CAREGIVERS EXPERIENCES OF LIVING WITH AN ADOLESCENT WHO ABUSES DRUGS IN THE SOL PLAATJIE MUNICIPAL AREA IN THE NORTHERN CAPE

Nomonde Patience Ditshetelo

STUDENT NUMBER: 22173785

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Supervisor: **Dr L.A. Hillermann**

Co-supervisor: **Dr D.G. Sokhela**

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DECLARATION

I, Nomonde Patience Ditshetelo, hereby declare that this dissertation, submitted for examination, is entirely my own work and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for examination or for any other purpose.

12 February 2024 2023

Signature of student

Approved for final submission

Dr LA Hillermann (PhD in Nursing) ________________________

Date

Dr DG Sokhela (PHD Nursing) ________________________

Date

DEDICATION

This study is dedicated to my loving husband and my lovely children who through their love and encouragement made an extensive contribution to this undertaking.

The dedication also goes to all caregivers who are experiencing the debilitating effects of living and caring for adolescents who abuse drugs.

ACKNOWLEDGMENTS

This dissertation would not have been possible without the guidance and support of several individuals who in one way or the other contributed and extended their valuable assistance in preparation and completion of this study.

I am grateful to God for His mercy and grace during the entire duration of my study.

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My gratitude also goes to the Northern Cape Departments of Health and Social Development, to the selected health and social development departments as well as the NGOs for giving me permission and an opportunity to conduct my study at their institution.

ABSTRACT

Aim

Drug abuse by adolescents has devastating effects on the ability of their families and caregivers to function. The aim of the study was to explore and describe the caregiver's lived experiences of living with an adolescent who was abusing drugs and receiving treatment in selected drug rehabilitation institutions.

Research

Design and Approach

A qualitative, descriptive, and contextual with a phenomenological approach. was adopted to explore caregivers' lived experiences living with adolescents who abuse drugs.

Research setting

The study was conducted at four purposively chosen Non-Governmental Organizations (NGOs) rehabilitation institutions situated in the Sol Plaatjie Municipality in Kimberly in the Northern Cape Province. Participants were recruited from selected rehabilitation government institutions and NGOs in the Sol Plaatjie Municipal area after full ethics approval was obtained from the DUT Institutional Research Ethics Committee (IREC).

A non-probability purposive sampling, also known as the judgment sampling method, was used in this study. to interviews with 15 purposively selected caregivers whose adolescents were abusing drugs. Interviews were recorded and then simultaneously translated and transcribed. Thematic analysis was used to identify themes related to the experiences of caregivers of adolescents with a drug abuse problem.

Results

Results show that the behaviour of these adolescents created an environment that led to feelings of shame and embarrassment, family disintegration, conflicts, and communication breakdown, suicidal feelings, and stress related ailments of these caregivers. Participants experienced personal challenges which included psychological and emotional effects of fear, stress, pain, and self-blame. Participants also highlighted family disruptions and financial drain as adverse experiences as a result of their adolescents' behaviour.

Conclusion

The study results highlighted the psychosocial challenges experienced by those caregivers of adolescents who abuse drugs. These findings underscore the need for efforts to be directed at the development of formal support interventions for caregivers of adolescents who are affected by this public health scourge.

Keywords: Adolescent, Caregiver, Drug abuse, Family, Harm reduction strategy, Rehabilitation.

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LIST OF ABBREVIATIONS AND ACRONYMS

Abbreviation	**Full term**
CDC	Centre for Disease Control
DoH	Department of Health
DSD	Department of Social Development
DUT	Durban University of Technology
FST	Family Systems Theory
HRS	Harm Reduction Strategy
IREC	Institutional Research Ethics Committee
MENA	Middle East and North Africa
NIDA	National Institute of Drug Abuse
NGO	Non-Governmental Organisations
NPO	Non-Profit Organisation
SACENDU	South African Community Epidemiology on Drug Use
SAMHSA	Substance Abuse Mental Health Science Administration
STATS SA	Statistic South Africa
UN	United Nations
WHO	World Health Organization

CHAPTER 1 - ORIENTATION TO THE STUDY

1.1 INTRODUCTION

The World Health Organization (WHO) (WHO:2019) defines ‘adolescents’ as those people who are in the 10-19-year age group. Conversely, Hlungwani et al. (2020:6) defines adolescence as that transitional stage of physical and psychological development that generally occurs during the puberty until legal adulthood, generally associated with the teenage years. Drug abuse by adolescents especially in schools, is now a worldwide societal problem (Bhirange et al. 2021:183). The WHO (2020), asserts that drug abuse has always been a major public health concern globally. The World Drug report of 2019 highlighted that drug abuse by adolescents was a high-profile public health concern. According to the Centre for Disease Control report (CDC:2020) drug abuse is the harmful or hazardous use of psychoactive substances. More simply it is the inappropriate use of drugs or habitual taking of addictive or illegal drugs. The report further stated that the evolution of the complex global illicit drug problem was clearly driven by a range of factors, which were highly documented by various researchers (Moradi et al. 2019; Choate 2016; Motshoeneng 2018; Groenewald 2018).

The WHO (2019) report further affirms that drug abuse by adolescents worldwide increased by 61% between 2016 and 2021 amongst grade eight learners and 62% of adolescents abused both drugs and alcohol in their 12th grade. Subsequently, the WHO (2019) report indicated that 50% of adolescents were reported to have abused drugs at least once and others were known to be using drugs during school hours. Further, the WHO (2020) report also revealed that adolescents aged 12–17 years old were reported to be using marijuana (12.7%), cocaine (0.42%) and methamphetamine (0.17%). These statistics portray a bleak future for adolescents and are of great concern.

