling the interviewer about her drinking patterns she is reminded of a particular event that she considers significant that had occurred in the previous year, but had forgotten to tell the interviewer about it.

"Researcher: Okay I see, so then tell me about the next time you drank again.

Interviewee: Yah, after exams, HEY! I forgot something, I'm sorry, I'm sorry! Now we are going very back!

Researcher: Oh Glory! Reverse. Let's go back. Are we going back to last year?

Interviewee: Our last paper, me and my friends were at [a park]. So we buy [vodka], we buy a six-pack, a six-pack of [ciders]. Yah those are the 3 things we bought and we go chill at the park.

Researcher: How many of you were there?

Interviewee: Five.

Researcher: You were five with a bottle of [Vodka], a six-pack of [ciders]

Interviewee: No a six-pack of [a particular brand of ciders] and a six-pack of [another particular brand of ciders]. And we drink the six-packs first. Okay Jess, one of my friends, she didn't drink much. She only drank the six-pack she didn't drink the Vodka. So we decided okay let's drink the Vodka. Now we in [the park] the worst place to [be]! Anyway, we didn't think of that at the time. So we drinking and uhm [Laughter]

Researcher: Oh goodness, what did you do?

Interviewee: No, I didn't do anything wrong, I just passed out and the police van came to fetch me and parents were called" (Abigail, 16-year-old, alcohol abuser).

This flexibility of the LG is apparent in the way that it allowed the conversation to go back and forth between dates and/or significant events. This was useful as associated events trigger memories that might not have been remembered. This further allowed the interviewer and participant to document particular events and discuss them in detail later in the interview or in a follow-up interview. This is particularly important for sensitive research such as the current study as it allows the participants the space to pause or return to certain issues when they are ready to discuss those (Wilson et al., 2007). This was also a key finding in timeline research conducted by Sheridan et al. (2011) on fatness and weight loss. In this way, the LG also acts as a reminder to the interviewer about the significant issues s/he wishes to discuss in detail which "provides direction to the interview when needed (Harrison et al., 2011, p.222). For example in the first extract below, Winston talks about the supportive and comforting relationship he felt he had with his cousin before his drug abuse. This conversation soon turned very emotional for him and the interviewer decided to change the focus of that discussion and asked him to comment on the support he received at the treatment center.

> "Researcher: So is that = what did you feel that time?
>
> Interviewee: I felt like I never wanted to talk about it. But you see me and my small cousin we use to talk about it.
>
> Researcher: =Yeah
>
> Interviewee: = we use to talk about our stories cause me and him we almost like the same you see [emotional]
>
> Researcher: I see, so how much younger is than you?
>
> Interviewee: He's in grade 9 now.
>
> Researcher: So you guys are, almost ... you close [in age]
>
> Interviewee: Yeah we close [crying]
>
> Researcher: So you had someone that you could speak to but it was a younger cousin?
>
> Interviewee: Yeah.
>
> Researcher: Is that why you actually enjoyed being at [treatment center] because you had that space to=
>
> Interviewee: =talk to someone yeah" (Winston, 15 years, cannabis abuser).

Later in the conversation, the interviewer was able to ask Winston about his relationship with cousin again.

> "Interviewee: I never use to feel it [abusing cannabis] was wrong.
>
> Researcher: Never felt it was wrong while you were smoking?

Interviewee: No

Researcher: But you felt it was wrong when other people, when this boy was with you?

Interviewee: Yeah, only when my cousin was with me.

Researcher: So why is that? Why do you think you felt?

Interviewee: No, because I felt, I know me and him were going through the same thing. Now I don't want him to be like me! So I was trying to show him that there= no I'm not in bad stuff and you mustn't do that there!

Researcher: Yeah, so you feel that you wanted to be a role model for him?

Interviewee: Yeah

Researcher: [pause] so this seems to be like difficult for you again, to speak about, especially this particular topic.

Interviewee: I don't know, because when I was drinking ... I never want to show him that I was still at it, I wanted to show him the good way, but I was still at it.

Researcher: And then talking about it now, makes you feel ...

Interviewee: Makes me feel bad" (Winston, 15 years, cannabis abuser).

Furthermore, while some researchers might argue that the information collected in LG interviews can be elicited in conventional questioning, we found the LG useful in encouraging the participants to tell their stories in a less confronting and more innovative way (Sheridan et al., 2011; Wilson et al., 2007). Wilson et al. (2007) point out that conventional interviewing have the potential to be boring and repetitive. The LG, they argue, was useful in their work to discuss sensitive issues without confronting participants with a long list of personal questions (Wilson et al., 2007.). Sheridan et al. (2011) further add that timeline interviews can represent an "aide-memoire, focusing attention beyond what is possible through talk alone, thus becoming not only a piece of data in its own right but a vehicle through which further data were produced" (p.554). In this regard, it is our experience that the LG itself represented the lives of the participants during the interviews in such a way that it became the object of discussion rather than the parents' experiences. This physical focus on the LG might have encouraged the participants to tell their stories more openly as they are perhaps indirectly reflecting on their lives, emotions, and experiences through the LG.

Cross-referencing and comparing events

The LG is usually completed by one participant at a time (see for example Berney & Blane, 2003; Harrison et al., 2011; Novogradec, 2009; Richardson et al., 2009; Wilson et al., 2007), although studies have used the LG with couples who completed it together (Bell, 2005). We used the LG with

adolescent-parent pairs in which the adolescents and parents completed separate LGs. This allowed us to compare the adolescent and parent's accounts of similar events. In instances where the adolescent or the mother neglect to discuss a significant event (like parents' divorce, death, admission to substance abuse treatment centers, etc.) the interviewer was able to pick this up and discuss it with the other. This was at times a challenging activity as it required the interviewer to probe for significant events that were not mentioned without making the participant aware that she received this information from either the mother or child (bridging confidentiality). The extract below highlights the complexity, and usefulness, of cross-referencing in our study. Jacky, who is the mother of Winston, told the interviewer on a previous occasion that during his drug abuse Winston had left home for a while to stay with his brother. For us, this was significant as his brother was a cocaine user at that time and we were interested in whether living with his brother encouraged his drug use.

"Researcher: Okay. And you were still with your mommy during that year you never moved anywhere, or visit anybody?

Interviewee: No.

Researcher: Going to visit too?

Interviewee: I don't, only use to go visit my family there, the ones the ones that are in [place], yeah only them

Researcher: And how [were] things with your brother during this time

Interviewee: My brother, he never use to stay here

Researcher: Here, but did you see him at all?

Interviewee: Yeah, he used to come see us.

Researcher: Yeah, and did go visit him at all?

Interviewee: Yeah I use to go visit him cause I use to see his son, cause his son always, his son just use to like me ...

Researcher: Yeah

Interviewee: Yeah use to visit his son.

Researcher: That so cute ...

Interviewee: Then I use to visit his son.

Researcher: Big uncle ... so but you never, you just went visit him but you never use to stay there or anything

Interviewee: I use to stay there but I use to come back home yeah.

Researcher: You came back home. So how long did you used to stay there?

Interviewee: It's about 3 months" (Winston, 15 years, cannabis abuser).

In a similar instance, Margaret, the mother of Abigail, indicated that she only became aware that Abigail had used alcohol hazardously once she was caught drinking at school and consequently referred to the treatment center. However, Abigail's narrative reads differently and indicates that her mother had been aware of her prior drinking habits. She explained that after she had gone drinking with her friends in the park, she consumed so much alcohol that she "was knocked out. I don't know what happened! The police came [and] parents were called."

"Researcher: So they call the parents to come get the children, so your mother comes in and what does she do?

Interviewee: My mother was in the car and my guardian that comes to stay here kicked and slapped me to wake me up, but I wouldn't wake up.

Researcher: You wouldn't wake up?

Interviewee: No, and they got me into the car. They got me home, I had a bath, and I woke up the following morning, not feeling so good.

Researcher: And what happened with you and your mom?

Interviewee: She was quite angry with me. Very, very angry with me. That's when she realized that I=

Researcher: You drink?

Interviewee: I drink, but then she thought I stopped, not knowing that I didn't actually. And yes she was angry with me for a few days but then after me apologizing and saying 'I'm sorry I didn't mean to disappoint you' she forgave me.

Researcher: Yes, but were you sorry?

Interviewee: Yes I was sorry. That was an embarrassment" (Abigail, 16 year old, alcohol abuser).

One possible reason why Abigail's mother did not tell the interviewer about this occasion was that she, like Abigail, might have been too embarrassed by Abigail's behavior. What this finding highlights is the significance of cross-referencing and the usefulness of the LG interview in facilitating this process. In the same way, the LG allowed us to identify the silences in the participant pairs' accounts; i.e. what the mothers identify as significant compared to what the child does not (and vice versa). Moreover, the LG allowed for a visual cross-referencing of life events where the interviewer was able to probe for the participant's perception of the interrelatedness of certain life events (Harrison et al., 2011).

"Researcher: Okay.

Interviewee: I was living at my mother's home.

Researcher: Oh I see. Were your mother and father still together?

Interviewee: Yeah

Researcher: But he [father] was at the farm and you were this side?

Interviewee: Yes and then when they get married that time I was starting to use drug

Researcher: I see ... Oh I see when they got married?

Interviewee: Yes.

Researcher: Do you think that there's, is there ... okay ... so why-why is, why during that time when they got married that you started using drugs?

Interviewee: Hmm (.) mam I didn't start= it didn't really start when they married. I started when they ... after [they got] married.

Researcher: After marriage?

Interviewee: Yeah.

Researcher: Okay. And did it have anything to do with the fact that they got married?

Interviewee: Uhm, no mam.

Researcher: No ... not for you?

Interviewee: No" (Ben, 15 years, whoonga[5] user).

This reflection offered us further insights that extend beyond simply reviewing the time-related associations between the life-events, which could be misinterpreted. For example, should this cross-referencing not have taken place, the researchers could have assumed an association between Ben's drug use and his parents' marriage.

Practical Challenges and Possible Solutions

We found the LG to be a flexible research tool that is useful in enhancing our understanding of participant's experiences by facilitating discussion, building rapport and allowing cross-referencing of life events and comparisons between participants' accounts. However, the LG approach is not without limitations. One limitation of retrospective research, in general, is related to the accuracy and reliability of the information provided by the participants. Harrison et al. (2011) propose that "we have no way of evaluating to what extent the memories approximated a true rendering of the experiences of these participants" (p.223). Richardson et al. (2009) have also commented on this debate between realism and constructionism and has argued for a middle-ground or pragmatic perspective. Richardson et al. (ibid.) suggest that recall and reconstruction are interrelated concepts and that in qualitative research, the accuracy of the recalled information is less important than

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5 Woonga is a highly addictive powder that is mixed with cannabis and smoked. It is consists of low grade heroine and other hazardous additives like rat poison (http://www.kznhealth.gov.za/mental/Whoonga.pdf [Accessed: date]).

meaning and experience. In our study we were not only interested in when life events occurred, but also the subjective experiences and meanings of these life events, and how these events influenced and changed the lives of the participants. Given our focus on experiences (and with concerns pertaining to recall in the back of our minds) we decided to interview the mothers and adolescents while the adolescent was completing his/her treatment at the rehabilitation centers. It is our experience that this facilitated recall as the participants were reflecting on current and fairly recent experiences.

Furthermore researching sensitive issues, like those discussed in our study, is a challenging task which required us to identify methodologies that are appropriately sensitive while at the same time facilitative. Using the literature as our guide (see for example Butler & Bauld, 2005; Usher et al., 2007), we understood that talking about the adolescent's substance abuse would be a difficult task for both the mothers and the adolescents (especially to a "stranger"). In this regard, we were cognizant of the possibility of selective recall where participants are unable (or perhaps unwilling) to recall certain events, or show selective recall bias in favor of what is "easier" to discuss. Studies show that individuals have the tendency to forget information that they perceive self-threatening (for full discussions on these issues, please refer to Green, Sedikides & Gregg, 2007; Saunders, 2012). We, therefore, recognized that participant recall, which was essential to obtain data that is information rich in our study, was intrinsically dependent on our participants' abilities and willingness to tell their stories. As put forth by Brown and Reavy (2014) recall operates as a shared activity and in our study the LG acted as a quasi-neutral stimulus to the participants memories that accommodated the complexities of recall and facilitated discussions in a non-threatening and sensitive way and extended the study beyond the traditional one-on-one (1:1) interview.

Some of the practical challenges (and solutions) we encountered with the LG are also important to note here. Initially, the interviewer used a semi-structured interview guide that posed questions chronologically which, as discussed earlier, did not appropriately lend itself to the conversational and the non-linear way in which the participants recalled their experiences. It is our experience that a formative phase helps allay anxieties about the tool, but also serves to prime the participant in identifying key questions and life events categories, such as relationships, school, work etc. that will be discussed in the LG interview. It might also be useful to identify possible life-events from the literature and incorporate these in the LG interview. In some instances, the participants thought that the LG was a way for the interviewer to document aspects of the participants' lives rather than an activity to be co-completed by the participants and the interviewer. Once this was brought to the attention of the interviewer, she was able to explain in as much detail as needed that the LG is a way to facilitate discussions. It is, therefore, useful for researchers to introduce the LG in such a way that the participants are not distracted by the notion of providing the "right answer" but are comfortable to discuss their experiences.

When using the LG with participant pairs (collateral informants) it is important for researchers to be careful not to "take sides" when cross-referencing and comparing events. In our study, we respected that the participants' accounts reflected their subjective experiences and perspectives. We certainly recognized the significance of the participants' silences and selective recall as it tells us something about the significance of particular experiences. In cross-referencing or comparing events between the participant pairs we were less interested in whose accounts were "right" or "wrong." Rather we found the LG useful in that it allowed us to use relevant information obtained from one participant (f.e., the adolescent) to probe for more detail from the other participant (f.e., the parent). This afforded us an opportunity to gain a more informed understanding of the participants' experiences and perspectives.

A further challenge relates to simultaneously conducting and analyzing the LG interviews. Given the fluidity of the participants' conversations, it is important for the interviewer to continually verbally note the dates (in days, months or years) that they are referring to when discussing the life events during the interview. In our study, for example, the interviewer sometimes neglected to record time and date sequences which may conflate events in the coding of the transcripts. This is especially imperative for researchers who are interested in tracking changes in life-events and experiences.

Conclusion

This article describes the utility of the LG in qualitative inquiries. We found the LG approach useful in helping explore the breadth and depth of events as we were not only interested in when significant events occurred but also the participants' experiences of, and changes in, these selected areas of their lives. While the LG worked well in our study, it is advisable that researchers conduct a formative phase to establish key questions and life event categories so as to ensure that their research questions are appropriately addressed. The LG as a tool and approach will be particularly valuable to qualitative researchers who are interested in retrospectively exploring sensitive emotional events in the development of adolescent risk behaviors.

Acknowledgments

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Paper 2 (in preparation)

"I was so lazy to write": Reflections on using research diaries in 'sensitive' research with mothers and adolescents

Candice Groenewald

Abstract

This paper is a commentary on the research diary approach where the author reflects on her experiences of using this methodology in research on sensitive issues with adolescents and their mothers. While studies have identified research diaries as useful tools to gain insights into sensitive issues, in this article the author describes the difficulties she faced in using research diaries. The author describes her challenges face according four main themes: a) onerousness, b) vulnerability and facing reality, c) literacy and self-expression, and d) drop-out. The findings of this article hold implications for researchers who are interested in using research diaries to explore sensitive issues with adolescents and mothers. Understanding the challenges associated with diary research allows researchers to make important decisions about whether and how to use diaries to collect information-rich data.

Keywords: diaries, challenges, sensitive research, mothers, adolescents, qualitative

Introduction

Qualitative researchers seeking to explore sensitive topics are required to identify appropriate methodologies that will encourage open expression in a non-threatening way (Gerrish, 2011; Guenette & Marshal, 2009). In this article, I reflect on my own experiences of using research diaries with adolescents and their mothers in a phenomenological investigation on mothers' experiences and coping responses to adolescent substance abuse. While data collected through research diaries can offer the researcher additional insights into the subjective, emotional and private realm of participants' experiences, in this article I will draw on my experiences and the available literature to describe the challenges I faced in using research diaries in my study. As a prelude, I will first present an overview of the use of diaries in sensitive research, followed by a description of how I used diaries in my study. I then interrogate the utility of research diaries in the current study by describing the challenges I encountered in using this methodology and also reflect on my experiences of why the diary approach did not work in my study.

Research diaries and 'sensitive research'

The notion of 'sensitivity' is a debated issue amongst qualitative researchers. While it is quite possible for any inquiry to be sensitive (Lee & Renzetti, 1990), 'sensitive topics' refer to inquiries that have the potential to produce participant distress such as anger, fear, sadness or anxiety (Cowles, 1988; Lee & Renzetti, 1990). For some, sensitive research is also related to specific topics like death and bereavement, mental health, abortion or HIV (Elmir, Schmeid, Jackson, & Wilkes, 2011). The current study was sensitive as it involved mothers telling about their lived experiences of coping with the challenges they endured as a result of the adolescent's substance abuse which is generally an extremely stressful experience for mothers (see Jackson & Mannix, 2003; Jackson, Usher & O'brien, 2007; Usher, Jackson & O'brien, 2007; Wegner, Arend, Bassadien, Bismath & Cros, 2014). In light of this, I surmised that mothers may find it difficult to talk about some of the more sensitive and traumatic experiences. I, therefore, identified two complimentary data collection sources to facilitate in-depth discussion and reflections: the life-grid and diaries (see Groenewald & Bhana, 2015a for a detailed discussion on how the life-grid was used in this study).

Research diaries have become popular data collection instruments in qualitative studies. Specifically, these studies have focused on healthcare research such as patients' experiences of pain and surgery recovery (Clarke & Iphofen, 2006; Day & Thatcher, 2009; Furness & Garrud, 2010; Harvey, 2011; Jacelon & Imperio, 2005; Keleher & Verrinder, 2003; Stone, Shiffman, Schwartz, Broderick & Hufford, 2003) as well as educational research to promote teacher development (Borg, 2001; O'Connell & Dyment, 2011; Engin, 2011). There has thus been a growing interest in the recording of individuals' experiences and perspectives, in close proximity to when they occur (Tennen, Affleck & Armeli, 2005). By virtue of their increased use, the value of research diaries in facilitating insights into sensitive issues and how participants experience and make meaning of their experiences are emphasised in many studies (Alaszewski, 2006; Day & Thatcher, 2009; Nicholl, 2010).

Diaries have been identified as useful information gathering sources (Bray, 2007; Jacelon & Imperio, 2005; Nicholl, 2010) as it provides participants with a sense of privacy to express their emotions and experiences more freely (Bolger, Davis & Rafeali, 2003; Boserman, 2009). This freedom and privacy is particularly important when studying sensitive topics as it could facilitate more open expressions of certain details that participants may be uncomfortable to discuss with the researcher directly. When participants fully engage with diaries, their writings could tell the researcher about intimate thoughts, perspectives, and attitudes and when these diaries are kept for longer periods of time, the researcher may also be able to assess how the participants' experiences have changed (Harvey, 2011; Travers, 2011).

However, diary research is not without limitations. Boddy and Smith (2006) for example indicate that diaries place demands on participants, like physically completing the diary, which compromise their motivation to participate in such studies. Day and Thatcher (2009) add that the depth of the participants' entries may also vary which Hayman, Wilkes and Jackson (2012) attribute to participants' concerns of feeling exposed and a lack of confidence in their own writing abilities.

Nevertheless, given the stressful nature of mothers' experiences when adolescents abuse substances, diaries were considered an appropriately sensitive tool to compliment my study. Travers (2011) adds that diaries may allow researchers to explore, in more detail, the "specific ways in which stress occurs and affects the individual and how stress and coping interrelate" (p. 206).

Research diaries in the current study

The study on which this paper is based was interested in understanding how mothers' lives are affected when the adolescent has a substance abuse problem. Research shows that mothers' lives (and parents' in general) are profoundly impacted by adolescent substance abuse given the economic and psychosocial stresses that parents are required to cope with (see for example Jackson & Mannix, 2003; Jackson, Usher & O'brien, 2007; Usher, Jackson & O'brien, 2007; Wegner, Arend, Bassadien, Bismath & Cros, 2014).

Diaries can be used as the primary source of research data or adjunct to interviews (Nicholl, 2010; Bray, 2007). In my study, I intended to use research diaries to compliment and enrich the information that was collected during the qualitative interviews. The participants were provided with an A5 hardcover book and a pen and the activity of diary keeping was explained to each participant in detail. I adopted an unstructured diary approach using prompts to encourage the participants' inputs and reflections (Nicholl, 2010). The participants were asked to keep the diaries for about three to four weeks; depending on their availability for subsequent interviews where we intended to discuss their contributions and I collected the diaries.

With the mother participants, the diaries were used to support the mothers to tell me about those personal and emotionally sensitive experiences that they were not able or willing to discuss during the LG interviews. The first formal interview that I conducted with the mothers focused on their experiences of finding out about the adolescents' substance abuse which was embedded with emotional narratives. Given this emotional experience, which was likely to unlock other emotions and cognitions, the mothers were asked to document the thoughts and feelings they experienced in the week following this interview. The mothers were also asked to write about the ways they had coped

with (responded to) the adolescents' substance abuse behaviours as a way to 'prepare' for our next discussions.

Although the primary focus of my study was on the mothers' experiences, I used the research diaries with the adolescents to provide them with a private space to talk about the development of their substance abuse and their conduct while they were abusing substances more freely (Bolger, Davis & Rafeali, 2003). Two of the adolescents found it difficult to open up to me during this first interview, especially when asked about their conduct while using drugs. These adolescents were then asked to write about these issues in their diaries and were informed that we will discuss these issues in a later interview. All the adolescents, like the mothers, were also requested to document the feelings and thoughts they had experienced in the week following the first interview.

The next section of this paper will describe the challenges I encountered in using diaries. I will also reflect on the reasons why the diary approach did not work in my study.

Results: Challenges associated with using research diaries

Onerousness

Although valuable, the literature identifies some limitations in using diaries in research. One of the common limitations noted relates to the onerousness of keeping diaries (Nicholl, 2008; 2010). Bolger et al. (2003) for example indicate that "in order to obtain reliable and valid data, diary studies must achieve a level of participant commitment and dedication rarely required in other types of research studies" (p. 591-592). In the current study, many of the participants indicated that "I haven't even started writing in my book yet" (Jacky) given their busy schedules. One of the mothers indicated that she does not feel comfortable (literate enough) to express herself in a written format. Four of the five mothers were full-time employed and were required to take care of other family members (children, siblings or partners) in addition to the emotional distress they were experiencing as a result of the adolescent's substance abuse (Groenewald & Bhana, 2015b). Similarly, some of the adolescent participants explained that they were too "busy" to complete the diaries given the various classes and daily activities they were required to participate in at the treatment centre. Another adolescent indicated that he felt "sick" (as a result of their detoxification and possibly withdrawal) and was not able to write in his diary. Completing the diary was thus perceived by the mothers and adolescents as a time-consuming 'task' which was also a key finding in research conducted by Nicholl (2010) with mothers on caring for children with complex needs.

Vulnerability and facing reality

The sensitivity and complexity of the research topic could also have contributed to the participants' reluctance to complete their diaries. One of the key findings of my study was that the mothers experienced significant emotional distress as a consequence of the adolescents' substance abuse (Groenewald & Bhana, 2015b). While all of the mothers felt comfortable to talk to me about their experiences and in fact reported that this assisted them in dealing with their adolescents' substance abuse, they might not have been emotionally ready to document their personal experiences reflexively on paper. Keeping a diary, or journaling, requires the writer to critically confront, through in-depth reflection, the topic that is being written about (Kotsokalis, 2008). This was particularly true in my study where I had intended to use research diaries to provide the participants a space to reflect on issues that might not have been adequately discussed during the interviews. However, it became apparent that most of the participants, both the adolescents and mothers, were not ready to confront their experiences at the time of the study. Illustrative of this is Jacky's account of why she could not write in her diary:

> Interviewer: Was there anything that is still out for you, anything you can talk more about?
>
> Jacky: Not really (.) I haven't even started writing in my book yet!
>
> Interviewer: Is there any reason that you feel you haven't or you are just not sure? (.)
>
> Jacky: No, not= I haven't written in the book yet because I am just thinking that If I'm gonna say anything good about him he is going to see in the book. So yeah, I have written in pieces of paper and towards the last week, I will write it on the book
>
> Interviewer: Okay
>
> Jacky: I don't want him to see it now what I am writing.

Jacky's account reveals that, although she had given it some thought, her participation in the diary exercise was muddied by her distrust in the recent positive changes she had seen in her son's behaviour. In stating that she does not "want him to see what [she] is writing" Jacky displays her fears that her son could hurt her again, and also that she is not ready to forgive him despite the changes she had noticed in his behaviour. Harvey (2011) points out that diaries are generally perceived as an intimate confession, which for Jacky appeared to be a challenging exercise. Instead, she indicated that she felt more comfortable to write on pieces of paper and input these 'confessional pieces' later when she is emotionally ready to do so. However, she never inputted these pieces of paper to her diary. Rather she diverted in her diary and spoke about the impact of drugs on the community with no mention of her experiences of parenting an adolescent with a drug abuse problem.

Literacy and self-expression

The participants' willingness and abilities to express themselves during the interviews also reflected their participation in the diary exercise. Although our conversations about 'how the adolescents' behaviours affected them' were difficult for all of the mothers, some of the mothers appeared to find it more challenging than others. For example, Anne, who often referred to our interview meetings as 'counselling' was more expressive during her initial interview and offered information regarding her emotions. She started our sessions by indicating "I'm not well, it seems as if someone stabbed me in my heart and I can't take it! I really can't!" and continued disclosing information about her emotions and experiences throughout the first interview. Anne was the only mother who used her diary to talk about her experiences according to the 'trigger' words we had decided on during our interviews. Building rapport with Ursula, on the other hand, took more time. Ursula was initially reluctant to share her experiences on her own and often only responded to the questions that were asked. She did not use her diary and also did not return the unused diary to me.

Another limitation of research diaries that is often mentioned in the literature is that a lack of literacy skills and self-expression compromises the participant's ability to respond meaningfully (Harvey, 2011; Hayman, Wilkes & Jackson, 2012; Jacelon & Imperio, 2005; Nicholl, 2010). None of the adolescents used their diaries or returned their empty diaries to me. Most of the adolescents who participated in the study reported that their academic performance had declined since they started using drugs which could have contributed to their reluctance [lack of confidence in their writing abilities] to write in their diaries. These insecurities were further illustrated in the adolescents' requests for me to do the writing during the lifegrid interviews (see Groenewald & Bhana, 2015a). While all of the mothers also indicated that I should fill in the grid during the lifegrid interviews, only one of the mothers, Margaret, indicated that she could not read or write well and was therefore not comfortable to use her diary.

Drop out

Participant attrition or withdrawal from the study after the adolescents had completed their rehabilitation programmes presented a further challenge. The adolescents who did not use their diaries during the 'interview period' (between their fourth week and seventh week of treatment) were asked if they were willing to keep the diary for an additional two weeks to document their feelings and experiences related to their own substance abuse and related behaviours. Although some of them agreed, it was difficult to contact the adolescents following their treatment. While the treatment centre served as a convenient point of access to meet the adolescents and their mothers, this was less so once they had completed their treatment as my attempts to reach them were unsuccessful. In order to

prevent the participants from feeling coerced into using their diaries, only two attempts were made to contact each family.

Discussion

Four primary reasons for participants' non-participation in the diary exercise were discussed namely the onerousness of diary keeping, participants' vulnerability, difficulties with literacy and self-expression, and participant drop-out. For the adolescent participants, their literacy and the onerousness of completing the diaries seemed to have influenced their non-completion of the diaries. Although diaries have been used successfully in studies with drug users, Boserman's (2009) research was conducted with a young adult, educated sample who was not admitted to treatment at the time of her research. In the current study, the adolescents were admitted to a treatment facility where they were required to participate in several workshops and daily activities which for some included school work and writing exams. It is thus important for future researchers to consider the various factors that may influence the participants' abilities to provide useful data through research diaries. A more structured approach to 'training' the participants on using diaries could also have encouraged their participation. Although I had verbally explained to the participants how they should use the dairy and provided them with detailed guidelines (verbally and written) about what to talk about in the diary, Nicholl (2010) asserts that structured written guidelines on how to use the diary need to be left with the participants as well.

In addition to the potential onerousness of keeping the diary, the sensitivity of the research topic contributed to the mothers' poor use of the diaries. The sensitivity of this research is revealed in that the mothers experienced several psychosocial stresses including feelings of hopelessness, self-blame, worry and symptoms of depression produced by the adolescents' misconduct and pilfering behaviours (Groenewald & Bhana, 2015b). While the mothers who participated in the study showed appreciation for the chance to verbally tell their (untold) stories, retelling and confronting these experiences a second time through the diaries would have been intolerable. Pennebaker and Segal (1999) argue that writing promotes the creation of meaning for the writer and it is perhaps this confrontation with their unwanted realities that prohibited the mothers' engagement with their diaries.

Additionally, the literature shows that in telling their stories participants relive their traumatic personal experiences which may produce further emotional distress (Bahn & Weatherill, 2012; Dickson-Swift, James, Kippe, & Liamputtong, 2007; Gerrish, 2011; Lee & Renzetti, 1990; Shaw, 2003). It is important for researchers to consider how the sensitivity of the research topic would influence the participants' willingness and abilities to participate in the diary exercise. In the current

study, the lifegrid interview approach was suitable as it encouraged in-depth discussions on sensitive topics, related to the mothers experiences of living with, and coping with the adolescents' substance abuse behaviours, in a non-threatening way, and at a pace that the mothers were comfortable with (Groenewald & Bhana, 2015a; Groenewald & Bhana, 2015b). Furthermore, Jacky's worry that her son would be able to access her diary information also conveys concerns pertaining to privacy and confidentiality. Rather than providing participants with general hardcover books, it is recommended that future researcher use lockable diaries. This would be more reassuring of privacy as the participants could 'protect' their subjective reflections when locking their diaries, especially if they are reflecting on issues that involve people that they are sharing a home with.

Conclusions

In this paper, I reported on some of the challenges that I faced in using research diaries as a data gathering tool when conducting research on sensitive issues with adolescents and mothers. Information on the difficulties that researchers experience in using qualitative tools is important and can inform the decisions that investigators make regarding the approach they adopt in using those tools (Hayman et al., 2012). Given the sensitivity and complexities of mothers' experiences when parenting an adolescent with a substance use problem (see Groenewald & Bhana, 2015a), understanding the challenges involved in using research diaries (a tool often considered appropriate for sensitive research) is beneficial to other researchers. Lee and Renzetti (1993, p. 10) encourage investigators to reflect on the research they conduct on sensitive issues and to "confront seriously and thoroughly the problems that these topics pose" (p. 10). Dickson-Swift, James, Kippen and Liamputtong (2006, p. 854) add that in order for research to confront these challenges, it "first requires documentation of the issues particular to qualitative research". While researchers have made references to the challenges associated with using diaries in qualitative studies, only a few articles solely document researchers' experiences and propositions on how to address these issues (see for example Hayman et al., 2010).

The findings of the current study thus add to the literature and are especially useful for researchers interested in exploring adolescent substance abuse from the perspectives of the parents. In addition to understanding researcher challenges, further research that aims to understand non-participation from the perspectives of the participants is also recommended. While the research diary approach was found to be less effective in my study, methodologically the diaries were used as an adjunct to the lifegrid interviews which yielded information rich data (see Groenewald & Bhana, 2015a; Groenewald & Bhana, 2015b; Groenewald & Bhana, under review). It is thus my experience that the quality of the data for the overall study was not compromised by the lack of diary data produced in this study.

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Chapter 3: Results

Introduction

This chapter presents the results of this research according to the study aims. To reiterate, this study aimed to explore the lived experiences of mothers of adolescents with substance abuse problems. Specifically, I explored

a) The stresses that the mothers face as a result of the adolescents' substance abuse and the impact of these stresses on the mothers' subjective wellbeing;
b) The mothers' coping responses to the adolescents' substance abuse behaviours; and
c) The mothers' experiences in relation to support

The results are presented in the form of two research papers and makes references to elements of the SSCS model (Orford et al., 1998) to conceptualise the mothers' experiences and coping responses. The first research paper (Paper 3) has a particular focus on the mothers narratives on 'stress' and 'strain' while the second research paper (Paper 4) is concerned with the mothers coping responses and experiences and behaviours related to support.

Citations

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Paper 4: Groenewald, C. & Bhana, A. (under review). Mothers experiences of coping with an adolescent with substance abuse problems. *Journal of Child and Family Studies*.

Paper 3
"It was bad; it was bad to see my [child] doing this": Mothers' experiences of living with adolescent with substance abuse problems

Candice Groenewald and Arvin Bhana

Abstract

This paper explores mothers' experiences of living with an adolescent with substance use problems; an under-researched topic of inquiry worldwide. Specifically, we were interested in the stressors that mothers face and how these stressors influenced their subjective wellbeing. A qualitative, phenomenological approach was adopted where five mother-adolescent pairs were recruited from two adolescent substance abuse treatment centres to participate in 1:1 in-depth interviews using a lifegrid tool. Interpretative phenomenological analysis revealed that adolescent's substance abuse produced several stressful life events, such as adolescent misconduct, family conflict and financial burdens that provoked feelings of hopelessness, guilt, self-blame, worry, shame, anger, and signs of depression. Understanding mothers' experiences is essential to the development of informed support interventions for mothers of adolescents troubled by substance abuse. We conclude this paper by discussing the research and practice implications of our findings.

Keywords: Adolescent substance use; families, mothers experiences; phenomenology; stress; qualitative

Introduction

While attention has been given to understanding the epidemiology of adolescent substance abuse in South Africa (see for example Dada et al., 2015; Plüddemann, Flisher, McKetin, Parry & Lombard, 2010; Patrick, Palen, Caldwell, Gleeson, Smith & Wagner, 2010), we know relatively little about how adolescent substance abuse impacts on the lives of family members, and specifically parents. Parents of adolescents with substance use problems often experience high levels of stress which significantly compromise their health and subjective wellbeing (Butler & Bauld, 2005; Jackson, Usher & O'Brien, 2007; Usher, Jackson & O'Brien, 2007; Abrahams, 2009; Orford, Velleman, Natera, Templeton, & Copello, 2013). There are several elements to this form of parental stress including adolescent misconduct, family conflict, financial burdens and disruptive relationships. Adolescent misconduct is characterised by threatening and pilfering behaviours that adolescents may engage in while they are abusing drugs or alcohol (Jackson & Mannix, 2003; Jackson et al., 2007; Usher et al., 2007; Masombuka, 2013). Jackson and Mannix (2003) found in their study that mothers and siblings experienced verbal and physical intimidation from the adolescent. These experiences left the mothers fearful of the adolescent and resulted in some of the siblings leaving the home (Jackson & Mannix, 2003). Jackson et al (2007) and Usher et al. (2007) reported similar findings. Affected mothers (mothers affected by adolescent substance abuse) in their studies were distressed by the adolescent's thieving and destructive acts which produced a lack of trust and feelings of betrayal (Jackson et al., 2007; Usher et al., 2007).

Relationships within the family are also negatively impacted by the stresses associated with the adolescent's substance abuse. For example, the literature shows that some mothers choose to put distance between themselves and the family, and the adolescent as a way to protect the family from the adolescent's destructive behaviours (Usher et al., 2007; Jackson et al., 2007). Stressed parental relationships have also been reported (Choate, 2011; Hoeck & Van Hal, 2012). Hoeck and Van Hal (2012) found that parental conflict was caused by disagreements on how to deal with the child's substance abuse. Choate (2011) reported that parental conflict was associated with increasing attention being given to the adolescent while family relationships were neglected. The financial impact of a relative's substance abuse on the family is difficult to establish (Velleman, 2010; Copello, Templeton & Powell, 2010). While some direct costs can be identified in the literature, such as those due to theft and unemployment (Jackson & Mannix, 2003; Jackson et al., 2007; Usher et al., 2007), intangible costs associated with emotional distress, pain and suffering are difficult to quantify (Velleman, 2010; Copello et al 2010). When the person abusing substances is an adolescent, much of the financial strain falls on the parents as they are required to pay for the child's rehabilitation, medical visits and general living costs (Mabusela, 1996; Jackson & Mannix, 2003; Jackson et al., 2007; Usher et al., 2007; Abrahams, 2009; Masombuka, 2013).

This paper is particularly interested in the experiences of mothers, who often suffer in silence and wear what Maushart (2006) refers to as the "mask of motherhood" to disguise the parenting difficulties they face. Given the socially ascribed role of ensuring the health and wellbeing of their offspring (Jackson & Mannix, 2004), mothers are often held accountable for their children's substance abusing behaviour (Smith & Estefan, 2014). This accountability weighs heavily on mothers and, for many, is the basis for non-disclosure when struggling with substance using adolescents (Butler & Bauld, 2005; Smith & Estefan, 2014). The literature further indicates that these stressful life events usually produce feelings of hopelessness, guilt, self-blame, shame, humiliation, anxiety, depression, anger and resentment (Butler & Bauld, 2005; Jackson et al., 2007; Usher et al., 2007; Abrahams, 2009; Orford et al., 2013).

Despite these stressful experiences of affected parents, they are seldom reported on in the literature. White, Arria and Moe (2011) indicate that very little is known about the experiences of parents with children in substance abuse rehabilitation programmes. Researchers have thus called for more empirical studies on affected mothers' experiences of living with an adolescent who abuses substances (Usher et al., 2007; Jackson et al., 2007; Orford et al., 2013). The aim of this paper is to explore South African mothers' experiences of living with an adolescent with substance use problems. We are particularly interested in the stressors that mothers face and how these stressors influenced their subjective wellbeing.

Materials and methods

Given the sparse literature around the experiences of affected mothers and the need to take account of disclosure of painful and personal experiences by them, we were prompted to think about information gathering tools that will accommodate and bring to the fore the complexity of experiences and at the same time facilitate discussions in a non-threatening and sensitive way. The interpretative phenomenological analysis (IPA) framework (Smith, 1996; 2004) was thus adopted. IPA is essentially idiographic and concerned with participants' lived experiences and how they understand that personal experience (Smith, 2008). We initially examined each mother's narrative independently to understand their distinct experiences, and thereafter, we identified mothers' experiences that shared common characteristics.

We recognised that our ability to obtain data that is information rich was intrinsically dependent on our participants' willingness to tell their stories. For these reasons, we decided to incorporate an information gathering tool, called the lifegrid (LG) (Berney & Blane, 1997; Parry, Thomson &

Fowkes, 1999) which extended our study beyond the traditional individual interview. The rationale behind choosing this particular tool was also to engage the participants and allow them to tell their stories in novel ways (See Groenewald & Bhana, 2015) for an in-depth discussion of this tool as used in the current study). Briefly, the LG is a chart tool that chronologically reflects changes and developments in several areas of an individual's life and is used to structure the interviews (Richardson, Ong, Sim, & Corbett, 2009). It allowed us to obtain chronological background information on the development of the adolescent's substance abuse during the initial interview and to touch upon other aspects that were more emotionally-laden. These aspects were then followed up at subsequent interviews while at the same time providing a non-threatening space to ask and discuss more personal and sensitive issues (Groenewald & Bhana, 2015).

Recruitment

Using a multiple case study design, five families with a substance abusing adolescent, who was admitted to treatment centres as the time of the study, were recruited into the study. The case studies involved five affected mothers and four adolescent boys and one adolescent girl aged 15 to 17 years respectively. Four additional families were approached to be part of the study but they were unwilling to participate despite several attempts to make contact with them. Their further participation was also compromised by the adolescents' decisions to leave the centre prior to the completion of their rehabilitation program.

While both mothers and fathers were invited to participate in our study, only mothers expressed a willingness to participate in the study. Notably, fathers' were involved in the adolescent's life for only two of the families who participated. In two families, the fathers had passed away and in one family, the father was not known to the adolescent. While our focus on mothers was not explicit, we embrace it as a significant finding in itself. This speaks to the commonly held perspective that mothers are the carers of their children and who take responsibility for monitoring their health and wellbeing (Jackson & Mannix, 2004), but also that in studies that document 'parents' perspectives, the number of fathers who participate is smaller (Choate, 2011; Jackson et al., 2007; Hoeck & Van Hal, 2012).