Motshoeneng (2018:17) states that among the key effects of illicit drug use on society, were the negative health consequences experienced by its members such as deterioration of a person’s physical health, impairment of mental functioning, and damage to their overall spirit. The impact of this was that young people fail to participate in economic activities, seek growth and a better life because those who are younger, absent themselves from school. This is a “big societal problem” currently being experienced by

communities in the Northern Cape. Further, drug use puts a heavy financial burden on the individual adolescents and their caregiver's families, which includes, high medical and hospital costs and the demand for more drugs to satisfy uncontrollable cravings by the abuser amongst others (Priyanka et al. 2018:171). Other effects include legal costs incurred through crimes committed by these adolescents as a result of drug abuse, the negative psychosocial effects on the immediate family and possible school dropouts (WHO 2019). The global negative effect of psychoactive substance use is evident in many domains of the lives of adolescents including intrapersonal, peer, parental, and environmental relationships (Ngantweni 2018:111). The negative effects of drug abuse are also associated with numerous physical and psychosocial problems. It was also highlighted by Moradi et al. (2019:463) that those same problems extended from the user to their families and society and were linked to parental, environmental, psychosocial, and economic challenges.

Amongst those highly affected by adolescent drug abuse are their caregivers. For the purpose of this study, a caregiver is any adult who lives with and is caring for a drug abusing adolescent. Ngantweni (2018:113) highlighted that most caregivers at the community level do not have the knowledge to identify that their children might be using drugs even if they present with rebellious or unacceptable behaviour. Mulyaningrat et al. (2019:851) conducted a study on mothers' experience which aimed to identify the description of a mother's experience in providing care for stimulant and hallucinogen drug-abusing adolescent in Yogyakarta, Indonesia. The findings of this study revealed that caregivers are the most affected by these life changing circumstances. These researchers further attested that the psychosocial effects of this problems were both enormous and unmeasurable (Mulyaningrat et al. 2019:850).

The research studies by Groenewald and Bhana (2018), Moradi et al. (2018:19), and Njoki et al. (2019) revealed that the caregiver's experience of living with an adolescent who abuses drugs had not been explored in any depth hence the aim of this study was to conduct in-depth study on the experiences of caregivers who live with and take care of an adolescent who abuses drugs. It is also noted from the study by Mulyaningrat et al. (2019:849) that the mother, as the closest person, plays a crucial role in seeking and maintaining the recuperation of an adolescent who is abusing drugs and is the main focus of any intervention due to substance abuse by the adolescent. These researchers concluded by stating that the behaviour of adolescents who abuse substances could be

identified as the cause or effect that resulted in the burden perceived by the mother as the caregiver.

Caregivers experience stress and stigma because of their adolescent who abuses substances. There also seems to be a link between substance abuse and mental illness, as many adolescents suffer from mental illness because of their substance abuse (Kalam & Mthembu 2018:468). Substance abuse has an impact on parents and/or caregivers, yet little is known about their experiences. Behavioural changes are in certain cases viewed and or perceived by some members of society and caregivers as normal behaviour and regarded as part of the adolescent developmental stages (Groenewald & Bhana 2018:468). The changes in the addict's behaviour affects the family unit directly and often negatively. Furthermore, the addict becomes prone to erratic behaviour especially when going through the withdrawal phase as they became aggressive, violent and begin to turn to criminal behaviour such as stealing from their family, to get the next fix. These behavioural changes then leave the family in fear, the household becomes tense and the conflict increases (Moradi et al. 2019:24).

Knowing and understanding the experiences of living with the adolescent who abuses drugs is a critical point of consideration in preventing and managing drug dependency (Choate 2016:462). Worldwide research conducted on adolescents who abuse drugs and the consequences thereof found that it was clear, that based on the statistics stated in the WHO, 2018 and 2019 reports on drug control, very little attention was given to the caregivers' experiences of living with that adolescent who abused rugs (Groenewald & Bhana 2018; Moradi et al. 2019:463). Caregivers become angry and disappointed with their adolescents for abusing substances, as it destroys their future and any expectations, they may have had for their child are not met. Hlungwani et al. (2020:8) attest that caregivers may experience stress in looking after drug abusing adolescents as most these abusers end up being affected by substance-related mental disorders, which may be experienced as a 'family burden.' Additionally, Hlungwani et al. (2020:6) said that the majority of problems surrounding the adolescent are caused by environmental forces and unfortunately the brunt is felt by those who are taking care of them as well as the entire family. These researchers further stated that the caregiver has to also manage the affairs of the rest of the family unit which include responsibilities associated with parenting and economic support. Thus, like caring for an elderly parent, a child with autism or mental retardation, or an adult with Alzheimer's disease, the work is never ending, tiring, and

potentially threatening to one's mental and physical health. Motshoeneng (2018:23) echoed this statement when he indicated that, these caregivers are likely to encounter high levels of distress because they have to care and parent an adolescent who has substance abuse problems and which could also include an element of mental illness or what is called a "dual diagnosis" for the caregivers.

1.2 PROBLEM STATEMENT

While working in the drug rehabilitation centres, the researcher observed that many families in the Sol Plaatjie Municipality were living with adolescents who abuse drugs. The researcher also noted that the caregivers who accompanied the drug-abusing adolescents to these facilities displayed severe consequences, including anger, anxiety, depression, hopelessness and despair. These caregivers experienced the challenges of living with the adolescents who abused drugs without them receiving support from healthcare professionals. As a result, the researcher became interested in conducting the current study aiming to address the issues faced by these caregivers and bring about positive change.

According to Dada et al. (2016:12) 72% of sampled male adolescents who were still attending school in the Northern Cape Province have been admitted to the drug treatment centre. Additionally, the 2018 Statistics South Africa report revealed that youth unemployment in this province was also high, standing at 3.3% (Stats SA 2019:167) meaning that for every ten young people, six of them were unemployed. This could be the reason for those adolescents become disgruntled, which then leads to substance abuse and other crime. Drug abuse by adolescents not only has negative effects on them, but extends to their families. If an individual becomes involved in the destructive world of drugs, it is only a matter of time before this begins to affect the rest of the family, particularly the caregivers (Choate 2016:463). Kalam et al. (2019:17) attest that most caregivers at the community level did not have the knowledge to identify that their children may be using drugs even if they present with rebellious or unacceptable behaviour.

The effects of drug abuse by adolescents on caregivers is a multifaceted issue and cuts across all sections of society although the major party affected was the drug abuser. It is therefore deemed imperative to explore the experiences of caregivers living with

adolescents who abused drugs, a study which has never been conducted in the Northern Cape, particularly in the Sol Plaatjie municipal area.