The families were recruited from two substance abuse rehabilitation centres that accommodate adolescents in the province of KwaZulu-Natal, South Africa. The child and youth care workers[6] of the rehabilitation centres were instrumental in informing the families of the research. Once families expressed interest in the study, these youth care workers provided us with the families' contact details. The families were informed during the consenting process that all information provided to the first author would remain confidential, with anonymisation of all the information provided. The role of

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[6] These are social workers who have been assigned to work with adolescents in substance abuse treatment centres

these gatekeepers was circumscribed to informing families of the study and when necessary to provide a space to conduct the interviews with either the adolescent or the affected mother. We recognise that the mothers' accounts of their lived experiences are only part of the story. However, given the depth and range of information obtained, the adolescents' experiences and the coping responses of the affected mothers' are discussed in a separate publication.

Ethical approval for the study was provided by the Humanities & Social Sciences Research Ethics Committee of the University of KwaZulu-Natal (protocol reference number: HSS/0980/13D). We obtained study clearance from both the treatment centres that participated in the study. Prior to conducting the interviews, the study was explained to the participants, after which the mothers' signed consent and assent forms for their and their child's participation and the adolescents signed assent forms.

Study processes

Prior to the formal interviews, the interviewer met with the participants and explained, in detail, the aims of the study and what was expected of them should they wish to participate. Following this meeting, the mothers were interviewed once using the LG and where additional interviews were arranged, the LG was used to facilitate these discussions (Groenewald & Bhana, 2015). Three of the mothers were formally interviewed twice while two were interviewed once. The first formal interview generally lasted longer (approximately1.5 to 2 hours) than the second interview (30-50 minutes) and entailed in-depth discussions regarding the mothers' experiences, coping approaches and parent-child relationships. The scheduling of the second interview was dependent on the mothers' availability and willingness to participate in an additional interview. The two mothers who were not able to participate in the second interview (primarily due to work commitments) were contacted telephonically. These conversations, along with the follow-up interviews of all of the mothers, were much shorter than the initial interviews and were arranged to clarify and discuss some of the issues that arose out of the first interview. While telephonic interviews restricted an interpersonal interaction between the interviewer and the mothers, the time commitments and availability of the mothers made this the most sensible and practical approach for our study. Furthermore, it was the interviewer's experience that the quality of the data was not compromised since the participants had previously interacted with the first researcher in face-to-face interviews.

Data analysis

As recommended by Smith and Osborn (2007) interpretative phenomenological analysis (IPA) analysis progressed through multiple phases where each interview is transcribed verbatim and the

transcripts are read and reread to conduct a free textual analysis. The aim of this step was to become familiar with the participants' narratives and note initial issues that may be relevant as standalone themes. The transcripts were then re-read together with the initial comments to help develop emerging theme categories.

Next, we searched for connections between the emerging themes that were identified and clustered these themes. During this stage, some themes were left out or merged. For example, if they were not sufficiently prominent (occurred on an odd occasion) within the text or were not directly related to other themes. The remaining themes, sub-themes and corresponding extracts from the transcript were coded with more than ten code families (units of analysis) comprising between five and ten codes each produced using ATLAS ti software (5.0). The coding was undertaken by the first author. Some experts have argued that, where research is embedded in the establishment of on-going relationships with study participants, it is preferred that a single researcher conducts the coding of the data (Morse & Richards 2002; Janesick 2003; Bradley, Curry & Devers, 2007).

In this paper, the interpretations of the themes are illustrated using extracts. In these quotations, square brackets contain material for clarification. Ellipsis points (…) indicate that the participants' thoughts have trailed off. A pause is illustrated by (.) and interruptions are indicated by =. Pseudonyms are used to protect the mothers' personal (identifiable) information and references to specific treatment centres have been omitted to further protect the participant.

Results

Our findings illustrate that parenting an adolescent with a substance abuse problem is enormously burdensome to affected mothers. The adolescent's substance abuse produced several stressful life events, such as adolescent misconduct, family conflict, and financial burdens which were associated with different forms of emotional strain such as hopelessness, guilt, self-blame, worry, shame, anger, and signs of depression (see Table I). The following major themes emerged from the mothers' narratives and depict the mothers' lived experiences:

a. Adolescent misconduct: Worry, anxiety, hopelessness and shame

b. Family conflict: Anger and resentment

c. Individual failure: Guilt, self-blame and signs of depression

d. Financial burdens

Table 3: Summary of case study characteristics

Mothers' aliases and background information	Adolescents' aliases and gender (M/F)	Age of adolescent	Residing with mother	Adolescents' substances of choice and age of initiation	Mothers' perceptions of the duration of adolescents' substance abuse	Rehab history	Stressful life events	Experiences of Stress
Ursula	Terrance (M)	15	Yes	Whoonga[7], 11 Cannabis, 10	Approximately 4 years	Adolescent readmitted to formal treatment four times	Adolescent misconduct, family conflict, financial cost	Worry, hopelessness, guilt, self-blame, signs of depression, resentment
Jacky	Winston (M)	17	Yes	Cannabis, 14	Approximately 2 years	First time in treatment	Adolescent misconduct, family conflict, financial cost	Worry, hopelessness, guilt, self-blame, shame, anger, signs of depression
Erica	Clint (M)	15	Yes	Whoonga, 11	Approximately 3 years	First time in treatment	Adolescent misconduct, financial cost	Worry, hopelessness, guilt, self-blame, signs of depression
Anne	Brandon (M)	15	Yes	Whoonga, 14 Cannabis, 13	Approximately 2 years	First time in treatment	Adolescent misconduct, family conflict	Worry, hopelessness, guilt, self-blame, signs of depression, anger,
Margaret	Abigail (F)	16	Yes	Alcohol, 15	Not sure*	First time in treatment	Adolescent misconduct	Worry, hopelessness, guilt, self-blame, shame,

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[7] Whoonga is a highly addictive powder that is mixed with cannabis and smoked. It is consists of low grade heroine and other hazardous additives like rat poison (http://www.kznhealth.gov.za/mental/Whoonga.pdf

Shared stressful life events						Adolescent misconduct 5/5 Family conflict 3/5 Financial cost 3/5	
Shared experiences of strain							Worry 5/5 Hopelessness 5/5 Guilt 5/5 Self-blame 5/5 Shame 2/5 Anger 3/5 Signs of depression 4/5

*Mother indicated that she was not aware that her daughter was misusing alcohol until she was informed by her daughter was caught drinking at school about two months prior to the interview.

Adolescent misconduct: Worry, anxiety, hopelessness and shame

A pervasive theme in the mothers' narratives was the challenges they had with the adolescent's menacing behaviours leading to experiences of worry, anxiety, hopelessness and shame. These behaviours included the adolescent staying away from home for long periods of time and stealing from them and others. Erica and Ursula's accounts capture much of the mothers' despair in relation to their adolescents' 'staying away' behaviours:

Interviewer: So tell me about that. What are some of the things that he would do?

Erica: He [would] just be rude! Hating, no time for anybody, just need to be alone with his friends only and stay there up to the midnight.

Interviewer: And what would you, what would you be thinking when he's away like that?

Erica: I was thinking maybe he died! Maybe he is doing this=maybe he is only at the police station, maybe… Ay, I was thinking if, if everything!

Interviewer: Hmm

Erica: Yes

Interviewer: And how do you feel?

Erica: I can't sleep! I can't sleep! Maybe I will sleep for only 2 hours a day.

Erica's account displays the distress, worry, and frustration she felt when her son stayed out later than what she had permitted him and she did not know where he was. She referred to her disturbing thoughts of 'what ifs' and worries about the possible death of her child that triggered her insomnia.

Similarly, Ursula's account reflects the suffering she experienced every time her son stayed away from home.

Interviewer: And so, and so when did he started running away from, you say he was staying away from 9 [years of age]?

Ursula: Yeah, sometimes he's not coming at home. Th-the-the he stay[s] [away] and then for one day he [does] not come [home] and then I never sleeping that day!

Interviewer: Yes

Ursula: I'm crying WHOLE night!

Interviewer: Yes because you don't know where he is =

Ursula: = Because I don't know where is he!

Emphasising that she was "crying WHOLE night" displays her hopelessness and concern for the safety of her child. This particular concern was salient in all of the mothers' narratives and perhaps conveys the mothers' frustration with the lack of control that they have over the adolescents' absenting themselves from home as well as protecting the child from harm.

Four of the five mothers reported that their children had stolen from them or others while they were using substances. Margaret talks about her daughters pilfering behaviours:

> Interviewer: And why do you think she took the things and the stuff like that? Do you think she had particular reasons?
>
> Margaret: I don't think there were reasons. There was that thing inside that told her 'go and do it, I am telling you go and do it'. Because she knows that I have to give her money! When she asks for money [if] I have, I buy her everything, you know. Even if we don't have a lot of money I always supported her with everything. But the thing said 'go inside, go and do it! Don't listen to her, go!' And I caught her once with the money on her and I said just give me that, give me that money!
>
> Interviewer: And what did she do when you caught her like that?
>
> Margaret: Who?
>
> Interviewer: Abigail.
>
> Margaret: She was crying! She was crying and said, mom, I don't know what happened to me. I don't know.
>
> Interviewer: So did she give you the money back?
>
> Margaret: She gave me and I said Hanna [house owner] here is the money. And I said to her I am sorry for what my child is doing to you
>
> Interviewer: I can see how this is affecting you and I can see it in your face and your eyes that you are getting very emotional.
>
> Margaret: That was frustrating! It was terrible and I couldn't believe that SHE was doing these things!

Margaret's account not only reflects her daughter's pilfering but reveals her own difficulty in trying to make sense of Abigail's behaviour. Margaret attributed Abigail's behaviour to "that thing that was inside [of her] that told her go and do it". In this way, it was perhaps easier for Margaret to understand her daughter's behaviour when it is caused by 'something' other than her child's unacceptable conduct: "It was terrible and I couldn't believe that SHE was doing these things!" This spares

Margaret from feeling hurt and betrayed by her daughter or that she may have in some way contributed to this behaviour. This is also evident in her rationalisations:

"Because she knows that I have to give her money! When she asks for money [if] I have, I buy her everything, you know. Even if we don't have a lot of money I always supported her with everything. But the thing said 'go inside, go and do it! Don't listen to her, go!'"

Margaret's account further illustrates the guilt and perhaps shame she felt because of her daughters stealing "and I said Hanna, here is the money. And I said to her I am sorry for what my child is doing to you".

The other mothers were also plagued by the adolescents' stealing behaviours. The severity of these experiences varied. Some mothers, like Margaret and Anne, reported that smaller amounts of money or goods were taken less frequently while Ursula and Erica reported more substantial losses. Ursula recounts her devastating experience:

Interviewer: How, how does all of this make you feel? How do you deal with it? Do you deal with it, I suppose?

Ursula: I feeling pain

Interviewer: Hmm

Ursula: Sometimes I decided to go to police and then I think that it's MY CHILD

Interviewer: Hmm

Ursula: One day, we going to the, to police and then the police they say= because I= the other day he came with the group of them, with his friends, they opening the here [showing the door] and that, and then they go to the bedroom they opening [the door]. They take uh you know that uh (.) uhm the (.) the safe!

Interviewer: Yes

Ursula: Yeah! The guy, [one of] the other friends TOOK the safe!

Interviewer: So Terrance friends?

Ursula: Terrance yeah!

Interviewer: Terrance and his friends came in, they opened the door, they opened that door, they went through this whole house and they took the safe and everything and they left? =

Ursula: YES with the gun wi-with the gun inside and the money inside!

Interviewer: With gun and money inside

Ursula: Hmmm the friends (.) his friends. I think [that was in] 2010 or 2011. That time, yeah. Terrance, that Terrance, ay was staying there [with] the big boy =

Interviewer: Yes?

Ursula: And then they took Terrance for 7 days! I [did] not see Terrance!

It was evident that all the mothers were disappointed in their children's behaviour. Yet, the severity of Erica and Ursula's experiences left them feeling particularly helpless and hopeless. This is evident in Ursula's confusion about whether to go to the police or to protect her child from the police. Ursula also struggled to come to terms with her son's destructive behaviours and her disbelief that her own child could steal from them was illustrated as she often avoided using the term steal but rather emphasised that they "TOOK" the safe and earlier in the conversation, "took" her car (not in the extract above).

Family conflict: Blame, unhappiness, and anger

Conflict between the adolescent and the family was also common, typically with the mother but with the father or immediate stepfather. Some parents also blamed each other for the adolescents' substance with two mothers reporting conflict with their partner or husband. Ursula, for example, explained that her relationship with her husband had deteriorated since her son started using drugs. She further reported that her husband often blamed her for her son's drug abuse problems:

Interviewer: So how do you feel (.) How do you feel all of this has affected you?

Ursula: Ay it affected me because even, even his father sometimes he (.) He say[s] Terrance is doing this because of this and that, and then he says to me that Terrance is doing that because it's you! Yes and then when he's coming with me and him and in the house (.) there's nobody [for me] now, it's all in this house = it's very bad! We are here because of this Terrance = because he's [the father] not fighting. But you see he's [the father] not good in the house with, with him (.)

In saying "we are here because of this Terrance= because he's not fighting" Ursula also seems to blame her husband's non-confrontational parenting approach for Terrance's drug abuse behaviours. The demanding nature of parenting Terrance also distracted Ursula and her husband from spending time together. She indicated that her relationship with her husband was "nice" while her son was at boarding school but once he came home they are stressed and required to constantly "watch him".

Later in the interview she reported that their relationship was, at that time, characterised by "him not talking to me and me, [I have] a short temper [and will] not talk to him".

Another mother, Jacky, also spoke about the blame she had experienced from her partner which produced arguments:

> Jacky: "Sometimes with my partner = 'cause he always says, you know, he says I'm taking Winston's part; that I'm encouraging him you know things like that and he always says 'oh I won't give you money because you give Winston the money to go smoke'. You know, it becomes like you have an argument over petty things"

Anne also reported on the conflict that developed between her and the adolescent's father. This was associated with their conflicting perspectives on an appropriate method to manage the adolescent's substance abuse. Anne indicated that she had not received enough support from Brandon's father and in this way, held him responsible for Brandon's drug abuse problems:

> Anne: I became angry towards the father because the way, the way he was handling things. Even after the divorce = because I used to tell him that okay fine, we are divorcing, I don't want to be in your relationship, but I don't want us to be separated! I want us to communicate about the child. I understand that you don't want me anymore. It's fine I have accepted [it]. But let's not lose our child. Let's cooperate and do things together! We used to have time together, go to [a restaurant] together and eat together. Can we continue like that? He said 'I have moved on, I am not going to do that with you. I thought that you wanted me to come back to you' and I said 'I don't want you to come back to me, [I] am fine with my kids, but please let's not fail our child'

> Anne: "He's not cooperating. I don't feel that he wants my child to change. I feel that he is the one who contributed more to this than anything else because if he was cooperative and then when we talk, we talk in one voice to say 'this is not going to happen, boy, this how you are going to do it'. But now he is that side and I am this side. We are pulling so that's how I felt; that we are not together, we are pulling apart"

Importantly, Anne's relationship with her ex-husband was conflictual prior to her son's drug abuse. However, confrontations between them appeared to have escalated during her son's drug abuse period.

Furthermore, the mothers also spoke about how the level of conflict between them and the adolescent had escalated. Conflict between the mother and the adolescent mostly occurred when the mothers attempted to control the adolescents' drug abuse. For some mothers, this mainly involved verbal confrontations, while other mothers described more physical displays of anger. For example, Margaret reported that her child would "swear at me" and Jacky indicated that her son would "shout at me". Erica, on the other hand, reported that her son would become more destructive by "banging the doors [and] throwing the plates and glasses on the floor" when she would not give into his demands for money.

Individual failure: Guilt, self-blame and signs of depression

Talk of self-blame and guilt were present in all of the mothers' narratives. Jacky related her experiences of self-blame and guilt:

> Interviewer: How has this experience been, if you can put it into words?
>
> Jacky: I don't know how to describe it to you (.) You know you always wonder where you went wrong, what did YOU do…Because my son too, my eldest son, he never use to do it when he was at school. You know only now in his old age NOW he started! Now I'm saying maybe I never taught Winston like uhm 'see what your brother is doing, don't follow his footsteps' you know? Teach him the right, the right, on the right track. Maybe all I say maybe I wasn't too stern with him or I was to open or… you know you always say where YOU went wrong, what happened that he turned out like that.
>
> Interviewer: So you tend, you tend to blame yourself?
>
> Jacky: Yeah you do! You do!

In trying to understand why her son decided to use drugs, Jacky interrogates her own parenting in an attempt to identify the mistakes she has made: "you always wonder where you went wrong, what did YOU do". Jacky feels a sense of responsibility for her son's drug abuse and implied that perhaps she allowed him to follow his brother's example because she did not do enough, as a mother, to keep him "on the right track".

> "I'm saying maybe I never taught Winston like uhm 'see what your brother is doing, don't follow his footsteps' you know? Teach him the right, the right, on the right track. Maybe all I say maybe I wasn't too stern [stern enough] with him or I was to open or… you know you always say where YOU went wrong, what happened that he turned out like that?"

Anne's narrative was also filled with references to the blame that she had placed on herself for her son's drug abuse:

> "I felt that I wasn't that mother to him enough; to recognise it at an earlier time now… but at the same time I say I have recognised this and I tried counselling this child. I don't know why it went wrong because I didn't want him to go to this situation but when we were finally divorced I just say 'how do you feel about it'? You [are] sad as a family again and you say how do you feel about it? You take it [him] for counselling whatsoever. You agree that no mom, I don't understand why you and dad are not together and dad is staying with someone else"

Anne's self-blame and guilt is best conveyed in her statement: "I felt that I wasn't that mother to him enough". Anne felt very guilty that she was not able to prevent her son from using drugs, especially because she allowed him to stay with his father which was where he started using drugs. Anne also seemed to blame herself through the divorce and questioned whether she had done enough to help her son deal with it: "but when we were finally divorce I just say 'how do you feel about it?'".

The mothers' self-blame, guilt, and worry about the child also produced signs of depression. Many of the mothers noticed that they had become withdrawn and isolated from their loved ones. At times, this was self-imposed as some of the mothers overtly decided not to interact with others. In addition to these feelings, many of the mothers reported feeling sad and crying became an outlet/way for them to express their feelings, often by themselves. Anne's account conveys much of the mothers' experiences and symptoms of depression.

> Interviewer: So you saying at the moment the things you are describing you don't do anymore
>
> Anne: Yeah I do them but it's difficult=
>
> Interviewer: = You don't want to?
>
> Anne: I don't want to but they [friends] force me to say this is our time we are going with you, like it or not! […]
>
> Interviewer: So you have good friends?
>
> Anne: Yeah I have supportive friends. I do have support more than anything else. I do have support I will not lie and say I don't have support. I think it's still with me, within to say know now I should do this and accept whatsoever, it's so difficult for me!

Interviewer: It seems like this whole thing has affected you more on a personal level =

Anne: = yeah on a personal level

Interviewer: So how have you been able to cope with all of this?

Anne: I am trying, praying. I can't go to church! I felt [like] going to church. Sometimes I feel like, [I] prepare to go to church… something came up, then I just don't go. I don't know why.

Interviewer: Why?

Anne: I don't know. I don't feel like [it], but I pray a lot, I pray a lot!

Interviewer: But you don't feel like going to church?

Anne: I don't feel like. Sometimes I don't feel like to be with a crowd. I don't feel like being with a crowd (.) So the gathering where there is too much crowd=

Interviewer: = you don't feel like=

Anne: I don't feel like being there. Even the family gatherings, whatsoever, I don't feel like going. I don't know whether I will manage in November because there is a family gathering that comes to the place where I will be. I don't know whether I will cope or not! It will be the first one since this cause I don't go to their houses. I said 'oh okay, I am coming, I will come guys, see you then', then prepare. When I am about to go, I can't go! So November; that would be the first to be with them. I will see what is going on.

Anne's account draws attention to the emotional struggles many of the mothers faced daily. Her use of the terms "force" (when she talks about her friends) and "prepare" (when she talks about visiting her family) might not have been explicit, but it implies that being around her family and friends presented a challenge for Anne. These feelings were related to her own struggle with coming to terms with her son's drug abuse. This was evident when she acknowledged the support that she received from her friends, yet struggled to embrace the support because she was not ready at that time to accept that her son was a drug abuser: "I do have support I will not lie and say I don't have support. I think it's still with me, within, to say know now I should do this and accept whatsoever, it's so difficult for me!"