The Eastern Cape Enyobeni Tavern tragedy, in South Africa, which left at least 21 teenagers dead, the youngest being just 13 years old will be a lifelong reminder of the escalating seriousness of substance abuse problem by adolescents and the devastating negative effect this problem had on the family, caregivers and society. As much as the cause of their death was not known, the fact was that this fatal incidence occurred at the tavern in the early hours of the morning and that was where the teens were found dead (TV News; SABC 405.26 June 2022). The sad story of Enyobeni is relevant to this study because it highlights just how young children are when they begin indulging in substance use, as it was confirmed that the youngest of the teenagers who died was just 13-years old.

Currently the rate of substance abuse amongst adolescents from diverse cultural, economic, and social backgrounds continues to increase to epidemic proportions, and more and more caregivers are being placed in the difficult situation of having to care for an adolescent with these problems (WHO 2022:31). As previously noted, these caregivers are often placed in the difficult situation of having to worry about their adolescent on a continuous basis as they fear them dying from an overdose, running away from home, entering the criminal justice system, or dropping out of school. Thus, caregivers are likely to experience severe interruptions to their daily routines including staying up all night waiting for their adolescent to come home.

1.3 AIM

The aim of this study was to explore and describe the lived experiences of caregivers living in the Sol Plaatjie municipal area whose adolescents were abusing drugs.

1.4 OBJECTIVES OF THE STUDY

1.4.1 Main Objectives

The main objective of the study was to:

Describe the lived experiences of caregivers living with adolescents who abuse drugs.

1.4.2 Sub-objectives

The sub-objectives of the study were to:

i. Determine the effects experienced by caregivers of adolescents who abuse drugs.
ii. To describe the coping strategies used by caregivers living with the adolescent who abuse drugs.
iii. To identify programmes available in the community that support the caregivers of adolescents who abuse drugs

1.5 RESEARCH QUESTIONS

Main research question

What are the experiences of caregivers living with an adolescent who is abusing drugs?

Sub-questions

i. What were the psychosocial effects experienced by caregivers of adolescents who abuse drugs?
ii. What coping strategies did caregivers living with the adolescent who abuse drugs use?
iii. What programs were available in the community to support caregivers and what support do they need?

Methods

A qualitative, descriptive, and contextual with a phenomenological approach was used to collect data from 15 caregivers living with adolescents who abuse drugs. Data were ananlysed using thematic analysis method to analyse data obtained from the interviews. Trustworthiness was achieved by the application of Lincoln and Guba’s framework of credibility, dependability, conformability and, transferability and it is explained below as criteria to evaluate the study’s quality. The standards of ethical conduct applied in this research were based on the three general principles of; beneficence, respect for human dignity, and justice.

1.6 SIGNIFICANCE OF THE STUDY

The significance of the study is as follows:

Health Care Policy reforms

i. The results of the study can significantly influence health care policy reforms, and develop policies to assist caregivers and health care workers dealing with adolescents and families who have adolescents who abuse drugs.
ii. The results will be shared with health care professionals of the Department of Health and Social Development, and the NGOS of the rehabilitation centres where the study was conducted. This may improve their knowledge on caregivers and society about the effects of living with an adolescent who is abusing drugs.

Caregivers

i. Caregivers will be given an outlet to talk about their experiences to a neutral person who is interested in listening to them, thus helping them psychologically.
ii. The results of the study might empower the caregivers with knowledge on how they can cope with the stress of living with an adolescent who is abusing drugs, thus improving their psychosocial wellbeing.
iii. In addition, the caregivers can reflect on their situation and consider how they can assist their adolescent children who have not yet become involved in drug taking to refrain from using them and stay in school for longer.

1.7 DEFINITIONS OF TERMS

1.7.1 Theoretical definitions

Adolescent: The WHO defines 'Adolescents' as those people who are between the 10-19-year age group. This age range falls within their definition of young people, which refers to individuals between ages 10 and 24.

Caregiver: The Oxford dictionary defines a caregiver as a family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person (Simpson 2013).

According to Njoki (2020:11) a caregiver is an adult who provides assistance or help to a person in need, whether it be with daily tasks or medical expertise.

Family: Family is a socially recognized group (usually joined by blood, marriage, cohabitation, or adoption) that forms an emotional connection among its members and then serves as an economic unit of society. Sociologists identify different types of families based on how one enters into them (du Toit & le Roux 2018:174)

Psychoactive substance/Drugs: Psychoactive substances are chemical substances that alter brain function to produce temporary changes in sensation, perception, mood, consciousness, cognition, and behaviour. Examples of psychoactive drugs include heroin, cocaine, LSD, MDMA, amphetamines, cannabis, alcohol, and nicotine (du Toit & le Roux 2016:242).

1.7.2 Operational definitions

Adolescent: For the purpose of this study, an adolescent refers to a person between the ages of 10 and 19.

Caregiver: A caregiver in this study can either be an adult person, a parent, grandparent or guardian who lives and takes care of an adolescent who abuses drugs.

Family: A family in this study means any adult person who stays and is related to the adolescent who abuses drugs

Psychoactive substance/ Drugs: A drug is any substance which when consumed causes a change in a person's physiology or psychology.

1.8 CHAPTER SUMMARRY

Chapter one has presented and discussed the introduction to the study in the context of the various core aspects that will be discussed in subsequent chapters. It has also outlined the research problem and the ways in which this study might make a significant contribution to society under study. In this regard, the next chapter focuses on the range of literature perspectives and scholarship in the field of caregiver’s experiences of living with an adolescent who abuses drugs.