Later in the interview Anne emphasised her need for isolation again and mentioned her concerns about a family gathering that was scheduled for the near future. Anne's hesitance to see her family is perhaps related to her anxieties about how they could react to her child's drug abuse. She could also be experiencing feelings of embarrassment. Isolating herself from her family and friends, therefore, avoids having to answer any questions about her son's drug abuse or how she is dealing with it. On

the other hand, withdrawing could also be related to her self-blaming where she had made reference to feeling like "I wasn't that mother to him enough to recognise it [her son's drug abuse] at an earlier time".

Erica also spoke about the devastation she felt when her son stole material which put her at a significant monetary loss. Unlike the rest of the mothers, she reported feeling so helpless and disheartened by the experience that she had decided to take her own life.

> "It's the day he stole my material. He stole everything in my house! From my father anything; curtains, anything they stole! Everything they selling at twenty rand, for thirty rand, for ten rand, for twenty rand. Things [that cost] R500 or R1000, [they are] selling for twenty rand, for fifty rand = I decided to kill myself!"

Erica's decision to "kill myself" was not only influenced by this particular situation but the years of suffering she endured as a result of her son's drug abuse. She reported that she had been thinking of killing herself for "three months" before she attempted to. Her suicide attempt could perhaps be understood as a desperate cry for help during a time she felt hopeless and helpless to change her son's behaviours. Her behaviour was further driven by her own alcohol abuse as she reported she was drinking excessively in the days preceding her suicide attempt. Reflecting on her drinking experiences, Erica reported:

> Erica: I can't see him. He just come and say[s] may I have fifty rand, may I have hundred rand. I just take my bag [and give him] hundred rand to fifty rand=
>
> Interviewer: Yeah, there you go.
>
> Erica: Yes I can't refuse anything
>
> Interviewer: So what do you, what do you think, when you sit back and think of this now? How does it make you feel?
>
> Erica: I'm just feeling happy, because I didn't think anything. I can't think he's, its 12 o' clock he didn't come, maybe he is died [dead], maybe he's in hospital, maybe he is taken by the police, I think - I can't think I'm feeling =
>
> Interviewer: You're not, you're not worried?
>
> Erica: Yes, I'm not worried about anything!
>
> Interviewer: Do you think that that was a good way to kind of deal with all of these things, for you?

Erica: No it's not good, but it help[ed] me for that time

Interviewer: Yes?

Erica: From worries. I can't worry about anything!

To her drinking was a way to escape her unwanted reality and go to a space where her "mind is upside" and she is "not worried about anything". She acknowledged that dealing with her son's drug abuse in this way was not appropriate, but adds that "it help[ed] me for that time". Importantly, the "time" Erica is referring to here is a period of two years which could suggest that she might have developed a dependency on alcohol that goes beyond it being a vice for her to cope with her son's drug abuse behaviours.

Furthermore, two mothers also referred to the impact of the adolescents' substance abuse on their work performance. For Anne, work was particularly difficult:

Anne: 'I am working in a peads [*orthopaedic*] ward. Seeing boys of his age depresses me! I don't talk to them. Like I use to encourage them, like saying 'guys do this, do that'. Even at work they would say 'no you are the one who would say 'guys where are your books, what did you do' and 'you are the one who will explain to them to' […] But that spirit is no longer there!

The changes in Anne's relational style towards the children in her ward are because they remind her of her son and the hurt that she is feeling because of his drug abuse. Later in the interview, she further relayed that she often cried at work and "at times I become so cheeky… and I try to withdraw. It's affecting my job more than anything else".

Ursula also recounted her work experiences:

Ursula: Yeah it impacts on what I do at work, not doing the work, not working nice at work so (.) I will, I the other day was sick for the things. Ay, I don't like to go back there [to work] that time because now I, the= I, I'm better now! I'm better now.

Interviewer: What were you before?

Ursula: Before I was thin every time THIN then you look me in the face is not [healthy]. Every time, everybody they looking at me oh but the mother of Terrance was [looking] stress[ed] shame-shame!

In saying that she was "sick for the things", Ursula is referring to the hopelessness she felt because of her son's behaviour which then made her withdraw from her work "I don't like to go back there that

time". Her work experience was further influenced by the comments and behaviours of her colleagues which perhaps induced feelings of shame.

Financial burdens

Evident in most of the mothers' narratives was the financial implications of the adolescents' substance abuse behaviours. For some mothers' such as Jacky, Anne, and Ursula, their financial burdens were related to the costs associated with the adolescents' rehabilitation. These did not only include the actual cost of the rehabilitation programme but also traveling to and from the treatment centre as well as hotel accommodation costs. For other mothers like Erica and Margaret, their financial burdens were consequences of the adolescents' stealing behaviours and damage to property.

Discussion

This study supports previous findings that living with an adolescent who has a substance use problem is an enormously difficult and stressful experience for mothers (Jackson & Mannix, 2003; Orford, Templeton, Velleman & Copello, 2005; Jackson et al., 2007; Usher et al., 2007; Hoeck & Van Hal, 2012; Orford et al., 2013). In our study, the incidence of distress and concern was inevitable for the mothers who were required to deal with several forms of pernicious behaviours. Repeated exposure to these destructive behaviours paired with daily worry about the child's wellbeing produced heightened levels of personal strain which manifested in feelings of sadness, isolation and loss of interest in their own lives. Orford et al. (2005) found that worrying about a substance-abusing relative's wellbeing is a significant construct in the stress that family members experience. This stress syndrome was evident in all the mothers' narratives and need to be a key focus for supportive intervention strategies.

The findings of this article contribute to the sparse literature documenting mothers' experiences of living with an adolescent who abuses substances. The findings reinforce the discourses which hold mothers accountable for their children's behaviours (Butler & Bauld, 2005; Smith & Estefan, 2014). In our study, this accountability was illustrated in the ways the women blamed themselves, as mothers, for the adolescent's substance abuse. This was implicit when some of the mothers interrogated their own mothering approaches in an attempt to understand why the adolescent used drugs. In this way, adolescents' substance abuse was intrinsically linked to the mothers' happiness and sorrow. Smith and Estefan (2012, p. 428) posit that mothers of children with substance abuse problems often "bear the burden" of the child's substance abuse and "see the children as extensions of their own identity".

Our findings hold implications for research and practice in South Africa. The study contributes to an underresearched topic of inquiry in South Africa. Further research is thus warranted on the experiences of affected mothers and other family members across various South African communities. In-depth inquiries represent a useful way to give voice to affected mothers' (and parents' in general) experiences and to evocate new dialogues on how these mothers can be supported (Smith & Estefan, 2014). We found the qualitative methodologies used in our study particularly helpful in drawing out the mothers' experiences, but also to provide them with an opportunity to share their experiences. They expressed appreciation for the chance to discuss these issues in depth, which many of them had not had before.

Importantly, further research that investigates the experiences and roles of affected fathers is necessary both nationally and internationally. While studies document the 'parents'' perspective, it is evident that some of them include a smaller sample of fathers than mothers (see for example Choate, 2011; Jackson et al., 2007; Hoeck & Van Hal, 2012). Our study also speaks to this challenge as, where available, the fathers refused to be part of the study. It is, therefore, essential for researchers to engage with these gendered sampling issues and identify strategies in support of telling the fathers' stories.

Given the small sample size and the subjective nature of our study, generalizability is not assumed. It is also possible that if we expanded our study, we may find life experiences of mother's may vary. The mothers who participated in our study were recruited from subsidised private rehabilitation centres where their adolescents were receiving treatment for drug or alcohol abuse. We, therefore, recognise that their experiences and perspectives may be different to that of mothers whose substance using adolescents have not received treatment.

Practically, the research has implications for healthcare providers who work closely with adolescents in substance abuse treatment facilities and their families. In South Africa, this generally refers to psychologists, social workers, nurses and child youth care workers who have been placed in adolescent treatment centres. Studies have reported on the dissatisfaction that parents have felt with the services they had available to them. In both Jackson and Mannix's (2003) and Choate's (2011) research, parents reported that they did not feel understood; on the contrary, they felt blamed by the service providers they had sought support from. Thus, understanding the challenges parents face in

dealing with their child's drug abuse may provide healthcare workers with insights into how best to support families who are troubled by adolescent drug abuse (Usher et al., 2005). Furthermore, Jackson and Mannix (2003) suggest that it would be beneficial if healthcare workers could provide mothers with a space to share their stories and anxieties and in this way acknowledge stresses that they might be going through in silence.

Acknowledgements

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Paper 4

Mothers' lived experiences of coping with adolescents with substance abuse problems

Candice Groenewald and Arvin Bhana

Abstract

Research shows that adolescent substance abuse significantly impacts on the lives of family members and especially parents. The stresses that parents endure as a result of the adolescents' substance abuse prompt them to find strategies to help them cope with these experiences. In this paper, we explored South African mothers' experiences of coping with an adolescent with a substance abuse problem using interpretative phenomenological analysis. Analysis revealed that the mothers used problem-focused and emotion-focused coping through different combinations of withdrawing, tolerating and engaged coping responses. Our findings provide valuable information on the complex coping responses that mothers' show which is important for the development of tailored support interventions for mothers, and potentially parents in general, who are required to cope with an adolescent who has a substance abuse problem. We conclude this paper by discussing the practical and research implications of our findings.

Keywords: Adolescent substance abuse; mothers; coping responses; experiences; phenomenology

Introduction

Research consistently shows that living with a close relative who has a substance abuse problem (hereafter referred to as 'the relative') has adverse effects on the lives of family members (hereafter referred to as affected family members (AFMs). These adverse conditions are construed as longstanding and highly stressful experiences that significantly impact on the health and wellbeing of AFMs and have been associated with increased psychological and physical morbidity (Copello, Templeton, Krishnan, Orford, & Velleman, 2000; Orford, Natera, Davies, Nava, Mora, Rigby et al., 1998; Orford, Velleman, Natera, Templeton, & Copello, 2013). AFMs have an increased likelihood to be diagnosed with depression, substance use disorders, and trauma when compared to family members of individuals suffering from diabetes or asthma (Ray, Mertens & Weisner, 2009). Symptoms of anxiety, depression, suicide, poor sleeping and eating patterns have also been reported (Abrahams, 2009; Butler & Bauld, 2005; Orford et al., 2013), including emotional difficulties such as feelings of loss, guilt, self-blame, shame and humiliation (Abrahams, 2009; Jackson et al., 2007; Usher et al., 2007). Furthermore, substance abuse in the family can lead to family conflict, strained family relationships (Gruber & Taylor, 2006; Orford et al., 2013; Rowe, 2012) and family financial strain due to theft and unemployment by the substance abuser (Jackson & Mannix, 2003; Jackson et al., 2007; Usher et al., 2007).

The stresses that AFMs endure as a result of the relative's substance abuse prompt them to find appropriate and impactful ways to cope (Orford, Natera, Velleman, Copello, Bowie, Bradbury, et al., 2001; Orford, Copello, Velleman, & Templeton, 2010a; Orford, Velleman, Copello, Templeton, & Ibanga, 2010b; Orford et al., 2013). Coping in this paper is conceptualised as the ways AFMs respond to or deal with, a relative's substance abuse behaviours (Orford, Rigby, Tod, Miller, Bennett, & Velleman, 1992; Orford et al., 1998; Orford et al., 2001). Orford et al. (2010a) indicate that coping with the relative's behaviour does not entail adopting a single coping response, but involves drawing on several coping strategies in a trial and error fashion (Orford et al., 2010a). In this way, coping is a process-oriented activity (Lazarus & Folkman, 1984) in which AFMs' coping responses, both cognitively and behaviourally, will vary in order to identify a perceived impactful way to deal with the relative's behaviour.

Coping responses and affected parents

Over the last two decades Orford and colleagues have refined a typology of coping to describe how AFMs deal with a relative's substance abuse (Orford et al., 1992; Orford et al., 1998; Orford et al., 2001; Orford et al., 2010a; Orford et al., 2013). Their research was based on mixed method studies conducted with different socio-cultural sample groups from Mexico, England, Australia (Orford et al.,

2005) and Italy, (Velleman, Arcidiacono, Procentese, Copello, & Sarnacchiaro, 2008) and included wives, husbands, children and parents of relatives with substance abuse problems (see Orford et al., 1992; Orford et al., 1998; Orford et al., 2001 for a description of the initial development of this coping typology).

Orford et al. found that in general, AFMs may respond to a relative's substance abuse iteratively through tolerating, engaging or withdrawing (Orford et al., 1992; also see Orford et al., 2010a). In adopting a tolerant coping position, AFMs 'put up' with the relative's substance abuse by making excuses, covering up, self-blame, inaction, empty threats and denial (Orford et al., 2001). Engaged AFMs 'stand up' to the relative's substance abuse through efforts aimed at regaining control (Orford et al., 2001; Orford et al., 2013). These include talking to the relative about the stress they are experiencing, showing the relative that they are upset about his/her substance abuse behaviours, setting rules about what is considered acceptable or unacceptable behaviours, placing restrictions to limit the relative's substance abuse, and supporting the relative to seek formal treatment (Orford et al., 1998; Orford et al., 2001; Orford et al., 2013). Withdrawal coping involves maintaining physical or emotional distance from the relative (Orford et al., 2010). This could include avoiding or ignoring the relative, putting the family and oneself first, leaving home or asking the relative to leave the home (Orford et al., 1998; Orford et al., 2001).

Given the range of coping responses that emerged in the mothers' narratives in the current study, we included Lazarus and Folkman's (1984) coping theory to compliment and enrich Orford's typology as it provides an additional perspective on the functions of coping. According to Lazarus and Folkman's (1984) coping responses have two main functions. Functions here refer to the (desired) outcomes or aims of the coping response. Firstly, problem-focused coping efforts aim to solve or resolve the particular problem or stressful event (Lazarus and Folkman, 1984). Secondly, emotion-focused coping efforts are employed to decrease emotional distress (Lyon, 2012). These strategies alter the way people perceive situations but do not change the situation or 'solve' the problem. Importantly, *coping responses* will not necessarily be classified as either emotion- or problem focused. Rather, the *function* of the coping response will classify it as problem focused or emotion focused. For example, withdrawing (coping response) from a relative to show disapproval as a tactic to get the relative to change his/her behaviour could be classified as problem-focused coping as the aim is behaviour change. On the other hand, withdrawing could also be seen as emotion-focused when the family member withdraws establish emotional and physical distance from the distress.

Moreover, Orford et al. (2001) point out that there are several factors that influence how AFMs experience and cope with the relative's substance abuse such as the nature and patterns of the relative's substance abuse and the relationship between the relative and the family member. In this

regard, the coping approaches of an AFM will be respectively different if s/he was responding to his/her own teenage child, adult child, brother, or spouse (Orford et al., 2001). The current paper is specifically focused on the coping responses and support needs of mothers of adolescents with substance abuse problems.

Despite the paucity of research, the literature suggests that parents embrace more than one coping position in response to the substance abuse. Usher et al. (2007) found that parents adopted multiple coping approaches. They found that parents had engaged coping approaches, such as being vigilant of the adolescent's behaviours, talking to the adolescent about his/her drug abuse and setting rules and punishments to limit the adolescent's drug abuse as well as withdrawing approaches such as disengaging from the adolescent. Similarly, research by Jackson et al. (2007) reported that parents would disengage from their adolescents as a last and desperate attempt to cope. Earlier work by Butler and Bauld (2005) found that some parents initially denied their child's drug abuse, but eventually sought assistance from agencies to help them cope with the challenges they had been facing. Jackson and Mannix (2003) reported that the parents in their study used engaged coping strategies such strict monitoring and restricting the child's freedom.

Coping and social support

Linked to coping is the availability of social support structures to help parents cope effectively. Orford et al. (2010a) conceptualise social support as both professional (formal) and informal networks like friends and family which comprised emotional and material support as well as the provision of relevant information (Orford et al., 2010a). Affected families require good social support networks to help them cope (Orford et al., 2010a; Orford et al., 2010b; Orford et al., 2013). Orford et al. (2010b) indicate that the quality of social support networks are not only about the number of people that AFMs have available to them but the kind of coping support that the relative receives from those people. Social support is also influenced by the AFMs willingness or reluctance to seek support, both from formal structures and informal networks like friends and family and for some this reluctance may be related to their feelings of self-blame, shame or fears of being blamed by others.

Furthermore, many barriers to the availability and accessibility of support services for affected parents continue to exist (Orford et al., 2013). International research shows that some parents who have access to support services, which are mostly offered at substance abuse treatment centres, report feeling "uninformed and helpless" Chaote (2011, p. 1361) and at times blamed (Jackson & Mannix,

2003). These findings thus suggest that although support services are available, they may not always be applicable, relevant or of good quality (Jackson & Mannix, 2003).

The current paper is concerned with the ways that mothers of adolescents with substance abuse problems (hereafter affected mothers) cope with the challenges they face as a result of the adolescents' behaviour. The mothers experienced are documented in a different paper where the mothers conveyed that living with the adolescent was a highly stressful experience and that they were required to cope with different forms of adolescent misconduct, family conflict, and financial strain which produced feelings of hopelessness, guilt, self-blame, anger, and signs of depression (for a detailed discussion of these findings, the reader is referred to Groenewald and Bhana (2015). In addition to our interest in the mothers' coping responses, we explored the nature of the mothers' support networks and support-seeking behaviours. Understanding the coping and support-seeking behaviours of mothers is extremely important for the development of relevant support interventions for affected mothers (and parents in general).

Materials and methods

An interpretative phenomenological analysis (IPA) framework (Smith, 1996; Smith, 2004) was used to explore the mothers subjective experiences (Reid, Flowers, Larkin, 2005) related to coping with the adolescents substance abuse. This framework was adopted as it allowed us to explore each of the mothers' experiences in depth while at the same time éxamine the convergences and divergences across all of the mothers' accounts. This approach was supported with the use of the Lifegrid (LG) interview approach to collect data that is emotionally sensitive (*Authors, 2015* [references to the authors work have been removed from the manuscript]). The LG interview incorporates a chart tool that is used to document changes and developments in the participant's life while facilitating discussion in an iterative and non-threatening way (*Authors, 2015*).

Participants and study processes

Five mother-adolescent pairs were recruited from two substance abuse treatment centres where the adolescent was seeking treatment at the time of the study (see Table 1). Both mothers and fathers were invited to participate in the study. However, only mothers were willing to participate in the study. Substance abuse treatment centre staff assisted with the recruitment of the families by

informing adolescents and their parents of the study and their role should they agree to participate. Five mothers and four adolescent boys and one adolescent girl aged 15 to 17 years respectively participated in the study. The mothers were recruited by the child and youth care workers (CYCW) at the respective treatment centres who contacted the first author when families consented to be part of the study.

[INSERT TABLE HERE]

Following this, meetings were then arranged with the mother-adolescent pairs where they were provided with detailed information about the study and required to complete consent and assent forms. The families were also informed that all information provided to the interviewer would remain confidential and that all identifiable information, will be anonymised using pseudonyms. The mothers and adolescents were interviewed independently. The current paper will reflect on the data from the mothers' interviews and will thus explain the study processes of the mothers' interviews here. The mothers were formally interviewed once using the LG and where additional interviews were arranged, the LG was used to facilitate these discussions and is described elsewhere (*Authors, 2015*). The initial interviews generally lasted between 1.5 to 2 hours while follow-up interviews lasted between 30-50 minutes. The scheduling of the follow-up interviews was dependent on the mothers' availability and willingness to partake in an additional interview.

Ethical approval for the study was provided by the Humanities & Social Sciences Research Ethics Committee of the University of KwaZulu-Natal (protocol reference number: HSS/0980/13D). Study clearance was also obtained from both the treatment centres that participated in the study.

Data analysis
Each interview was audio recorded and transcribed verbatim. Smith and Osborn's (2007) interpretative phenomenological analysis (IPA) framework was used to analyse the transcripts. Data analysis progressed through multiple phases. The first phase involved a free textual analysis of the transcripts where initial standalone themes and emerging theme categories were identified. Next, linkages between these themes and categories were recognised and themes that were not sufficiently prominent or relevant (occurred on an odd occasion) were either left out or merged with other related themes. Following this, code families (units of analysis) were produced using ATLAS ti software (7.5.0). In this paper, we report on the 'coping' and 'support' codes that emerged in our analysis.

Results

We present the coping and support themes that emerged in our data using representative extracts from the mothers' narratives to illustrate our analysis and interpretation. In these quotations, square brackets contain material for clarification. Ellipsis points (…) indicate that the participants' thoughts have trailed off. A pause is illustrated by (.) and interruptions are indicated by =. Pseudonyms are used to protect the mothers' personal (identifiable) information and references to specific treatment centres have been omitted to further protect the participant. Each of the mothers' narrative related to coping and support is discussed individually to convey the complexities that emerged in our analysis. Following this, the discussion section will summarise the convergences and divergences between the mothers' reports.

Coping: "how do you deal with it?"

Margaret

Coping for Margaret meant adopting a supportive approach in dealing with her daughter's hazardous drinking. She spoke at length about this supportive maternal role that she embraced, both before she became aware of Abigail's alcohol use and after:

> "Abigail was always telling me, 'mum I will come right. I will'. She always told me that things will come right. And I told her I will support you, I will stand by you! So let us stand together!"

> "I can see that Abigail can see that I am *really* there for her. [No matter] what happened, I am standing behind her. I am helping her. What you [referring to Abigail] do you [referring to Abigail] must understand it's wrong, it's not right and you [referring to Abigail] must know that you [referring to Abigail] don't have someone else to help you. I am your [referring to Abigail] mum, I am your [referring to Abigail] dad! So please listen to me for once. Listen!"

Embedded in Margaret's account is also the challenges she faced in trying to be a supportive mother. Her outcries of "let <u>us</u> stand together" and "let <u>us</u> help each other" are explicit and display both her commitment to her daughter and her helplessness and desperation for Abigail to change. Margaret's supportive position is further displayed in her rationalisations of "you [Abigail] must know that you don't have someone else to help you. I am your mum, I am your dad". This statement suggests that Margaret felt accountable and that she is responsible for changing in her daughter's behaviour which is illustrated once more when she explained that "Abigail can see that I am *really* there for her" and "[no matter] what happened I am standing behind her".

Margaret mainly used emotion-focused coping responses of denial and blaming others. Margaret struggled to recognise her daughter's role in the events and circumstances around her drinking. By denying that her daughter has a problem, Margaret rationalises her daughter's behaviour to herself. This is perhaps best illustrated in Margaret's account of finding out about Abigail's expulsion due to her drinking behaviour at school:

> Margaret: "She was going to [the treatment centre] because another friend of her gave her; I don't know is it whisky or what…
>
> Interviewer: So she drank alcohol?
>
> Margaret: Yes, but this friend of her told her listen here Abigail, I think she mixed it with coke, and she told Abigail here is [it], drink. And Abigail took it because she told her it's cool-drink, something like that, and she drink and I don't know what happened. Someone caught this other girl and I don't know if it was the principle or a teacher and she had to explain who she gave it to and so forth. And that's how Abigail got in trouble."

Margaret blamed Abigail's peers for her getting "in trouble". She avoided reference to Abigail's own negative behaviour and cast her as the 'victim' of someone else's reckless decisions. In a further example, Margaret mentioned that Abigail had become bad mannered and had stolen money from the women she had been working for. In response to this, Margaret was asked whether she thinks Abigail's behaviour could be associated with her alcohol misuse. She responded:

> Margaret: "No, not at all.
>
> Interviewer: Not smoking or anything?
>
> Margaret: No, no, no! But you must know, children don't always tell us the truth. They are always hiding things. It could be that she had had two or three beers somewhere and maybe ate something to mask the smell you see"

By making excuses, blaming others and implicit denial, Margaret employed a supportive- tolerant, emotion-focused coping response. Margaret's narrative highlighted the intricate coping dilemmas that many mothers face when coming to terms with the adolescent's behaviours. The obligation, love and care she feels for her daughter impacted on how she coped with her daughter's alcohol abuse and related behaviours. Margaret described her bond with her daughter as close and open, and thus found

it difficult to acknowledge her daughter's role in her own alcohol abuse. Rather, she blamed her daughter's friends and in this way adopted a supportive-tolerant coping response.

Anne
Anne's narrative illustrated her struggle in coming to terms with her son's drug abuse. As a way of coping, she frequently rationalised her son's behaviour by pointing out the challenges he had faced. To her, Brandon was not entirely responsible for the development of his drug abuse and viewed her divorce from his father as a primary reason for his drug abuse. Anne also blamed herself and her ex-husband for her son's drug abuse. Anne's self-blame was largely related to the fact that she was not living with her son and therefore not able to be involved in his daily life. She thus felt that she had failed as a mother:

> "… it's my fault also that I didn't find time to say 'you are going to do this as I want you to do it' or 'give me a chance', 'tell me what is going on with your life' and have time to say 'tell me, don't tell anyone else'.

> "I felt that I wasn't that mother to him enough, to recognise it at an earlier time now"

Informed by her self-blame and guilt, Anne's coping response was also characterised by her desperate attempts to keep her son happy. She believed that by keeping him happy she could distract him from his drug abuse and eventually he would stop using drugs. Ursula also consistently tested and retested her son in order to establish the severity of his drug abuse. Once she was convinced that his drug use requires professional treatment, she decided to "take him to rehab".

> R: Dagga [*cannabis*], I don't understand the other substances but [his counsellor] says its dagga more than any other thing else (.) OK, that's when we started counselling him and doing all those things to say okay stop doing that boy, it's like this. And we kept on taking urine tests, urine tests. The one that made us to say now this is it, is the one that said his blood has six times more of the substance in his blood and I am= We kept on saying 'if you continue like this, you will go to rehab', 'you will go to rehab', 'try to change', 'try to do this', and most of the time I tried to again make him feel happy. I never stopped doing what I was doing with him before! He was still staying with his dad so I would see him when I was in [town]. We would come to my sister's place because now we are divorced and whatsoever, we would come to my sister's place, and then school holidays, he will be with me [at my place]. So I kept doing all the things that I was doing to make him feel happy. He was with my sister's child, also my daughter. We would go together and have=just to say let's go to the mall, have lunch together, let's play. And I used to play games with him but still he was withdrawn and that's when [his counsellor] said now this is too much, let's take him to rehab.

Anne's narrative reveals that she adopted several coping responses in a trial and error approach. Anne moved between emotion-focused, tolerant coping strategies, such as self-blame, rationalisations, and keeping her son happy, and problem-focused, engaged coping which involved consistently testing him for drugs and admitting him to a treatment facility. Similar to Margaret, Anne's coping response was also influenced by the kind of relationship she had with her son. Anne's son was not living with her at the time that he had started using drugs. Because of this, Anne's relationship with her son was fragile and filled with the guilt and responsibility she felt. She thus constantly tried to keep him happy and delayed seeking treatment until she had exhausted her personal efforts.

Jacky

A pervasive coping response that emerged in Jacky's narrative was verbal confrontation, a form of engaged coping in Orford's model. Jacky reported that she often accused her son and started arguments in an attempt to get him to own up to his drug abuse:

> Jacky: Yes I was watching, whenever he comes from school he was fine, once he goes and comes back at the evening you could see something is wrong not in his speech but his eyes use to be so red all the time because from past experience you could see people that there is something different.

> Interviewer: So then, when you then saw okay now, something is up on this child, what did you do?

> Jacky: No I questioned him and I asked him. I said to him is he smoking and he said no he is not. But I said to him DO NOT LIE because I could see it in his face! Then he laughed at us. One time he got angry on me. He just shouted at me and I said by the grace of God he is using!

During these confrontations, Winston repeatedly lied to Jacky about his drug abuse. Jacky's account displays the anger she felt when Winston tried to deceive her as evident is in her emphasis "DO NOT LIE because I could see it in his face". Jacky's narrative further revealed that she would argue with Winston until "he gets anger" or "shouted" at her. This appeared to have been intentional and her way of showing him that she was not 'backing down' or going to allow his drug abuse behaviour.

> Jacky: Well like you know, like, I will argue with him. I will say to him 'you doing this here' and he will say 'ma I'm not doing this' but I will say like you can see like = say for instance like when he goes and he smokes and he comes back, then I will say to him Winston, you

[are] smoking dagga again! He [will] say 'you mad', 'what you talking about you', 'don't talk like that'. And then when I carry on insisting then he gets angry

Interviewer: I see

Jacky: So then I have to now just pull back

Jacky's narrative also illustrates her disappointment, frustration, and helplessness in which she uses her anger as a ploy to regain control over Winston's behaviour. This is further evident in Jacky's reflection on how she spoke to Winston about the impacts of his drug abuse on the family:

Jacky: "Yeah I told him! Always I tell him! I always tell him! I say to him we get sworn. Like, the things that his is doing, we get blamed. Like my partner say[s] [it is] 'cause we taking his part, we [are] encouraging him. Or 'you giving him that', 'you leaving', 'you don't even worry about him' and all that there. I always tell him that!"

In repeating "always I tell him!", "I always tell him" and "I always tell him that", Jacky is emphasising both her helplessness in affecting his behaviour but also indicating a sense of self-blame.

Another element of Jacky's coping was her actions to limit Winston's drug abuse by confronting those individuals whom she suspected had engaged Winston to use drugs. These individuals were much older than Winston and all of them were living in close proximity to Winston.

Jacky: "I even stopped the friend and told him I'm gonna send the police there. [He said] 'Auntie we don't call Winston, Winston comes on his own'"

Interviewer: So you have tried to speak to them?

Jacky: I've spoken to many of them! Many of them!

Interviewer: And their response is just "he comes on his own"?

Jacky: That 'we don't call him, he comes on his own'"

Jacky relayed another interaction she had with a neighbour where she pleaded with him not to smoke with her son. During this time, Winston was attending a substance abuse rehabilitation programme:

Jacky: "But the lady here at the back her husband also smoke. And I have spoken to him time and time again not to sit and smoke with Winston. And don't encourage him 'cause he's a big man. Don't encourage him to smoke and all that but still!

Interviewer: Do you think Winston smokes with him still?

Jacky: Ay I'm not sure because he smokes here in the yard and Winston doesn't sit with him…

Interviewer: I see

Jacky: And just sometimes now again, he goes to the back and comes back inside because they play music together. But what happens behind our backs, you never know…"

While Jacky was not convinced that her son was using drugs again, Winston's previous lies and deceit caused Jacky to distrust him and be hyper-vigilant of his movements. She thus felt it necessary to approach her neighbour in an attempt to prevent Winston from relapsing, and perhaps in this way prevent the family from going through the same challenges again.

Like the other mothers, Jacky's coping response was complex and suggested an ebb and flow between emotion-focused coping, when she constantly reacted to her anger, disappointment and resentment, and (ineffectual) problem-focused coping responses, when she confronted individuals whom she thought had influenced her son's drug abuse behaviours. These coping strategies are also indicative of an engaged coping response where she, mostly aggressively, tried to regain control over her son's behaviour and constantly showed disapproval of his drug abuse.

Erica

When asked about how she responded to her son's drug abuse behaviours, Erica reported that she generally remained inactive. Erica indicated that she had known about Clint's drug abuse for about two years and, as a way of coping, avoided interacting with him by staying away from home when he is present. Her decision to avoid her son was influenced by her son destructive behaviour. When she was not able to financially support him, Clint would respond in rage and try to intimidate her to give him money. When this happened she would leave home and avoid Clint for a while:

Erica: "If I didn't have [money], I [would] say I didn't have any money. He [then] becomes rude, banging the doors, putting the plates down, [breaking] the glasses, doing everything!

Interviewer: And how did how did, what would you do when he would react in that way? If he would be rude and throwing things, what did you do to him? Would you do anything?

> Erica: I just say I don't have any money = I'm afraid of hitting him because of their rudeness. I just do that and go out maybe till the midday"

In response to her son's drug abuse behaviours, Erica also reported that she started drinking excessively. She explained that she used alcohol to distract her from worrying about her son:

> Erica: Because I, I didn't think anything, I can't think: it's 12 o' clock he didn't come [home], maybe he is dead, maybe he's in hospital, [and] maybe he is taken by the police. I think! I can't think I'm feeling =
>
> Interviewer: You're not, you're not worried?
>
> Erica: Yes I'm not worried about anything!

Although she acknowledged that excessive alcohol use was not an appropriate coping response, she indicated that alcohol made her happy and "it help[ed] me for that time".

Erica's avoidant behaviour and own hazardous drinking suggests that she was not ready to accept that her son had a drug abuse problem. Her son's intimidating and destructive behaviours also extended the distance in their relationship, which was relatively non-existent while he was abusing drugs. Later in the interview, Erica reported that that her son's behaviour had become intolerable. She indicated that he had stolen a significant amount of expensive goods from the family home and then disappeared for two weeks. This experience was extremely devastating for Erica, who subsequently attempted to commit suicide. During her stay in the hospital, she confided in a psychologist, for the first time, about her son's drug abuse and the psychologist helped her to find a rehabilitation programme for her son. Following her suicide attempt, Erica exchanged her emotion-focused tolerant-withdrawn coping response for problem-focused coping. Erica started talking to her son about going to treatment until he agreed, although she continued misusing alcohol.

Ursula
Ursula's coping response was influenced by the numerous occasions that her son had disappeared from home. In response to these experiences, Ursula developed a hyper-vigilant coping response:

> Ursula: "The school closes in November and then he comes back here. When he came back here I'm looking [watching him], ay for one week I see [watch him]. Okay, I see my son and then [after] two weeks he has changed. [He] says okay 'mummy I'm going' [and he] is going away and coming late. And then I'm watching and then I say no I think that Terrance is starting again that things now [referring to drugs]. And then I spoke to his father and then

what must I do because and then he [his father] says no you must try something now because I see now that Terrance is starting that thing".

Ursula reported that she and her husband constantly observed her son's behaviour in order to identify signs that he is using drugs and (re)admit him into a treatment programme as soon as possible: "try something now because I see now that Terrance is starting that things". Embedded in her account is also her sense of helplessness and desperation for her son to stop using drugs. Her hopelessness and distress are further illustrated in the extract below. Aware that he had been caught with drugs at boarding school and subsequently asked to leave school accommodation, his return provokes both anxiety and hyper-vigilance in both her and her husband.

> Ursula: Yeah, even at boarding school and then they [are] starting to do everything [referring to drugs]. If they come here, they [are] stressing us!
>
> Interviewer: So when Terrance is gone you guys are better with each other?
>
> Ursula: Hmm
>
> Interviewer: But when he comes home =
>
> Ursula: = Because there's now= we, we must watch him!
>
> Interviewer: Yes
>
> Ursula: Watching him!
>
> Interviewer: Yes
>
> Ursula: Watching him. Even now there is somebody at the gate [and] they say 'come here, Terrance'. Terrance does not come [and] tell us, mother, ma somebody say I must come with him. They say [nothing], they gone [leave] with him [and then] I don't know what happen[s].

Ursula and her husband were very responsive to Terrance's drug abuse by ensuring professional help each occasion that he was found to be using drugs. Terrance had been readmitted to registered substance abuse treatment facilities, at least, four times but these failed to change his drug use behaviour. In trying to assert greater control over Terrance's drug abuse behaviours, Ursula, and her husband also placed their son in unregistered, religious or cultural, drug abuse treatment facilities, which Ursula was not always in favour of. Ursula was particularly devastated when her husband decided to readmit her son to "the church", a religious drug abuse treatment programme:

Ursula: At [the church] and then when ay there they putting you know the (.) [The church] they put (.) Ay, I don't like those things.

Interviewer: What is that? Sorry, I didn't understand what you were saying.

Ursula: At church [*showing with her hands what happened*]

Interviewer: Were they tying him up?

Ursula: Yeah. For 2, for 3 months

Interviewer: They tied him up?

Ursula: YEAH!

Interviewer: On the legs?

Ursula: On the legs!

Interviewer: What were they tying him up with?

Ursula: They say that because they tying [him] up to stop him from running away… Ay, I don't like that!

Ursula reported that Terrance had tried to run away from 'the church' many times. 'The church' then reacted to this by tying him up. Later Terrance succeeded in running away and returned to the place he frequented for drugs. Once Ursula and her husband were informed that he had run away, they searched for him and his father eventually found him. His father then decided to readmit him to 'the church' and gave them permission to tie him up for an additional two months. Ursula was very angry about this but reported that her pleas to remove him from 'the church' were ignored: "they say I must go back [*she must go home*], and [then] they go back and then they put him for 2 months, another 2 months! So I don't like that! I know that time I was crying" This experience was extremely traumatic for Ursula. Her hopelessness and helplessness to stop her son's drug abuse are also evident and she thus agrees to readmit him to the 'church' as she, at that time, was desperate for help from any source:

Ursula: The father, they say he must go to 'church' because (.) Ay to for- to forget because when he's here he's got a lot [of] friends coming and calling him and then they say I can't do anything [to help him]. They must go there because Terrance, sometimes he does not come home!

Ursula's coping response mainly depicted a problem-focused, engaged coping position. Her coping response was centred on trying to regain control over her son's behaviour by becoming watchful and constantly readmitting him to different forms of treatment. Ursula's enactment of engaged coping is also different to that of Jacky but similar to Anne's coping responses. While Jacky used an aggressive and controlling form of engaged coping, Ursula and Anne adopted watchful, controlling and responsive coping strategies.

Support and seeking support: "I don't really tell anyone about it"

Social support emerged as a complex theme and was intrinsically linked to the mothers' coping responses and personal experiences. While most of the mothers reported that they were not aware of any formal support networks or services in their communities for affected mothers, their narratives suggest that the process of seeking support had to do with more than just the (in)availability of services or support networks. All of the mothers reported that they had a social support network of friends and family that they could rely on during the adolescents' period of substance abuse. However, some of the mothers appeared to have stronger support networks available to them than others.

For example, Anne's social support structure was unique amongst the mother as she was the only mother who sought the assistance of a counsellor to help her cope with the emotional challenges she had been facing during her son's drug abuse. However, Anne's support seeking seemed to have been hindered by the self-blame and guilt she had felt. Her narrative revealed that she continuously tried to find ways to "escape" from talking to her counsellor:

> "Anne: I said I'll call [her] when he's out of rehab and I'll give [her] the whole thing [story]. [But] I'm not going to call [her]. And she said 'I'm going to force you to tell me' and I said you not going to find me! So unfortunately when she's on duty, I'm off and I'm asleep. That's what makes me escape!
>
> Interviewer: But do you want to go and speak to her?
>
> Anne: No we do talk, on [a chat site] at times and say, you know, when I am going to sleep whatsoever, but I'm fine and whatsoever. Then we will talk on [a chat site] but now we had to have that session to say *this* is what happened, *this* is what it is (.)"

For Anne, talking on a chat site was easier as she was able to avoid talking about her son and rather had more casual conversations or chats with the counsellor. She only really met, in person, with her the counsellor when she had sought her assistance to find a social worker to help get her son into treatment. Anne's reluctance to seek and accept support is further emphasised in the way that she isolated herself from her "supportive friends" (Authors, 2015). In a previous paper, we reported on the significant sense of guilt Anne had felt which influenced her abilities to cope (Authors, 2015). Earlier in the current paper we further explained that Anne had become withdrawn and isolated herself from her support networks and felt that she was not a good enough mother to her son (Authors, 2015). Anne's emotion-focused, tolerant coping then restricted her support seeking behaviour, which further compromised her abilities to cope effectively.

Similarly, Jacky's self-blame, guilt, and fear of being blamed restricted her from finding support in her friends and family members. She explained:

> "Jacky: There's no-one that I can speak to 'cause you know some people don't understand that's [why] I always just keep it all to myself. I don't really talk about it to anyone.
>
> Interviewer: And why is that?
>
> Jacky: As I said to you I am not a very, like, a sharing person.
>
> Interviewer: Would you like to have people to talk to about this?
>
> Jacky: Yeah, no I do like it- even the time I went to the [treatment centre] like (.) you see now I can say like I'm an emotional person. When I things- I talk about things li- (.) my emotions (.) Yeah. So sometimes that's, I think that's why I don't really tell anyone about it.
>
> Interviewer: Yeah. So are you concerned about what people may think or is it just because you don't like to talk about things?
>
> Jacky: Well you know when you tell people sometimes people tend to label a person. You know they say 'oh because she didn't have a, like, strong hold on her child, look how her child is, look what her child is doing' all those things you know. What the people that we live with today, they always wanna find fault with other people… they first blame, they say it's because of the parents"

Jacky's expression on being an "emotional person" and that she doesn't "really talk about it to anyone" is also indicative of her struggles in facing the reality of her son's drug abuse and her own devastation. Jacky's support seeking was thus influenced by her coping experiences and the lack of

available formal support networks in her community. Yet, even if there were support services accessible in her community, Jacky's fears of being blamed could still hinder her support seeking.