1.9 STRUCTURE OF THE DISSERTATION

Chapter	Title	Content
Chapter One	Overview of the study	Background and introduction of the topic where the researcher will give brief background and introduction. The problem statement, the aim, objectives and the research questions and sub-questions of the study.
Chapter Two	Literature Review	The global, regional, and local literature review on caregivers' perceptions of drug abuse. The study was grounded on the application of the Family Systems theory.
Chapter Three	Research Methodology	This chapter includes a detailed description of the methodology that was used. It discusses the: research design, study setting, recruitment of the study population, sampling strategy, sample size, data collection, data analysis, data management and storage, and ethical considerations. Techniques and methods of the study are also discussed.
Chapter Four	Presentation of Findings	In this section, the findings of the study and collected data are analysed in relation to the aim and objectives of the research study.
Chapter Five	Discussion of findings, limitations, and recommendations	This chapter consist of the discussion of the study results, supporting them with literature used in the previous chapters.
Chapter Six	Summary of findings, recommendations, and conclusion	This chapter discusses the findings of the study, outlines the recommendations, limitations of the study and the conclusion of this study

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

The previous chapter addressed the introduction and background of the drug abuse by adolescents and how it affects their caregivers. The current chapter outlines important research trends on the research topic, assess the strengths and weaknesses of previous research studies relating to the current study as well as the existing research as a whole in order to identify potential gaps in knowledge and to establish the need for current and/ or future research relevant to the topic under study.

According to Polit and Beck (2021:42) a literature review is a summary of research on a topic of interest. It is often prepared to put a research problem into a less rigorous context. This simply means that a literature review also includes a critical evaluation of the research study. This research study reviewed the available literature on the extent and trends of drug abuse amongst adolescents in a global, regional and local context, the adolescents and caregiver's perspectives of drug abuse among adolescents and the psychosocial effects these problems have on those caregivers living with adolescents who abuse drugs. This chapter also unpacks the interrelationship and connectedness of the levels of the family system and how each of the four subsystem levels of the Family System Theory influence each other as illustrated in Figure 2.

The complexity of the identified problem is explained by giving a brief overview of the literature review related to the extent of drug abuse by adolescents in the global, regional and local context, the adolescent's perception ofdrug abuse, and the family perspective on adolescent drug abuse. The researcher unpacked the experiences of caregivers living with adolescents who abused drugs and the rehabilitation strategies or Harm Reduction Strategies (HRS) globally, regionally and locally. Jack and Judith's Family System Theory (FST) was applied to understand and observe the nature of self-perpetuating patterns ofa problem and behaviour as well as to place greater emphasis on tracking the sequence of recurring transgressions occurring in the family as a result of adolescent drug abuse.

2.1.1 Strategies used for the literature search

The primary sources of information gathered and used by the researcher were obtained from prescribed textbooks, articles published in scholarly journals, as well as conclusions from completed research studies. Information was retrieved from the internet, google scholar, and the library. Secondary sources used were reviews and reports of organizations from such as the WHO were used as a yardstick for the research problem. The researcher used the following search terms to source literature from google scholar and libraries; adolescent, caregivers, experience and drug abuse. In addition, the researcher followed the process as illustrated in the Figure 1 below.

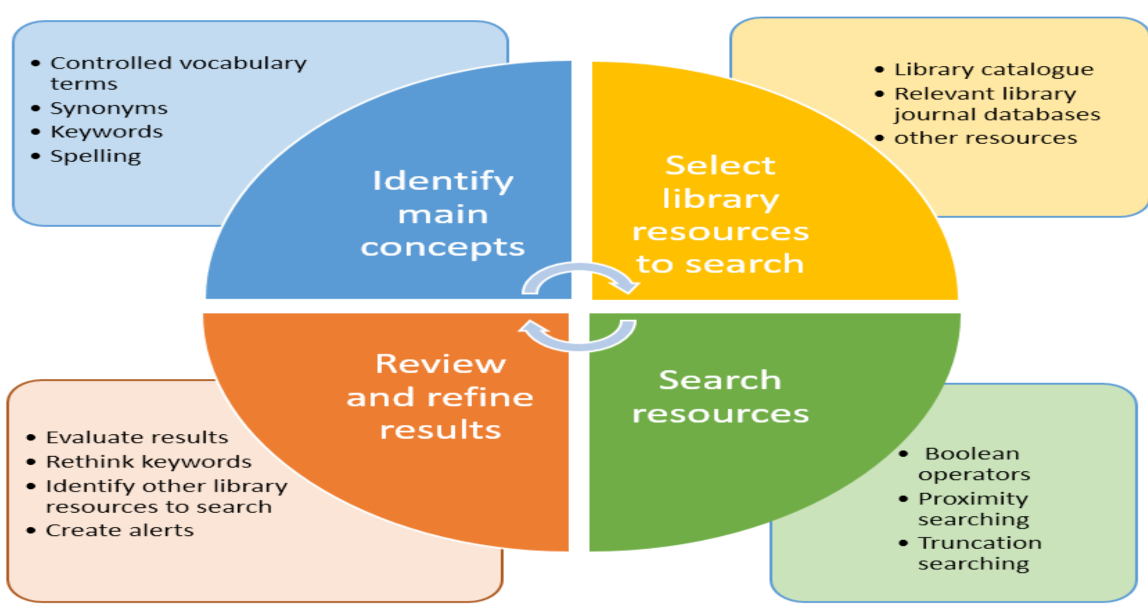


Figure 2.1: Steps followed in Literature Review Process

2.2 OVERVIEW OF DRUG ABUSE

Drug abuse has been a global problem for hundreds of years, and its negative effects have always lingered for the longest of time, according to Moradi (2019:24). He also stated that despite all the measures taken by government and civil society to address the

issue, drug abuse among teenagers was still on the rise. Choate (2016:364) echoes this sentiment when he claims that drug abuse has always existed and that it is becoming more prevalent among adolescents. This has resulted in full-blown addictions, with devastating effects on the family and caregivers. Choate (2016) further stated that some of the negative effects of drug abuse include major psychosocial problems such as withdrawal from society, friends and family, isolation, anxiety, depression, anger, and sometimes irritability and violent behaviour. Similarly, Priyanka et al. (2018:119) reported that those caregivers and/ or family members who live with them face the brunt of the problems from adolescents who abuse drugs. Priyanka (2018) further asserted that the adverse health consequences of drug use, such as decreased cognitive function amongst adolescents are more severe and widespread than previously thought. In addition to this the researchers stated above, also found that the problems associated with adolescent drug abuse could result in making the adolescent's life chaotic and disorganized (Hlungwani et al. 2020:6)

According to Groenewald (2018), Choate (2016), and Priyanka et al. (2018) there is limited global research on the emotional and psychological difficulties those parents and other caregivers face when trying to raise an adolescent who abuses drugs. Anger, feelings of failure as a caregiver, loneliness, feelings of worthlessness, and depression are just a few of the emotions that caregivers exhibited (Njoki et al. 2022:393). Similarly, Hlungwani et al. (2020:6) stated that across the continent, families and or caregivers who lived with an adolescent who abused drugs were so negatively impacted to the extent they eventually disowned their children or fled their homes in search of safety and peace of mind. Conversely, Njoki (2018:27) asserted that the issue of drug abuse has been in existence for thousands of years and that it has been an integral part of life in most societies. Njoki (2018) further argued that drug abuse was currently a problem that affected both young and old people, though drug abuse by adolescents tends to have a more severe impact.