The rest of the mothers, Ursula, Erica and Margaret, also reported being significantly affected by the adolescents' behaviours, yet they did not recognise the need to seek professional support for themselves. Rather, Margaret, Ursula, and Erica mainly relied on their faith and church networks for support. For Erica, specifically, professional support only became an option after her attempted suicide. The mothers were also not aware of any services for affected mothers and advocated for the establishment of such community services. In all, the mothers' lack of awareness of the importance of seeking formal (professional) support for themselves is a testament to the need for creating community awareness about coping support for affected mothers and families, which has to be validated by the availability of formal support networks and structures.

Discussion

It was evident that the mothers used a combination of the coping types described by Orford et al. (2001) which substantiates previous literature (Butler & Bauld, 2005; Jackson et al., 2007; Usher et al., 2005; User et al., 2007). Four forms of coping can be gleaned from our research; a) emotion-focused, tolerant-withdrawn coping, b) a hybrid coping combination of problem and emotion-focused as well as engaged-coping responses, c) problem-focused, engaged coping and d) emotion-focused, tolerant coping. Withdrawn coping responses involved either physically or emotionally withdrawing from the adolescent which for some mothers reflected hurt or disappointment while for others it was indicative of their helplessness and hopelessness. Tolerant coping responses meant making excuses for the adolescent, being inactive and not holding the adolescent accountable for his/her behaviour. Engaged coping mainly involved efforts to regain control over the adolescents' behaviour such as being watchful, confronting the adolescent and supporting the adolescent to seek treatment. Problem-focused coping included efforts that were directed at changing, or regaining control over the adolescent's behaviour. Emotion-focused coping involved actions such as reacting in anger, avoiding, denial or withdrawing from the adolescent.

While Orford's coping model is useful to quantitatively classify AFMs' coping responses, our findings suggest that a simplified perspective that contrasts 'tolerating', 'engaging' and 'withdrawing' coping responses is inadequate in recognising the complexities in mothers' coping experiences. We found that coping with an adolescent with a substance abuse problem involves the interplay of coping

behaviour and emotions (Orford et al. 1992; Orford et al. 2010). For example, coping appeared to be intrinsically linked to the nature of the mothers' relationships with their adolescents. Mothers, who reported 'closer' bonds with the adolescent during his /her period of substance abuse, responded in ways that were indicative of emotion-focused, tolerant coping. Whereas mothers who had conflictual relationships with their adolescents either avoided the adolescent or related to the adolescent in a confrontational way. The mothers coping behaviour was also influenced by their own emotional distress. For example, some of the main emotions that emerged in Jacky's narrative were anger, resentment and shame. She thus responded to her son's drug abuse behaviours by confronting him and starting arguments as a way to illustrate her disappointment and hurt. Another example would be Anne, who felt guilty and responsible for her son's drug abuse and subsequently indirectly tolerated his behaviour.

We further noted that two of the mothers moved between emotion-focused and problem-focused coping responses while three of the mothers', Erica, Ursula and Margaret coping responses remained consistent. However, while some of the mothers had similar coping responses, the enactment of the same coping approach was different across the mothers' narratives. For example, two mothers adopted a tolerant coping response, yet Margaret's coping was characterised by denial and blaming others while the Erica avoided interacting with her son. Engaged coping was also adopted by three of the mothers. For two of these mothers, this meant aggressively trying to assert control over the adolescent's behaviour through confrontations (Jacky) or forcefully and consistently readmitting the adolescent to treatment (Ursula), while Anne avoided conflict with her son and tried to regain control over the adolescent's drug abuse through regular drug tests and eventual admittance to treatment.

Understanding the coping experiences of affected parents' is extremely important for the development of support interventions to help them cope effectively and decrease the possibility of maladaptive coping responses. Good quality support networks are considered important resources for effective coping (Orford et al., 1998; Orford et al., 2010b). Essential to the development and provision of support interventions is the availability, accessibility, awareness and applicability of these services. One of the key issues that emerged in my research was that the mothers had limited formal support resources readily available to them in their communities. This not only compromised the accessibility of these services but also their willingness to seek assistance as they generally did not know where to go, apart from the substance abuse treatment centre which for many was quite a distance away.

The availability, accessibility and awareness of support services are thus interrelated and essential. If mothers are to be supported to cope, they should not only have easy access to support services but should be made aware that their wellbeing is as important as the adolescent's and be encouraged to seek support. As pointed out by Bogenschneider, Little, Ooms, Benning and Cadigan (2012, p.16) "if families are to assume responsibility for supporting the development of their members, they need to function effectively". One way for affected families to function effectively is to ensure that mothers (and parents in general) are equipped with the support they need to cope better. The mothers in the current study generally did not recognise the importance of their own coping support as they mainly prioritised the needs of the adolescent. Also, for some of the mothers, their own support needs were overshadowed by the sense of guilt and blame they had been feeling which created hesitance to seek both formal and informal support. This particular finding highlights that coping for affected mothers is surely not a simple process, but may involve different approaches with the hope that it will produce different forms of relief or change.

Moreover, the uptake of support services and its association with the mothers' coping responses and personal experiences also emerged as important. For example, a key finding in the current study was that seeking support was related to the mothers' self-concept and issues related to blame and guilt. Support interventions should thus use approaches and narratives that explicitly avoid blame and encourage mothers to seek assistance. These interventions also need to understand that mothers may cope differently with the stresses they experience and thus need to be sensitive to the diverse needs of mothers. Mothers are also likely to have access to (or not) different resources. For example, while most of the mothers in the current study reported that they had informal networks to support them (like friends and/or family) available to them, only two of the mothers were able to access formal counselling to help them cope. The findings the current paper thus emphasise the need for promoting awareness amongst families about the significance of maternal support to help mothers cope effectively.

Conclusion

It is acknowledged that the coping responses presented in this paper do not represent the experiences of all affected mothers. While generalizability is not assumed, the findings of this paper have implications for researchers and practitioners who work with AFMs and adolescent substance abusers Findings from elsewhere frequently report the frustration that affected parents experience in accessing services that help mitigate the impact of an adolescent substance abusing individual on the parent. These parents have indicated that they felt misunderstood, blamed and not adequately supported

(Choate, 2011; Jackson & Mannix, 2003). However, further research is needed to understand how affected mothers in South Africa experience and evaluate support services.

Furthermore, the qualitative, phenomenological approach adopted in this study helped provide rich and complex information, but also gave voice to mothers who often suffer in silence. The interactive Lifegrid approach further enhanced the quality of our data as it assisted in building rapport with the mothers as well as to explore the breadth and depth of issues as they emerged (*Authors, 2015*). Given that in this study the mothers were recruited from subsidised private rehabilitation centres where their adolescents were undergoing treatment for substance abuse, we acknowledge that these mothers' experiences and perspectives may be different to other mothers whose adolescent is not, or has not received any professional support. In the South African context, the absence of fathers is notable. In the current study, fathers' who were present in the adolescents' lives were not willing to participate in the study. The role of fathers in this groups of individuals (if not absent altogether) was to respond with aggressive control or the absence of any accountability or responsibility. It is evident that many of the current studies that document parents' experiences include a relatively smaller sample of fathers compared to mothers (see for example Choate, 2011; Hoeck & Van Hal, 2012; Jackson et al., 2007). It is, therefore, imperative for researchers who are interested in exploring the coping experiences of AFMs to engage with these gendered sampling challenges and identify strategies in support of narrating the fathers' stories.

Acknowledgements

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Table 4: Participants

Mothers' aliases	Adolescents' aliases and gender (M/F)	Age of adolescent	Residing with mother	Substance adolescent was admitted to treatment for	Duration of adolescents' substance abuse	Rehab history
Ursula	Terrance (M)	15	Yes	Whoonga* and cannabis	Approximately 4 years	Fourth time in treatment
Jacky	Winston (M)	17	Yes	Cannabis	Approximately 2 years	First time in treatment
Erica	Clint (M)	15	Yes	Whoonga	Approximately 4 years	First time in treatment
Anne	Brandon (M)	15	Yes	Whoonga and cannabis	Approximately 2 years	First time in treatment
Margaret	Abigail (F)	16	Yes	Alcohol	Approximately 1 year	First time in treatment

* Whoonga is a highly addictive powder that is mixed with cannabis and smoked. It consists of low-grade heroine and other hazardous additives like rat poison (http://www.kznhealth.gov.za/mental/Whoonga.pdf). It is also known, in South Africa, as 'nyope' or 'sugars'.

Chapter four: Implications

Overview

This chapter will discuss the implications of the findings of this thesis. I will first present the implications for theory and research, followed by a discussion of the policy implications in the form of a policy review article (Paper 5).

Implications for theory research and practice

In the current study, I adopted the Stress-strain-coping-support (SSCS) model developed by Orford and colleagues (1992; also see Orford et al., 2013) as an explanatory theory to the mothers' experiences. The SSCS model has been used with samples from a variety of contexts including Italy, Australia, England and Mexico (Orford et al., 2013). Using Lazarus and Folkman's (1984) notions of emotion-focused and problem-focused coping was useful to understand the mothers coping experiences, however, Orford's typology assisted in making finer distinctions in relation to the various forms of coping that were used.

The SSCS model was adopted as it presented a multifaceted conceptualisation of family members' experiences when living with a relative with substance abuse problems. The SSCS model conceives the stresses that are produced by the relative's substance abuse to be significant and hazardous to the health and wellbeing of the family members and that it prompts them to find ways to cope (Orford et al 2010). It further recognises the need for coping support for affected family members[8] who are required to deal with the relative's substance abuse behaviours in addition to their own emotional challenges ensuing from the relative's behaviour. The SSCS model proved valuable in elucidating and classifying the mothers' experiences, although it presented a much stronger focus on adult substance abusers than on adolescents. Nevertheless, the model theoretically and practically allowed me to explore the mothers' narratives both as individual case studies and a collection of (unheard) voices.

The findings of my study that relate to the mothers everyday experiences of stress and strain generally corroborate Orford et al.'s research and that of other international (see Butler & Bauld, 2005; Jackson et al., 2007; Orford et al., 2013; Usher et al., 2007) and local (see Abrahams, 2009; Fouten, Groenewald & Abrahams, *unpublished*; Mabusela, 1996; Masombuka, 2013; Rebello, 2015) studies. The distress the mothers experienced manifested in feelings of concern for the adolescent's well-being, sadness, isolation, self-blame, worry, anger, hopelessness, signs of depression and loss of

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[8] Family members affected by a relative's substance abuse

interest in their own lives (see Paper 3, Groenewald & Bhana, 2015). However, in relation to coping and support, the findings of this study expand the SSCS model's conceptualisation and the current literature.

The current study found that the mothers used problem-focused and emotion-focused coping through a combination of tolerating, withdrawing and engaged responses. The mothers' coping responses were complex and diverse. Where some of the mothers adopted more than one coping response to the adolescents' behaviours, other mothers' coping responses remained singularly focused and were applied consistently. Although the SSCS model was valuable to identify different coping responses, the findings showed that simply classifying the mothers' coping responses neglects to recognise the complexities in mothers' coping behaviours. For the mothers in my study, coping was not a straightforward process but was influenced by the nature of their relationships with the adolescents and their own emotional positions. For example, mothers who reported 'closer' bonds with the adolescent while s/he was using substances and blamed themselves for the adolescent's behaviour, responded in ways that were indicative of emotion-focused, tolerant coping, whereas mothers who had conflictual relationships with their adolescents and felt angry towards them, either avoided the adolescent or related to the adolescent in confrontational ways.

The findings of this study also showed that the enactment of the same coping response differed across the mothers' narratives. Where engaged coping, for some of the mothers, comprised aggressive responses like confrontations or forcefully readmitting the adolescent to treatment in an effort to regain control over the adolescent's behaviour. For others engaged coping involved avoiding conflict and regular drug tests and admittance to treatment. Unlike the current study, the literature generally does not delve into the complexity of coping responses but is largely concerned with parents' experiences and/or classifying parents' coping responses (see for example Butler & Bauld, 2005). While understanding the mothers' experiences was central in the current study as well, it is important for studies to additionally explore how coping is comparatively enacted in order to develop relevant support initiatives to assist mothers to cope effectively.

In relation to support, the mothers reported that the availability of support services for affected families in their communities was limited. This has also been found in studies conducted by Abrahams (2009), Jackson & Mannix (2003), and Usher et al. (2007). While the current literature on support generally focuses on the availability and accessibility of support services for affected families,

my study also revealed the intricate relationships that exist between the mothers' coping responses, personal experiences, and support seeking behaviour. In other words, the ways in which some of the mothers responded to the distress they had been experiencing as a result of the adolescents' behaviour (for example by withdrawing due to feelings of guilt or hopelessness) to a large extent dictated whether or not the mothers sought formal coping support. Further research on the nature of these relationships is warranted in order to contribute to and amend current theories and practices regarding coping support for affected mothers and families as a whole.

Given the findings of my study, the need for multifaceted interventions and support services for mothers is recognised. These interventions need to include components that will provide mothers with the necessary skills to identify and subsequently prevent the adolescent's substance abuse or relapse, but also has to have a strong focus on the provision of coping support. One particular support model that has proven effective with families internationally is the 5-Step method, an intervention designed to support families of substance abusers (Copello, Templeton, Orford & Velleman, 2010; Ibanga, 2010). This model was informed by the Stress-Strain-Coping-Support model (SSCS) developed by Orford et al. which recognises that both the substance-abuser and the family members are disempowered by the substance abusers behaviours (Orford et al., 1998; 2001; 2013). It incorporates a flexible, multifaceted approach to supporting families and can be conducted in a face-to-face format or web-based (please refer to paper 5, Groenewald & Bhana, *under review*). This intervention has been found to be effective with families in the UK and Italy (Arcidiacono, Velleman, Procentese, Albanesi, & Sommantico, 2009; Copello et al., 2010; Ibanga, 2010; Templeton, Zohhadi, & Velleman, 2007; Velleman, Arcidiacono, Procentese, Copello, & Sarnacchiaro, 2008) and is currently being tested in India as well.

Adapting the 5-Step intervention model to maximise its efficacy in South African contexts is an important direction for applied research. Nevertheless, as with many intervention approaches, its sustainability requires the support of national and local policymakers, family researchers and healthcare providers. Such empirical data could inform the amendment of current family and substance abuse related policy documents which will facilitate the prioritisation of support for mothers (and parents in general) of adolescent substance abusers (Paper 5, Groenewald & Bhana, under review).

Furthermore, the qualitative, phenomenological approach adopted in this study proved particularly useful in drawing out the mothers' experiences and provided rich and complex information. The methodology also enabled the mothers to give voice to their stories which are often missed or neglected as the primary focus is on the adolescents' substance abuse. The mothers were afforded a space to engage with a range of challenging issues that they had not confronted before. For this opportunity, the mothers expressed appreciation and considered our interviews as a form of therapy. This further highlights the mothers' desire to be understood and supported to cope with the emotional challenges they endure daily.

The study also points to the importance of identifying appropriate data gathering tools when conducting sensitive research. While studies have reported on the usefulness of research diaries for inquiries on sensitive topics (see for example Clarke & Iphofen, 2006; Day & Thatcher, 2009; Furness & Garrud, 2010; Harvey, 2011), we found this approach less useful in various ways (see Chapter 2, paper 2). However, researchers interested in understanding sensitive issues and how the impact of these issues on the lives of the participants over time, may find the lifegrid (LG) useful. The LG approach helped enhance the quality the information as it allowed me to explore the breadth and depth of issues as they emerged in an interactive and non-threatening way (Groenewald & Bhana, 2015). In essence, because of the strong association between specific life events and mothers experiences of these events, the quality of the information provided helps alleviate the need for enrolling a larger number of participants. This is an important consideration in contexts where recruiting participants into a study is impacted upon by the sensitivity of the topic or where the phenomenon itself may be rare.

Therapeutic implications of research techniques

The Lifegrid (LG)

In addition to the methodological advantages associated with LG, this study further suggests that the LG has the potential to structure the recall of significant life events in a therapeutic setting, thereby potentially providing event-focused resolutions rather than general therapeutic guidance. First, the LG can engage the client (more so than a general conversation would) to provide detailed accounts of their experiences as it has been found to act as a "reassuring memory hook" (Wilson, Cunningham-Burley, Bancroft, Backett-Milburn & Masters, 2007, p. 144; also see Groenewald & Bhana, 2015). For clients who show difficulty with recalling of certain events, be it because of memory or sensitivity of the issues, the visual and temporal chart encourages discussion and researchers have argued that graphic elicitation tools promote the participants' awareness of their own agency (Kesby, 2000;

Sheridan, Chamberlain & Dupuis, 2011). The flexibility of the LG is also notable here as it will allow the clients to articulate their stories in a conversational and normative way at a pace that the clients are able and willing to recall them.

Second, through the LG, the therapist can become aware of, and physically document, those issues that are upsetting to the client. The LG conversation can thus be stopped at any time, which then allows the client to reflect on what was discussed and engage further in the next session (see Groenewald & Bhana, 2015; Harrison, Veeck & Gentry, 2011; Sheridan et al., 2011). In the context of substance abuse, life histories are particularly significant as it will reveal elements related to the development of the persons substance use. As Mattingly and Garro (1994) assert, narratives help us make sense of "how things have come to pass and how our actions and the actions of others have helped shape our history; we try to understand who we are becoming by reference to where we have been" (p. 771).

Third, the LG has the potential to strengthen the therapist-client relationship. This is because of the flexibility and collaborative completion of the tool where the client has control over what s/he wishes to disclose at a pace that s/he is most comfortable with. This allows the client to visually and emotionally construct their past and present realities, supported by therapist through questions of clarity, depth and understanding.

Fourth, in using a collaborative tool like the LG which documents the client's accounts in a non-clinical way, the therapist can adopt a less clinical role (apparent) during therapy which could further promote openness during sessions. The collaborative and open documentation of the clients' narrative on the LG tool could also avert the therapist from taking notes in a private book which some clients could associate with feeling 'studied'. Rather, research shows that the LG makes participants feel heard and allows them to start processing their own experiences (Wilson et al., 2007).

Finally, while historical information and depth can certainly be obtained through standard therapy sessions, the LG produces a visual and temporal documentation of a person's life, or aspects thereof, which the person can connect to, cognitively and emotionally. This then encourages self-reflection and meaning making in different ways to that of therapeutic interviewing. The LG therefore can serve both as a tool for data collection while at the same time providing the research client with a sense of genuinely being listened to, an important element for building trusting relationships.

Research diaries

Diary entries, also referred to as journaling, therapeutic writing or writing therapy, are often used as homework assignments in psychotherapeutic approaches such as cognitive behavioural therapy (CBT) (Gonzales, Schmitz & DeLaune, 2006; Kazantzis, Deane & Ronan, 2000; Rees, McEvoy & Nathan, 2005; Wright, 2002). Wiitala & Dansereau (2004, p. 187) indicate that therapeutic writing is used as "a means of dealing with stressful or traumatic events [...] that involves writing (without feedback) about the thoughts and feelings surrounding a stressful event". Many have reported on the value of writing therapy which has been associated with effective coping responses (Lumley & Provenzano, 2003) and personal growth (Ulrich & Lutgendorf, 2002). However, as found in my study, *writing* is not always effective in encouraging people to talk about stressful events (see Chapter 2) which may hold implications for counsellors who wish to make use of diaries or therapeutic writing as a form of homework in therapy.

Qualitative phenomenological research can be reminiscent of therapy in its ideological interest in lived experience, depth of understanding and meaning making. Research diaries have also been found to be useful for its abilities to encourage disclosure of sensitive issues in a non-threatening way (Bolger, Davis & Rafeali, 2003; Boserman, 2009). However, when compared to therapeutic settings, qualitative *research* is limited by the time constraints to which project work is often bound. In my study, these time constraints compromised participant engagement in three ways. First, the use of dairies may require a period of training to become part of everyday reflective practice. While the participants in the study knew the concept of diaries, none of them had actually used it as a way of reflecting on their experiences or even to record daily events. Second, in a research context, there was insufficient time available to familiarise themselves with the activity of writing. Third, it was evident that the participants had not yet come to terms with their experiences and were thus not ready to confront and engage with their experiences through writing. Notably, the participants were also engaging with the researcher through the LG interview at the time and thus retelling and confronting these experiences through this approach.