2.2.1 Drug Problems in adolescents: global overview

The WHO (2019:24) reported that the increase in drug abuse amongst adolescents was partly due to a ten percent (10%) increase in the global population growth. Data reported

by the WHO (2018) portrays a higher prevalence rate in the use of opioids in Africa, Asia, Europe and North America. However, the report further highlighted that cannabis continued to be the most widely used drug worldwide with an estimated 188-million people having used the drug since 2017. Additionally, 35% of the global opioid users and almost half of all opioid users worldwide reside in South Asia whereas Latin America, the Caribbean, the Middle East and North Africa (MENA) are expected to experience an increase of 14%, 23% and 18%, respectively (WHO 2019:11). Data reported by the WHO (2020) about global drug abuse problem by adolescents show that the battle against drug use is far from over despite all efforts put in place by different countries to combat this problem. The significance of this data was that it showed that there was a global escalation of drug abuse problems amongst adolescents, which is in line with the global increase in population. This problem reflects a significant global increase in drug abuse by adolescents and correlates with an increase in drug problems both regionally and locally.

2.2.1 Drug Problems in adolescents: regional overview

According to Olawe et al. (2018:34), studies and reports on drug abuse and addiction have established that there is a growing epidemic of illegal drug use by adolescents, which poses a formidable problem to governments, both from a law enforcement and a public health perspective in African countries. According to the WHO (2019:8), Nigeria has the highest reported rate of adolescent drug abuse on the African continent. These statistical findings supported findings that 35.3 million people in Nigeria were believed to have a drug use disorder. In a similar finding, the WHO (2019) further highlighted that the number indicated above was 15% higher than the previous estimate of 30.5 million. The WHO also stated that this problem has given rise to the term “people with drug use disorders” which designated people for whom their drug use is harmful to the point where they may experience drug dependence (WHO, 2018:5). While adolescent use of drugs has had a significant increase in Africa, it is far outpaced by East Asia and the Pacific and South Asia where prevalence rates were projected to increase by nearly one-third by the 22nd century.

It was however noted in a study conducted by Ongwae in 2016, that Kenya was an African country that was experiencing a 22% increase in the prevalence rate of adolescents who were abusing drugs, resulting in many secondary school dropouts, teenage pregnancy, female prostitution, behavioural changes, poor academic performance and psychotic behaviour (Ongwae 2016:7). This implies that the problem of adolescent drug abuse was escalating, and was no longer just a regional drug problem, but was now a global public health problem.

2.2.2 Drug Problems in adolescents: local overview

The Central Drug Authority (CDA, 2019:24) stated that close to 15% of South Africans struggle with drug abuse-related issues, which result in significant poverty, decreased productivity, unemployment, and dysfunctional family life in this nation. Motshoeneng (2018:7) states that most drug abusers exist within a social context, which includes family members as either parents, siblings, partners, caregivers' children or wider kin. The findings of the study conducted by Peltzer and Plazana (2018:19) revealed that 7.9% of men and 1.3% of women between the ages of 15 and 35 abuse drugs in South Africa. More specifically, the proportion of cannabis use among adolescents was 4.0%, followed by sedatives or sleeping pills at 0.4%, amphetamine-type stimulants 0.3%, cocaine 0.3%, opiates 0.3%, inhalants 0.2% and hallucinogens at 0.1% (Peltzer & Plazana 2018:19). The statistical data reflected above reflects that South Africa's substance abuse problem is a serious matter of concern. This is confirmed by the fact that South Africa ranks 10th in the global provenance ranking (WHO, 2017).

Additionally, the findings of the study conducted by Peltzer and Plazana (2019:18) concerning the problem of adolescent drug abuse in the nine South African provinces indicated that drug abuse was at its highest among the youth aged 10 to 15 years, occurring in the space of every three months. The study also highlighted that the increase was at 7.1% in the Western Cape, followed by the Free State with 6.3% and Northern Cape with 5.2%. They further confirmed that this increase in drug use prevalence rates amongst adolescents were observed from 2008 to 2018 in South Africa. Similarly, Dada et al. (2019 :12) states that the South African Community Epidemiology Network on Drug Use (SACENDU), reported that at least 17% of adolescents are receiving drug abuse

treatment in the Northern region whereas 50% of them in the Central region used alcohol as their primary drug of abuse which eventually resulted in them turning to drugs. They also established that about 1% of adolescents in the Eastern Cape, 11% in the Western Cape and 6.2% in the Northern region of adolescents who were under the age of 15 indicated that drugs were their primary substance of abuse.

It was also documented that the use of heroin amongst young people aged 13 to 22 years was 6.2% in South Africa (SACENDU 2017:24) These statistics were comparable to the notable escalation of global drug abuse amongst adolescents and the negative effects it had on caregivers as mentioned above. Similarly, the results of a survey conducted by the Centre for Drug Abuse (CDC 2018) in South Africa amongst young people aged 13 to 22 years in 2016 highlighted that the rate of cannabis abuse was 12.7%, whilst in the USA, cannabis usage by grade 10 pupils in 2010 was 33.4 % (Takalani et al. 2016:720). These statistics reflected a rising trend of drug abuse problems by adolescents both internationally and in South Africa. The Northern Cape was not spared from the adolescent drug abuse problem based on the statistical data reflected in this study. It was shocking to have this high percentage given the very low population of 2.4-million (Stats South Africa 2020) in the Northern Cape.

2.3 DRUG ABUSE: ADOLESCENT'S PERSPECTIVE

The WHO defines "adolescence" as that transitional stage of physical and psychological human development that generally occurs between the ages of 10 and 19 (Priyanka et.al 2016:120). These researchers further stated that drug abuse by adolescents was due to the following factors, biological predisposition to drug abuse, personality traits that reflect a lack of social bonding, a low socioeconomic status of the family, family bonding, family relationships and parental guidance and care. Similarly, according to Kalam et al. (2018:22), a history of being abused or neglected, low emotional or psychiatric problems, stress and inadequate coping skills and social support, association with drug-using peers, and rejection by peers leads to drug abuse by adolescents. The CDC (2018) report highlighted that about 12% of South African adolescents experimented first with alcohol before they started abusing drugs at the age of 13 years. Research conducted by Kalam et al. (2018:16) determined that the adolescents who abused drugs were mainly

influenced by their internal environment The results of this study confirm that it is of paramount importance that parents with adolescents who abuse substances need professional assistance and support as evidenced by the challenges they face in terms of promoting, maintaining and restoring their mental health.

The South African Community Epidemiology Network on Drug Use (SACENDU 2017:22) reported that there has been an increase of 22% in substance abuse from 2014 to 26% in 2016 in the Northern regions. This report also notes that this is a significant cause for concern as it increases the risk of Human Immunodeficiency Virus (HIV) infections, teenage pregnancy, school dropout, delinquent or criminal behaviour, and mental illness. Peer group pressure is significantly linked with drug misuse during this stage of adolescence. Parents also play a vital role during this time as young adolescents can emulate their own parents' habits. This leads to adolescents portraying strange behaviour and being seen to be irritable and aggressive. Dauber et at. (2018:67) however, argue that not all adverse consequences of substance abuse can be linked to peer pressure or delinquency. For instance, female adolescents turned to prostitution to support their expensive drug abuse habit (Ongwae 2016:19).

The research study "Experiences of parents with adolescents abusing drugs admitted in mental health institutions" conducted by Hlungwani et al. (2020:4) revealed that adolescents who abuse drugs experience feelings of having more energy. This was often perceived as an improved performance in their manual or intellectual tasks. It is described as them being extremely happy or exuberant, with grandiose ideas, and spending an excessive amount of money. The purpose of the study by Hlungwani et al. (2020:4) was to explore and describe the experiences of parents of adolescents who were abusing substances and who had been admitted to a mental health institution in Giyani. The study described the following themes: parents experienced uncontrolled thoughts regarding their adolescent abusing substances, not being able to control their adolescent abusing substances through discipline, negative feelings about their adolescent abusing substances and negative consequences resulting from their adolescents abusing substances. These themes yielded findings which emphasized that parents with an adolescent who abuse substances need professional assistance and support, as evidenced by the challenges faced in terms of promoting, maintaining and restoring their mental health.

Further, these adolescents no longer seemed to care about their physical appearance and often failed to attend to their personal hygiene (Kalam & Mthembu 2020:465). Additionally, Hlungwani et al. (2020:22) stated that adolescents who abused drugs showed unpredictable behaviour, and had physical and emotional problems such as depression, aggression, theft, crime, poor performance at school, dropping out of school, violence and ran a risk of being disowned by family and or caregivers. They also reported that any drug taking results in some form of intoxication, which altered the person's judgment and perception, and users also started acting strangely becoming agitated and aggressive. Motshoeneng (2018:37) asserted that drug abusers suffer from a variety of negative health effects, including a decline in physical health, mental impairment, and general spirit damage. He further asserts that these young people do not participate in economic activities, growth, or look for a better life; these effects eventually lead to dropping out from school for the younger ones.

2.4 DRUG ABUSE: THE FAMILY'S CONTEXT

Motshoeneng (2018:24) defines "family" as a group of people who are connected emotionally, by blood, or both ways, which have developed patterns of interaction and relationship. He further states that the behaviour and lifestyle of adolescents who abuse drugs could be influenced by the characteristics and dynamics of the family if this happens to be a family lifestyle. This could also be why family members have a shared history and a shared future because the family remains the primary source of attachment in our current society, nurturing, and socializing its members. Similarly, Moradi et al. (2019:4) in their qualitative study "Adolescent Substance Abuse and Family Environment "carried out in Iran determined that drug-abuse by adolescents often results in family crises and can jeopardize the family relationships and result in negative psychosocial effects on the immediate family and caregivers, especially those who are living with and taking care of them.

This study aims to explore the family factors which cause the development of adolescents indulging in substance abuse. The participants in this study were purposely selected adolescents. However, the findings of this research emphasises a parenting role in protecting adolescents from drug use. Finally, the results of this particular research study

suggests that families living in disadvantaged neighbourhoods with a high prevalence of drug use and families with a drug user should have a higher priority in implementing prevention programs.

Similarly, Ngantweni (2018:111) asserted that the negative effect of psychoactive substance use such as intrapersonal, peer, parental, and environmental relationships is evident in many domains of the lives of the adolescents. It was further indicated that these negative effects of drug abuse by adolescents are also associated with numerous physical and psychosocial problems mostly manifested by caregivers. Moradi et al. (2019:463) further argued that these problems extend from the user to their families and society and are linked to parental and environmental psychosocial and economic challenges. A sentiment shared by Kauri et al. (2021:462) is that drug abuse by adolescents affects all aspects of family life. This includes parents, other family members and siblings as well as caregivers who might feel that the family is being torn apart while also experiencing the youth as a complex, demanding, overwhelming and highly stressful situation. Kauri et al. (2021:536) further noted that in addition to this unpleasant experiences parents and or caregivers feel betrayed and loose trust in the child. Similarly, the family experiences ongoing turbulence, described as being torn between wanting to support for their drug abusing child and a need to ensure a stable family environment for their other children.