Unlike in research, therapists are able to engage with their clients over longer periods of time and at a pace that the client is most comfortable with. The use of diaries in my study may have been more productive if additional structure was provided initially to allow familiarisation with keeping a meaningful record by participants. It is also possible that engagement with writing activities could be better embraced during therapy as there is an expectation that it would promote positive change whereas this is not the case in research studies (although it could be an outcome). The current study thus suggests that diary exercises be introduced later in treatment, once the client has shown progress

in processing his/her experiences to encourage more meaningful narratives and avoid disclosure fatigue. For example, the LG could be used in initial sessions to start conversations around how the child's substance abuse started and how the family was impacted using time and events as hooks for extended discussion. Later in the therapy process, the LG could be exchanged for therapeutic writing where mothers can be asked to discuss specific events through writing which will form the basis of discussion in the next therapy session.

Ultimately, although writing can be an effective homework exercise, it is important to recognise that diaries may not work for everyone, and is best suited to individuals who are able and willing to engage in self-expression and reflection through writing (Harvey, 2011; Hayman, Wilkes & Jackson, 2012).

Understanding how affected families are represented in national policies

Policy documents that are carefully designed and informed by empirical research offer an important platform to prioritise affected families and provide policy directives for practitioners. To explore the role of affected families in national policies, I reviewed three national policies that relate to substance abuse and families respectively. The findings of this policy review are presented in the paper that follows.

Paper 5 (Accepted in DEPP)

Substance abuse and the family: An analysis of the South African policy context

Candice Groenewald and Arvin Bhana

Abstract

Using the Family Impact Lens (FIL) framework, this paper explored how family issues in relation to substance abuse are addressed within three South African policy and strategic documents: the *Prevention of and Treatment for Substance Abuse Act (2008)*, the *National Drug Master Plan (2013-2017)* and the *White paper on families in South Africa.* In keeping with the framework of the FIL, we evaluated whether the policies 1) mention the effects of substance abuse on the family, 2) recognise the importance of the family in the relative's rehabilitation, and 3) address the needs of family members by providing policy directives to support families who are affected by substance abuse (AFMs). While all three policies recognise that families are negatively impacted by a relative's substance abuse, the policies are overly focused on individual approaches to dealing with substance abuse and fail to adequately address the support needs of AFMs. Research on the support needs of AFMs is warranted in addition to the evaluation or development of evidence-based strategies to support AFMs. Further implications and recommendations for policy makers, researchers and practitioners are provided in the paper.

Introduction

Substance abuse and addiction are complex and highly prevalent public health problems amongst both adults and youth worldwide. In South Africa recent prevalence estimates from the South African Community Epidemiology Network of Drug Use (SACENDU), a national alcohol and drugs sentinel surveillance system that monitors trends in substance abuse based on data from specialist treatment facilities across South Africa, indicate that over 17 000 patients were admitted to treatment centres across South Africa for substance abuse and addiction during 2014 alone (Dada, 2015). Of these patients, 20% were under the age of 20 years (Dada, 2015) and for the period July to December of 2014, approximately three-quarters of all patients were first-time admissions (Dada et al., 2015).

However, these numbers are likely to underestimate the substance abuse problem in South Africa given that they only represent individuals who are able to access treatment. National epidemiological evidence further indicates that South Africa has high rates of untreated substance use disorders (Herman, Stein, Seedat, Heeringa, Moomal, Williams, 2009) exacerbated by the limited availability of inpatient and outpatient treatment services offered by specialists staff and few low threshold early intervention services in primary care facilities (Myers and Sorsdahl, 2014).

The impact of substance abuse on the family

The effects of substance abuse extend beyond the individual user and profoundly affect the health, emotional and economic wellbeing of the family (Copello, Templeton, Krishnan, Orford, & Velleman, 2000; Orford, Velleman, Natera, Templeton, & Copello, 2013;). It is estimated that at least 2 family members will be adversely affected by a relative's substance abuse (Copello, et al., 2000) suggesting that over 34,000 family members will be affected (hereafter referred to as affected family members (AFMs)) given the treatment admission statistics for South Africa. Globally, the number of family members adversely affected by substance abuse is estimated at around 100 million (Orford et al., 2013).

Over the last decade, Orford and colleagues have developed a model that explains the experiences and supportive needs of families affected by a relative's substance abuse called the Stress-Strain-Coping-Support model (SSCS) (Orford et al., Orford et al.,2013). The SSCS model takes into account the psychosocial and economic effects of a relative's substance abuse on the family (Copello et al., 2008) and recognises that both the user and the family are disempowered through the relative's substance abuse behaviours (Orford et al., 2013). The stresses experienced as a consequence of the relative's substance abuse have been associated with increased psychological and physical morbidity (Orford, Natera, Davies, Nava, Mora, Rigby et al., 1998; Copello et al., 2000;). Depression, suicide, insomnia and emotional distress such as feelings of shame, humiliation, blame and loss are common experiences for AFMS (Butler & Bauld, 2005; Abrahams, 2009; Orford et al., 2013; Jackson, Usher

& O'Brien, 2007; Usher, Jackson & O'Brien, 2007; Abrahams, 2009). Ray and colleagues show that AFMs have an increased likelihood to be diagnosed with several mental health problems including depression, substance use disorders, and trauma when compared to family members of individuals who are suffering from diabetes or asthma (Ray, Mertens & Weisner, 2009). A relative's substance abuse also causes family conflict, strained family relationships (Orford et al., 2013; Rowe, 2012; Gruber & Taylor, 2006) and family financial strain as a result of theft and unemployment by the substance abuser (Jackson & Mannix, 2003; also see Jackson et al., 2007; Usher et al., 2007). When the substance abuser is an adolescent, much of the financial strain falls on the parents as, in addition to experiencing theft and destruction of property, they are expected to pay for the child's rehabilitation, medical visits and general living costs (Jackson & Mannix, 2003; Masombuka, 2013). Family life is thereby disrupted by the relative's substance abuse and targeted interventions to help family members cope with the stresses they face is indicated (Orford et al., 2013).

Despite the stress associated with a relative's substance abuse being profound and complex, (Copello, Templeton & Powell, 2009), family members of substance abusers often suffer in silence and have little support (Orford et al., 2013). Recent international reviews indicate that substance abuse treatment services are generally directed at treating the individual's addiction and many neglect to also provide services to support families stressed by the relative's substance abuse (Velleman, 2010; Gruber & Taylor, 2006). Velleman (2010) indicates that, in the UK, treatment approaches typically consider the family as dysfunctional and in need of corrective change. In addition to strengthening families, support services are needed to help family members cope with the psychosocial challenges they endure as a result of the relative's substance abuse.

Critically, while the regulation of alcohol use is well established in legal and regulatory systems, less common are public policies which consider substance abuse as a social or health problem (Babor et al.2010). Policies are a first step and imperative to the development of supportive and holistic approaches for AFMs. This paper specifically examines whether and how AFMs are prioritised in three South African policy documents pertaining to families and substance use.

South African policies related to substance abuse and families

In the past decade, there has been some progress towards the development of policy documents for families and the prevention and treatment of substance abuse in South Africa. In this paper we examined family issues in relation to substance abuse in three South African policy documents: the *Prevention of and Treatment for Substance Abuse Act (2008)*, the *National Drug Master Plan (2013-2017)* and the *White paper on families in South Africa*. While a number of other policy documents

have some interest in issues related to substance abuse such as the Liquor Act (2003), the South African schools Act (1996), the Department of Basic Education's National Strategy for the Prevention and Management of Alcohol and Drug Use Amongst Learners in School (2013), the Draft National Youth Policy (2014-2019), and the Mental Health Care Act (2002), these policies are not *primarily* addressed to family substance abuse issues. Further, given our specific interest in AFMs, only national policies that have a particular interest in substance abuse prevention and/or treatment in families were considered in our analysis. A brief overview of the aims of each of the policies reviewed in this paper helps provide a backdrop to the analysis of these policies.

The Prevention of and Treatment for Substance Abuse (PTSA) Act was adopted in 2008 and is South Africa's main drug and alcohol policy. It was developed as a national response to South Africa's rapidly increasing substance abuse problem with a strong focus on supply, demand and harm reduction. *The National Drug Master Plan (NDMP) (2013-2017)* was developed by the Central Drug Authority (CDA) of South Africa and is informed by the PTSA Act (1992 & 2008). The CDA is represented by experts in the field of substance abuse as well as national and local government representatives (NDMP, 2013-2017). The aim of the CDA is to "direct, guide and oversee it's [the NDMP] implementation, as well as to monitor and evaluate the success of the NDMP and to make such amendments to the plan as are necessary for success" (NDMP, pp. 21-22).

The *White paper on families in South Africa (2012)* is still in its infancy and was developed by the national Department of Social Development of South Africa. This Department also has primary responsibility, in collaboration with the Department of Health, for providing public services for the treatment of substance use. The White paper aims to provide a platform to "undertake activities, programmes, projects and plans to promote, support and nourish well-functioning families that are loving, peaceful, safe, stable, and economically self-sustaining that also provide care and physical, emotional, psychological, financial, spiritual, and intellectual support for their families" (p.9). The dominant focus of this document is on fostering positive family environments within the diverse family structures of South Africa.

Policy review methodology

In this paper the critical questions posed by Velleman (2010) in his recent review of the place of AFMs in UK policies provided the basis for evaluating the role and response to AFMs in the policy documents:

> 1) Do the policies mention the effects of drug and/or alcohol use and/or abuse on family members?

2) Do the policies discuss family members' need for help or support and identify strategies in mitigation of these needs?

3) Do the policies recognise the importance of including the family in the treatment of the relative's substance abuse?

To explore these questions, we used the Family Impact Lens (FIL) and associated checklist developed by Bogenschneider and colleagues (Bogenschneider & Mills, 2002; also see Bogenschneider et al., 2012). Through the FIL approach, Bogenschneider shows that all policies, even if they are not specifically focused on families, have an impact on family life (Bogenschneider et al., 2012). According to Bogenschneider et al. (2012, p. 517), particular consideration should be given to "how families are affected by an issue, if families contribute to an issue, and whether involving families in the response would result in more effective and efficient solutions" (Bogenschneider et al., 2012, p.517). Thus, the FIL framework can be used to assess established policies or programs, as well as the ways policies or programs, are implemented (Dunst et al., 2007). The FIL was considered a useful tool for analysing the policies in this paper because it has a specific interest in the role of families, it has broad applicability to understanding how substance abuse policies fulfil criteria for effective and efficient policy solutions involving families, and it has been devised to analyse how policies are developed and implemented regardless of the whether the policies are established or newly formed. The FIL and family impact checklist have proven useful in assessing policies such as the Family and Medical Leave Act (1993) (Breidenbach, 2003) and the Mental Health Parity Act in the United States (Balling, 2003). According to the authors' knowledge, there is no other policy analysis framework that position families at the centre of policy development and implementation.

In order to operationalize the FIL, Bogenschneider and colleagues (see Bogenschneider & Mills, 2002; Bogenschneider et al., 2012) developed a checklist based on five guiding principles: (a) family support and responsibility, (b) family stability, (c) family relationships, (d) family diversity and (e) family engagement. These elements are outlined in the table below (Table 1).

[INSERT TABLE HERE]

Following a review of the policies and completion of the checklist by the first author, the results were independently reviewed by the second author. Discrepancies were resolved through consensus between the two authors.

Results

Before embarking on a formal analysis of the policies in question, we begin this discussion by describing the extent to which the policies recognise the effects of substance abuse on the family. All three policies make some reference to the family effects of substance abuse. While the *PTSA Act (2008)* does not explicitly mention the family effects of drugs and alcohol, it does recognise that families and communities are negatively impacted and therefore require social support. These services are discussed in the section on support below.

 The impact of substance abuse on the family is referred to several times in the foreword of the *NDMP (2013-2017*, p. 2):

> The impact of alcohol and substance abuse continues to ravage families, communities and society"; "The use of alcohol and illicit drugs impact negatively on the users, their families and communities; Socially, families of addicts are placed under significant financial pressures due to the costs associated with theft from the family, legal fees for users and the high costs of treatment. The emotional and psychological impacts on families and the high levels of crime and other social ills have left many communities under siege by the scale of alcohol and drug abuse.

However this does not translate into a policy directive in the body of the policy where family effects are captured in the following quote:

> As in the case of alcohol abuse, it is important to bear in mind that the emotional, social and financial costs arising from the abuse of drugs other than alcohol affect not only the abusers themselves, but also other members of their (immediate) families. (NDMP, 2013-2017, p. 44)

The *White Paper on Families in South Africa (2012)* outlines a range of socio-economic conditions that negatively affect South African families (see section 2.3.3 of the White Paper). These include poverty and inequality, father absenteeism, lack of suitable housing, HIV and AIDS, crime, substance abuse, gender-based violence, child abuse and neglect, teenage pregnancy, moral degeneration, and declining intergenerational relations. The White Paper states the following:

> Substance abuse by family members places major stress on the family, places constraints on financial resources, and can lead to a breakdown in family relationships as family members- both nuclear and extended, may experience feelings of abandonment, anxiety, fear, anger, concern, embarrassment, or guilt. In consequence substance abusers are likely to find themselves increasingly isolated from their families (White Paper on Families in South Africa, 2012, p. 27)

Additionally, two of the policies, namely the *NDPM (2013-17)* and the *PTSA Act (2008)* mention the inclusion of the family in the treatment of the relative: "Family therapy and significant family/parental involvement in treatment should be a major component of treatment of SUDs" (NDMP, p. 157) and "involving and promoting the participation of children, youth, parents and families, in identifying and seeking solutions to their problems" (PTSA, p. 22). However, these declarations seem relatively unsupported in the body of the policies. Although the endorsement of family-focused interventions demonstrates that families are gaining more recognition in South Africa's policy and political agendas, Velleman (2010) warns that this "does not necessarily mean that [the government] will actually insist on implementation".

We now focus on a formal analysis of the relevant policies in relation to the guiding principles of the FIL.

Family support and responsibility

Recent surveillance evidence indicates that the family continues to be either the primary (in most cases) or a secondary source of payment for individuals admitted to treatment centres in South Africa (Johnson et al., 2014). The financial consequences related to substance abuse are substantial as they not only include theft or destruction of property but also costs associated with rehabilitation. Rehabilitation costs include treatment centre costs as well as other expenses such as family costs associated with travel to and from treatment for visits and family meetings, and time taken off work. This financial burden is especially acute among families already struggling economically and who make up the bulk of those seeking treatment.

Aside from a brief mention in the *NDMP (2013-2017)*, the policy documents make very little reference to the financial costs of substance abuse on families or strategies to provide financial relief to families. The NDMP (2013-2017) states:

> The harmful use of alcohol and drugs exposes non-users to injury and death due to people driving under the influence of alcohol and drugs and through being victims of violent crime. Socially, the families of addicts are placed under significant financial pressures due to the costs associated with theft from the family, legal fees for users and the high costs of treatment. The emotional and psychological impacts on families and the high levels of crime and other social ills have left many communities under siege by the scale of alcohol and drug abuse. (NDMP, 2013-2017, p. 2)

No particular strategies to alleviate the financial burden of substance abuse on families are mentioned in the NDMP (2013-2017). While the *PTSA (2008)* does not mention the financial costs of substance abuse on families, the document does refer to establishing public treatment centres (page 26) which could provide families with some relief.

Family stability and family relationships

The family stability and family relationship principles are combined as these terms are used interchangeably in the policy documents. All three policies discussed issues pertaining to the prevention and treatment of substance abuse in relation to the family.

The PTSA (2008) lists various intervention strategies related to family members and/or affected persons. Prevention strategies for families and affected persons focus on the preservation of family structure, development of parenting skills for at-risk families, and equipping parents and families with drug- and rehabilitation related information as well as tactics to identify early warning signs. Early intervention approaches related to families and affected persons include identifying at-risk families and communities, enabling affected persons to identify the warning signs of substance abuse, informing families and communities about the resources and support systems available to them, "involving and promoting the participation of children, youth, parents and families in identifying and seeking solutions to their problems" (PTSA, 2008, p. 22), economic empowerment and skills development.

Treatment strategies for families are mentioned under the out-patient services category indicating that the "manager of a treatment centre may establish any of the following out-patient service […] (d) holistic treatment services, including family programmes, treatment services, therapeutic intervention, aftercare and reintegration" (PTSA, 2008, p. 36). In a similar vein to out-patient services, support services for families and affected persons are articulated as suggestions rather than implementation guidelines. The PTSA (2008) stipulates that

> [t]he minister may (a) from funds appropriated by Parliament for that purpose, provide financial assistance to service providers that provide services in relation to substance abuse; (b) for the purposes of paragraph (a) prioritise certain needs of services for persons affected by substance abuse; (c) in the prescribed manner, enter into contracts with service providers to ensure that the services contemplated in paragraph (b) are provided (PTSA, 2008, p.18)

The NDMP (2013-2017) identified "families in all their manifestations" as target populations for "attention and action by national and provincial departments" (p. 76) though this was not listed as a priority area for either family support or research. The NDMP (2013-2017) highlights demand, supply, and harm reduction. The demand reduction strategy aims to reduce "the need for substances through prevention that includes educating potential users, making the use of substances culturally undesirable […] and imposing restrictions on the use of substances"(NDMP, 2013-2017, p. 29). Demand reduction interventions that mention families in the NDMP (2013-2017) include improving families' and communities' drug-related knowledge, creating supportive networks for families and

communities who are affected by substance abuse and using families' experiences to inform the development of relevant drug policies.

The harm reduction strategy intends to limit or ameliorate "the damage caused to individuals or communities who already abuse substances. This can be achieved, for example, by treatment, aftercare and reintegration of substance abusers/dependents in society" (p. 29). Although families are prioritised under the harm reduction category in the PTSA Act (2008), no particular actions to support AFMs are mentioned in the NDMP (2013-2017). Instead, the policy states that "some harm will accrue to users of drugs and to their families and friends, the so-called 'co-dependents', and to society at large, despite efforts to reduce the supply and demand for drugs" (NDMP, 2013-2017, p. 69).

Notably, the NDMP unpacks what comprehensive prevention programmes to address substance abuse should look like (see NDMP, 2013-2017, appendix 2, pg. 156). Again, however, in relation to families the policy only argues for promoting positive parenting and reducing the harm caused to drug users, their families, and communities.

The White Paper on Families in South Africa (2012) has identified three strategic priorities that directly relate to family stability and relationships. These are: promoting healthy family life, family strengthening, and family preservation (see section 4.3). The first strategy refers to the promotion of positive family attitudes and values. Family strengthening involves providing families with opportunities, support, and protection to facilitate positive outcomes. Family preservation is concerned with the provision of services and programmes to strengthen families and "reduce the removal of family members from troubled families" (White Paper on Families in South Africa, 2012, p. 38). It also suggests actions to address substance abuse in the family under the prevention, early intervention, and reunification sub-categories. The following actions are recommended respectively:

> "Develop and strengthen the programmes and structures to address and minimize family conditions such as family disintegration, substance abuse, child abuse, neglect, exploitation, HIV and AIDS, child headed households and poverty" (White Paper on Families in South Africa, 2012, p. 42).

> "Offer family-focused health education for improving hygiene and nutrition, HIV and AIDS care, support and treatment; reducing substance abuse as well as education on sexual reproductive health for all members of the family" (White Paper on Families in South Africa, 2012, p. 42).

"Provide capacity building and empowerment of parents and families to deal with and handle challenging child and youth behaviour" (White Paper on Families in South Africa, 2012, p. 43).

Family diversity

Bogenscheider and Corbett (2010) point out that failure to recognise the diversities of contemporary families can lead to the establishment of myopic family policies and programs. The diverse background characteristics that are embedded in families as a function of culture, race, gender, socio-community context and socio-economic status may hinder or promote family functioning. The substance abuse policies reviewed in this paper are relatively silent on this element but the generic support strategies mentioned in these policies are discussed throughout the results section of this paper. The White paper on families in South Africa (2012) on the other hand was designed to promote family functioning and resilience, and to define the diverse family structures in South Africa. While there is minimal focus on families affected by substance abuse, the White paper documents various support services for vulnerable families. These include easily accessible and affordable therapeutic services for families and their members; "sensitize community members to the special requirements of vulnerable families" and "provide capacity building and empowerment of parents and families to deal with and handle challenging child and youth behaviour" (The White paper on families in South Africa, 2012. p. 43).