An argument made by Moradi et al. (2019:26) is that the prevalence of drug abuse within families must be properly explored due to its influence on household relationships, household violence, and toddler abuse to allow recognition of the fact that drug abuse is a family trouble. Conversely, Groenewald and Bhana (2018:142) said that while there is a wealth of know-how in our appreciation of parenting and its effect on adolescent dangerous behaviour, little is considered about how family lives are affected through their children abusing drugs. They additionally asserted that there is restricted perception into the lived experiences of affected parents, and caregivers with respect to coping strategies when dealing with the adolescent who has a drug abuse problem and associated behaviours and its psychosocial effects; that help need to be given to the caregivers and families who reside with them. Choate (2018:465) asserts that the effect of drug abuse disorders on the family, other household occupants and caregivers needs attention because this will subsequently lead to an endless drug abuse challenges by the adolescents.

2.5 DRUG ABUSE: THE CAREGIVERS' PERSPECTIVE

According to Botha and Hornet [nd], "experience" is one of the most-used terms in Social Science education, and is recognized as being related to learning and education. The research study about experiences of mothers coping with adolescent substance abuse conducted by Groenewald and Bhana (2017:306) indicated that a mother's coping response to adolescent drug abuse problem seems to be characterised by a variety of complexities such as early diagnosis, access to treatment facilities and support systems and/ or understanding of the psychosocial effects of drug abuse on both the users and the family.

Njoki (2018:11) considers that caregiving in today's era is a more intense, complex, and long-term role than in the past. Caregivers are seldom adequately prepared for the role. Further, that according to our history as a society, when affected members are unable to care for themselves or function independently, they involve other family members in the care of their families. These caregivers also play a role in providing emotional and sometimes financial support for the entire family (Njoki et al. 2022:392). Njoki (2020:6) also maintains that caregivers living with substance-abusing adolescents are adversely affected physically and psychosocially. According to Kalam and Mthembu (2020:468), the people who frequently spend the most time with addicts and are most likely to suffer negatively from drug addiction among young people are friends, family members, caregivers, and co-workers. These detrimental consequences include being forced to atone for family members and caregivers, particularly addicts, justifying actions, possibly experiencing sexual, physical, and emotional abuse, parental alienation, mutual blame or remorse, and family dissolution.

The extended family members, caregivers, and close friends are often required to provide financial and other support to meet the neglected responsibilities of the addict (Hlungwani et al. 2020:27). Mulyaningrat et al. (2019:862) also shared the same opinion, that families or caregivers face the problem of addiction head-on and begin to accept it, or that the caregivers may withdraw and become ignorant. Barriers prevent them from disclosing or discussing the very general problems they are facing. Additionally, sharing family secrets is viewed negatively, which heightens the need to keep them private and might put affected families into a downward spiral of issues (Mulyaningrat et al. 2019:856).

2.6 REHABILITATION INSTITUTIONS AS A DISCOURSE

2.6.1 Global context

Using harm reduction techniques can be an efficient and forward-thinking tactic and various strategies have been developed all over the world. According to the WHO (2018), harm reduction is a collection of practical tactics and concepts aimed to lessen the negative effects of drug use and its associated stigma, has on people's health and communities. The WHO (2019) defines rehabilitation as a process that enables a service user to achieve and maintain optimal levels of physical, psychological, intellectual, mental, psychiatric, or social functioning. It also includes measures aimed to restore and compensate for lost, or absent functions. According to their goals, priorities, and the United States doctrines, nations worldwide have adopted various approaches to drug management (National Master Plan 2018). This master plan also specifies that nations fall along a spectrum of ideologies, from a more conservative approach marked by a primary focus on law enforcement and criminal justice to a more liberal approach whose primary focus is on reducing the health and social illness brought on by drug abuse. This initiative was realized by establishing more rehabilitation institutions that provide inpatient and outpatient services. However, it is noted that there is a vast gap in the provision of such services in private and public institutions in African countries in comparison to the global context. This is attributed to the fact that most African countries are still developing countries and as a consequence have challenges funding such institutions. The South African Master Plan on substance abuse further reveals that private institutions are better resourced than public institutions across the globe.

Furthermore, only one out of every eight people needs treatment for drug abuse receives it, while only one in five people are receiving treatment and one in three drug users are female (WHO 2020:19). In addition, of the 11 million people who inject drugs, half have hepatitis C and are receiving treatment for it, while 1 in 4 have HIV. Similarly, Australia is said to have developed a nationally coordinated drug harm strategy based on the principle of harm minimization, which refers to policies and programs aimed at reducing drug-related harm, in response to increased drug abuse and drug trafficking. The main goal of this strategy was to offer a variety of recommendations used to enhance communities'

and individuals' health, social, and economic outcomes (National Drug Master Plan 2019).

2.6.2 Regional context

Generally, HRS for drug addiction are absent in the majority of African nations (Ogunrombi 2015:38). Ogunrombi goes on to note that several factors contribute to the poor utilization of HRS around the world, including community opposition, unclear governmental policies, a lack of political support, and the idea that HRS are immoral. All of these factors have been reported on in the literature.

Ogunrombi, (2018) mentions that the WHO (2018) global report from Harm Reduction International shows that the sub-region has made some progress in HRS, with roughly 10 countries in the region having explicit policy documents supporting it (Ogunrombi 2018:45). In addition, he added that over time, Nigeria's drug policy had become more focused on reducing the drug supply, resulting in the incarceration of offenders without the possibility of a legal appeal. According to the United Nations Office on Drugs and Crime (2018), the Nigerian Federal Ministry of Health started holding consultations in 2018 to develop recommendations for the administration of methadone as part of drug rehabilitation treatment.

2.6.2 Local context

The South African Government's Harm Reduction strategy resulted from post-1994 policy changes. The South African Controlled Substance Act of 1991 and the Drug and Drug Trafficking Act 140 of 1982 were ame€nded because of the growing drug abuse problem. The Prevention and Treatment for Substance Abuse Act 70 of 2008 was subsequently developed to control and regulate Harm Reduction Strategy (HRS). This sparked the idea to create norms and standards for in-patient treatment facilities for both the public and private sectors (SACENDU 2017:26). The South African Harm Reduction Strategy's primary goals are to reduce demand and prevent deaths and injuries brought on by drug abuse, drug overdose and misuse, and substance abuse and its disorders. Government

and civil societies work together to implement this, with the latter receiving direct or indirect government funding. This strategy is based on the following four levels of implementation: awareness raising, operational coordination, and reducing drug supply through improved investigation and prosecution procedures.