Some additional reasons associated with barriers to accessing substance abuse treatment services includes geographical and financial barriers, as well as a lack of awareness of services (Myers, Louw & Pasche, 2010). There are also differences in the population that is able to access treatment facilities. For example, between 65% and 89% of people admitted to treatment centres in South Africa are males (Johnson et al., 2014), which need to be interpreted with caution. Myers, Louw and Pasche (2011) found that females from disadvantaged communities when compared to males, do not have equal access to treatment services in South Africa. A similar finding amongst black South Africans suggests that black individuals continue to be underrepresented in treatment centres (Myers & Parry, 2005; also see Johnson et al., 2014). Myers and Parry (2005) argue that this may be due to logistical and financial challenges pertaining to accessing treatment centres, and cultural and linguistic challenges in the treatment program. Given these challenges, it is important for policies to address the gender, race and financial implications concerning the availability and accessibility of support services, for individuals and families. In doing so, it is important for policymakers to note that all

communities, individuals, and families may not necessarily have the same need for support and are not affected in the same way, as to avoid the exclusion of certain groups.

Family engagement

The NDMP (2013-2017) and PTSA Act (2008) were designed to decrease and prevent the occurrence of substance abuse, and to treat individuals with substance abuse problems. Inevitably, this favours an individualised approach to substance abuse, with scant attention to support programs for families. Nevertheless, the PTSA Act (2008) does provide guidelines for the development of community-based services for affected persons. These guidelines stipulate that the community-based strategies must target school-going and non-school going children and youth, people with disabilities, rural and urban communities, families and older persons. In addition, community-based services must provide lay and professional assistance within the home environment, and establish support groups for affected persons and services users. As indicated in the previous section, The White paper on families in South Africa (2012) identifies support services for vulnerable families which include easily accessible and affordable therapeutic services for families and the provision of programs to help parents and families cope with difficult children.

Discussion

Using the FIL framework, we explored the extent to which families affected by a relative's substance abuse are prioritised in three national substance abuse and family policy documents: the *Prevention of and Treatment for Substance Abuse Act (PTSA) (2008)*, the *National Drug Master Plan (NDMP) (2013-2017)*, and the *White paper on families in South Africa.* In particular, we wanted to determine whether the policies recognise that a) families are significantly affected by a relative's substance abuse, b) families need support for themselves and c) families need to be involved in the treatment of a relative's substance abuse.

While the PTSA Act (2008) identified various intervention strategies for families and persons who are affected by substance abuse, it remains unclear what these family programmes and community-based services would look like and whether these programmes would be directed at support for family or management of the relative's substance abuse through the family.

The NDMP (2013-2017) also notes the importance of supportive networks for affected families and communities as well as promoting positive parenting and reducing harm caused to families of substance abusers. As with the PTSA Act, the NDMP fails to describe how these strategies are to be

rolled out and what they would entail. Although family strengthening is at the forefront in the White paper on families, and substance abuse was recognised as a social concern in South Africa, the link between the two is inadequately addressed. Given the burden of substance abuse in South Africa, it is imperative that the White paper includes a stronger focus on affected families and identifies strategies of support. Similarly, the PTSA (2008) and the NDMP (2013-2017) would benefit from including a more critical perspective on the family effects of substance abuse that do not only recognise an effect but prioritises the needs of families and services that are supportive and ameliorative.

South Africa still has a long way to go in order to embed families of substance abusers more centrally in these policy documents. As pointed out by Bogenschneider et al. (2012, p. 515), "it remains one thing to endorse the important contributions families make and quite another to systematically place families at the center of policy and practice". These findings do not appear to be unique to the South African context as Velleman (2010), in his review of UK based policies, has also argued for "a wider understanding and the development of better and more inclusive services" for AFMs. Policy and research implications and recommendations can be drawn from our analysis.

Implications and recommendations for policy makers

The importance of prioritising the experiences and support needs of AFMs in family- and substance abuse policies cannot be stressed more. Carefully designed policies that magnify rather than minimize support of the family can help lessen the burden of substance abuse on families. While the policy context might not be considered an appropriate space to unpack the implementation of family-focused interventions, it is an important space to prioritise families and recommend that programme implementers and interventionists consider the support needs of families in the development of their action plans. It is important for policies to address *what needs to be done and why* while practitioners and researchers should promote the implementation of these strategies. While policy development cannot address every aspect of an implementation strategy, it is important that policies rely on evidence-informed policy directives to help create an enabling framework for implementation strategies. Emphasising the need to involve families in the treatment framework is likely to spur research into the development of evidence-based practice guidelines which are effective and cost-efficient. We, therefore, advocate for continuous and open communication between policymakers, family researchers and practitioners (Small, 2005; Friese & Bogenschneider, 2009; Bogenschneider & Corbett, 2010; Smyth, 2011; Bogenschneider et al., 2012) to ensure that a unified action plan to support affected families is developed and operationalised accordingly. It will also be useful for South African policymakers and researchers to review international substance abuse policies and strategic

documents that incorporate a strong focus on families and family support. For example, policies and strategies that have been adopted in the UK such as the *Drugs: protecting families and communities (2008)* strategy (which has a strong focus on children affected by parental substance abuse), the *Carers and families of substance misusers. A framework for the provision of support and involvement policy (undated, as cited in Copello & Templeton, 2012)* (which has a strong focus on adult AFMs) and the '*Think Family: Improving the Life Chances of Families at Risk' (2008)* strategy.

Implications and recommendations for researchers and practitioners

Empirical research is essential to the development (or refinement) of evidence-based policies. South Africa can certainly benefit from a stronger family focus in substance abuse research as local studies on the experiences and support-needs of AFMs is extremely limited. Further research can tell us about the emotional, social and financial implications of substance abuse for the family of which the latter is often overlooked in this area of family research. The author's current work, which focusses on the experiences of mothers of adolescents with substance abuse problems, shows that mothers have several expenses related to the adolescent's substance abuse and rehabilitation (see Authors[9], in press). For families who come from modest backgrounds, such as the ones who participated in the aforementioned study, paying for a relative's substance abuse treatment and the burden associated with travel and accommodation cost of visits by the family compromises an already unstable financial environment.

Furthermore, many of the strategies posed in the PTSA (2008) and the NDMP (2013-2017) are aimed at identifying at-risk families and enabling families to recognise the warning signs of substance abuse. While this is undoubtedly important, what is needed are evidence-based strategies that focus on promoting the family as an important ally in the treatment of substance abusing youth, but also providing services to families which can assist them to cope effectively with substance abusing youth. By understanding the challenges that AFMs experience, researchers, practitioners, and policymakers will be able to identify and further develop multi-layered interventions to assist families to cope with the challenges they face as a result of the relative's substance abuse. Families that are poorly supported in coping with a relative's substance abuse may further compromise family relationships, stability and functioning (Bogenschneider et al., 2012; also see Orford et al., 2013; Rowe, 2012; Gruber & Taylor, 2006). In any case "prevention and support services that are made available at earlier stages when a problem is developing may help avoid more intensive interventions when a problem becomes a crisis or chronic situation" (Bogenschneider et al., 2012, p. 521).

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[9] Authors' information anonymised and removed from reference list

Finally, research is needed in adapting successful family-based interventions to local contexts in South Africa to support AFMs such as the 5-Step Method step-wise intervention described by Copello et al (Copello, Templeton, Orford & Velleman, 2010; Ibanga, 2010). It is through building this evidence-base that policies on substance abuse will likely better incorporate the role of families.

Limitations of the study

In this paper, we only reviewed national policies from the health and social development sectors. Local and provincial policies and strategic plans related to substance abuse should also be evaluated using the FIL framework in order to further prioritise strategies to support AFMs in South Africa. Moreover, this review only focused on policy documents and did not evaluate the place of AFMs in substance abuse treatment implementation plans.

Conclusions

Our analysis of the three policies has shown that considerable amount of work is still needed to prioritise the support needs of families affected by a relative's substance abuse in South Africa. While some of the policies recognise the role of families, strategic directions on how to better support families are virtually non-existent. Further research on the experiences of families in diverse settings together with an examination of best practice approaches elsewhere for adaptation to local contexts should provide the building blocks in developing evidence-based interventions to suit local contexts.

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Chapter five: Concluding comments

This study is not without limitations and several challenges emerged at different points in my research. Recruitment, data collection, and analysis was time-consuming and costly as it required multiple follow-ups, failure to meet set appointments, negative feelings arising from on-going difficulties in dealing with the adolescents' treatment as well as costs associated with transport. Upon reflection, some families who did not participate in the study did not appear to be ready to share their experiences, probably because some of the adolescents had decided to drop out of the treatment programme which could have produced feelings of hopelessness and shame.

The study was conducted with families of adolescents who already have substance abuse problems and had access to substance abuse treatment for the adolescents. It is thus important to recognise that the experiences and perspectives of mothers whose adolescents are not admitted to, or do not have access to, treatment may be different to that of the mothers who participated in my study. Research is necessary to explore the support needs of these mothers and parents in general as they are required to cope with the adolescents' destructive behaviours for an extended period of time which is likely to hold additional consequences for the adolescent and the parents. An example of this would be the case of a South African mother who murdered her son who was a methamphetamine addict. Ellen Pakkies reported that she had strangled her son to death as a response to the verbal and physical abuse she had endured at the hands of her drug-addicted son (Thesnaar, 2011). While Ellen's response to her son's drug abuse was extreme, the anger, hopelessness, and devastation she felt is not unique but resonates with the experiences of mothers in this study. Ellen also reported that her son, when euphoric and experiencing cravings or withdrawal had been tormenting her for several years and although she had made attempts to seek formal assistance and personal protection, she did not receive the support that she needed. The lack of support, feelings of hopelessness, angry and resentment were the drivers of Ellen's maladaptive response of murder. Ellen's story is a testament of the importance of understanding mothers' experiences, coping behaviours and support needs. Further comparative studies on the experiences of mothers of children with less chronic or more chronic substance use problems are also recommended which could lead to the development of tailored support services that are sensitive to the differential needs of affected mothers.

Finally, fathers' perspectives are absent in this study. As has been mentioned previously, while it was envisaged that both parents would form part of the family interviews only the mothers expressed a willingness to participate. This finding is not unique to my study as the participation of fathers in

studies elsewhere indicates a similar trend (for example Choate, 2011; Hoeck & Van Hal, 2012; Jackson et al., 2007). It is, therefore, important for researchers who are interested in exploring 'parents' experiences to consider these gendered sampling challenges and identify recruitment strategies in support of including fathers and mothers stories.

To conclude, this thesis argues that in order to understand and successfully support affected mothers[10] (and parents) to cope with their distress, our conceptualisations of 'coping' need to move beyond traditional notions of the emotion-focused and problem-focused dichotomy put forth by Lazarus and Folkman (1984). Rather research should move towards a multidimensional theory that recognises the roles of a range of factors in the mothers' coping behaviour including a) the mothers' psychosocial experiences, b) the mothers' support seeking behaviour, c) the nature of the mother-adolescent relationship during the adolescent's substance abuse and d) the availability and accessibility of support services for mothers and families. Likewise, support interventions also need to recognise the roles of coping and the aforementioned factors in the uptake of support services and thus make theoretical and practical provisions for these influences. A renewed emphasis on the needs of mothers (and parents) through research, practice and policy is likely to enhance the opportunities for support and provide much-needed relief to embattled families dealing with substance abusing adolescents.

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[10] Mothers affected by adolescent substance abuse

APPENDIX A: SEMI-STRUCTURED INTERVIEW GUIDES

FOR PARENT PARTICIPANTS

These questions focus on the parent-child relationship

1. Tell me about yourself?
    a. How old are you?
    b. Where are you from?
    c. What do you do?
    d. How many children do you have?
    e. How old are they and what do they do?
    f. Are you married?
    g. What does your husband/partner do?
    h. Do you work?
        i. What kind of work do you do?
        ii. How long are you away from home?
        iii. When you are at work, who looks after the children?

2. Tell me about your son/daughter that is in rehab?
    a. Who is he/she
    b. How old is he/she
    c. Before rehab, was he/she attending school?
    d. How was he doing at school?
    e. When was he/she admitted to a treatment facility?
        i. Was he/she admitted more than once?
        ii. What drug was he/she admitted for before?
        iii. When was he/she admitted before?
        iv. How old was he/she when he/she was admitted before?
        v. Why do you think he/she is back in treatment?
    f. Does he/she have any friends?
        i. Can you please tell me about his/her friends?
        ii. Have you met any of his/her friends?

3. Tell me about your relationship with your son/daughter that is in rehab?
    a. How would you describe your relationship before he/she started using substances?
        i. Did you spend a lot of time together?
        ii. Were you close?

      iii.   What kinds of things would you do together?
         1.   When would you do these things?
      iv.   How often would you see him/her?
      v.   How often would you talk to him/her?
         1.   What would you talk about?
         2.   Who would start these conversations?
         3.   When would you talk?

b. Focussing on the period before he/she starting using substances, did your relationship changed at all?
    i.   When did you start noticing this change?
    ii.   What changed?

c. How would you describe your relationship after he/she started using substances?
    i.   Did your relationship change?
      1.   How did it change?
      2.   When did you start noticing this change?
      3.   How were you affected by this change?

d. How would you describe your relationship after you became aware of your child's substance using problem?
    i.   Did your relationship change?
      1.   How did it change?
      2.   When did you start noticing this change?
      3.   How were you affected by this change?

These questions focus on the development of adolescent substance abuse

1. Why do you think your child started using substances?
    a. How do you think his/her substance use started?
      i.   What kind of substances do you think he/she started with?
      ii.   Who do you think was he/she using substances with?
      iii.   How often do you think he/she was using these substances?
    b. When did you become aware that he/she was using substances?
      i.   What did you do?

2. When did you start noticing that your child has a substance use problem?
    a. What convinced you that your child has a substance use problem
    b. What kind of substance was your child using most often at that time?
    c. Who was he/she using with?

These questions focus on parents experiences

1. Tell me about your experience of having a child who has a substance use problem?

     a. What are some of the personal difficulties you've had to face?

     b. What are some of the things you've had to deal with?

         i. For example, has he/she become violent, aggressive or stolen from you?

         ii. How did you deal with these things?

     c.

These questions focus on dealing with adolescent substance abuse

1. When you became aware of your child's substance use problems, what did you do?
    a. How did you try to deal with it?
        i. When and why did you decide to do something?
        ii. Why did you try that specific approach?
    b. When you did this, how did he/she react?
        i. Did things get better or get worse?
            1. How so?
        ii. How do you think this influenced his/her substance use?
        iii. How do you think this influenced your relationship?
    c. Where did you go to find help? (Who helped you?)

These questions focus on ending the interview

1. Do you have any questions for me?
2. Is there anything you would like to talk about that I may not have asked during the interview?

FOR ADOLESCENT PARTICIPANTS

These questions focus on the parent-child relationship

1. Tell me about yourself?
    e. Who are you?
    f. How old are you?
    g. Where are you from?
    h. Before you were admitted to rehab, were you attending school?
    i. How were you doing at school?
    j. How many siblings do you have?
    k. How old are they and what do they do?
    l. When were you admitted to the treatment facility you are currently at?
        i. Have you been admitted more than once?
        ii. What drug were you admitted for before?
        iii. When were you admitted before?
        iv. How old were you when you were admitted before?
    m. Do you have any friends?
        i. Can you please tell me about them?
        ii. Have your parents ever met any of your friends?
        iii. Do they get along?

2. Tell me about your parent(s)?
    a. What do your mother and father do?
        i. What kind of work do they do?
        ii. How long do they generally stay away from home?
        iii. When they are at work, who looks after you (and your siblings?)
    b. Are your parents married?

3. Tell me about your relationship with your parent(s)?
   (Questions to be repeated for both parents)
    a. How would you describe your relationship with your mother/father before you started using substances?
        i. Did you spend a lot of time together?
        ii. Were you close?
        iii. What kinds of things would you do together?
            1. When would you do these things?
        iv. How often would you see him/her?
        v. How often would you talk to him/her?
            1. What would you talk about?
            2. Who would start these conversations?
            3. When would you talk?

    b. Focussing on the period before he/she starting using substances, did your relationship changed at all?
        i. When did you start noticing this change?
        ii. What changed?
    c. How would you describe your relationship with your mother/father after you started using substances?
        i. Did your relationship change?
            1. How did it change?
            2. When did you start noticing this change?
            3. How were you affected by this change?
            4. How do you think your mother/father was affected by this change?
    d. How would you describe your relationship with your mother/father after you started abusing substances (developed a substance using problem)?
        i. Did your relationship change?
            1. How did it change?
            2. When did you start noticing this change?
            3. How were you affected by this change?
            4. How do you think your mother/father was affected by this change?

These questions focus on the development of adolescent substance abuse

1. When did you start using substances?
2. What kind of substances did you start with?
3. How often were you using these substances?
4. Were there any particular substances you favoured?
    a. Why did you favour that specific substance?
    b. Where/ from whom did you get this substance?
5. When do you think your parent(s) became aware that you were using substances?
        i. What did they do?
        ii. Did your mother and father react differently?
            1. How so?

6. When did you become aware that you had developed a substance use problem?
    d. What convinced you that you had a problem?
    e. What kind of substance were you using most often at that time?
        i. Who were you using with?
        ii. Why do you think you started using this drug so often?
7. When do you think your parent(s) became aware that you were using substances?
        iii. What did they do?
        iv. Did your mother and father react differently?
            1. How so?

These questions focus on being a substance abuser

2. Tell me about your experience of being a substance abuser?
   a. What are some of the personal difficulties you've had to face?
   b. Are there any particular things you did in order to get your substance of choice?
      i. Please elaborate
   c. What are some of the things your family has had to deal with because of your substance addiction?
      i. For example, have you ever been violent, aggressive or stolen from them? Please elaborate

These questions focus on dealing with adolescent substance abuse

2. When your mother/father became aware of your substance use problems, what did they do?
   a. How did they try to deal with it?
   b. When they did this, how would you react?
      i. Did things get better or get worse?
         1. How so?
      ii. How did this (way in which parent(s) dealt with the problem) influence your substance use?
         1. Did you start using more or less? Why?
      iii. How do you think this influenced your relationship with your mother/father?
   c. When did you decide that you need help?
   d. Where did you find help?/Who helped you?

These questions focus on ending the interview

1. Do you have any questions for me?
2. Is there anything you would like to talk about that I may not have asked during the interview?

APPENDIX B: SUMMARY TABLE

Mothers' aliases	Adol. aliases and gender (M/F)	Age of adol[11]	Adol. residing with mother (current)	Adol. substances of choice	Duration of adol. substance abuse	Adol. methods to finance own substance abuse	Rehabilitation history of adol.	Mothers' stressful life events	Mothers' experiences of stress	Mothers' coping responses
Ursula	Terrance (M)	15	Yes	Whoonga[12] and cannabis	Approximately 4 years	Stealing parents' personal goods and money Robbing people and break-ins	Readmitted four times	Adolescent misconduct, family conflict, financial cost	Worry, hopelessness, guilt, self-blame, signs of depression, resentment	*Problem-focused, engaged coping*
Jacky	Winston (M)	17	Yes	Cannabis	Approximately 2 years	Combining friends' money Use allowance Working on taxi's	First time in treatment	Adolescent misconduct, family conflict, financial cost	Worry, hopelessness, guilt, self-blame, shame, anger, signs of depression	Moved between *emotion-focused coping*, (ineffectual) *problem-focused coping responses* and *engaged coping*
Erica	Clint (M)	15	Yes	Whoonga and cannabis	Approximately 3 years	Robberies and house break-ins Stealing families' personal goods and money	First time in treatment	Adolescent misconduct, financial cost	Worry, hopelessness, guilt, self-blame, signs of depression	Moved between *emotion-focused tolerant-withdrawn coping* and *problem-focused coping*.
Anne	Brandon (M)	15	Yes	Cannabis [and possibly whoonga[13]]	Approximately 2 years	Used allowance Used money that was meant for school related activities Combining money with friends'	First time in treatment	Adolescent misconduct, family conflict	Worry, hopelessness, guilt, self-blame, signs of depression, anger	Moved between *emotion-focused, tolerant coping strategies*, and *problem-focused, engaged coping*
Margaret	Abigail (F)	16	Yes	Alcohol	About 1 year	Stole money from mothers employer Alcohol was often free available at social gatherings/parties	First time in treatment	Adolescent misconduct	Worry, hopelessness, guilt, self-blame, shame	*Supportive- tolerant, emotion-focused coping responses*

[11] At time of interview

[12] A highly addictive powder that is mixed with cannabis and smoked in the form of a joint. It consists of low grade heroine and other additives like rat poison (http://www.kznhealth.gov.za/mental/Whoonga.pdf).

[13] Adolescent not sure about what he was smoking.