A wide range of stakeholders, including civil society, traditional leaders, non-profit organizations, corporations, and faith-based organizations, work with various government agencies to provide services aimed at reducing and preventing substance abuse. In a similar manner to other countries, South Africa's harm reduction is limited to the comprehensive care of service users and their families, through minimizing the social, psychological, and health effects of substance abuse; supply reduction through health education and campaigns; and efforts aimed at preventing the production and distribution of illicit substances and associated crimes by law enforcement authorities by the strategies provided for in the applicable laws (National Master Plan 2008:10). Dauber et al. (2018:67), highlight the fact that the holistic management of both psychosis and drug addiction should be a part of the comprehensive treatment for adolescents who abuse drugs and have psychotic symptoms. They went on to say that because drug addiction significantly impacts families, healing from drug addiction must also involve healing the entire family.

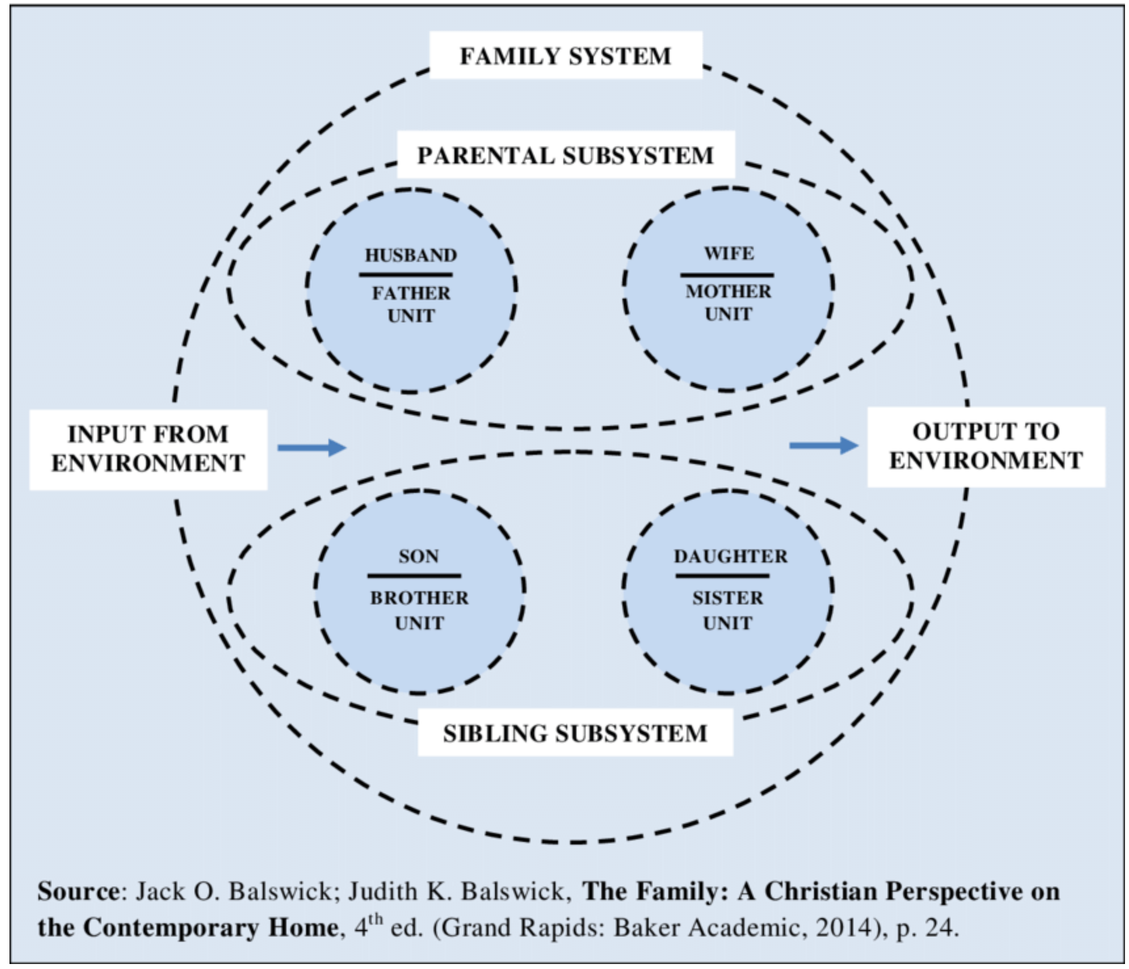
2.7 THEORETICAL FRAMEWORK

According to Polit and Beck (2021:43), the theoretical framework is the structure that supports the research study. It is, therefore, necessary for a researcher to apply a relevant theoretical framework in support of the research study they are undertaking. The Family Systems Theory (FST) evolved in 1940 and was conceptualized from 1950 onwards by theorists such as Bowen (1960), Kerr and Bowen (1990), Neumann (1974) and Jack and Judith Balswick (1994) as cited by Balswick (1994) This Theory is explained as illustrated in Figure 2.2.

Balswick (2014:5) stated that the family system theory is a holistic approach that describes every part of family life in terms of the family as a whole, where individuals who are interconnected and influence each other run day-to-day operations. It should be noted

that family could include or exclude a mother, father, sister, or brother. The family could also include a stepfather, stepmother, or step-siblings. Therefore, the FST is not only limited to the typical nuclear family but can extend to a stepfamily or an extended family. The difference between the Family System Theory and the individual oriented theories of behaviour is that the latter focuses on what is happening inside the individual as a primary point of reference.

In contrast, the FST intentionally shifted from a lineal causal to a circular conception of causality that connects the problem behaviour of one person with the surrounding behaviour of the other family members. In addition, each family system has a boundary that indicates the degree of interaction with its subsystems and supra-systems. It uses it to regulate the input (stimulus) received from the environment and output (response) to the environment. The following levels of the FST relevant to this study will be applied.



Source: Jack O. Balswick; Judith K. Balswick, **The Family: A Christian Perspective on the Contemporary Home**, 4th ed. (Grand Rapids: Baker Academic, 2014), p. 24.

Figure 2.2: The Family System Theory

2.6.3 The Parental Subsystem Level

This level is comprised of the husband and the wife, son and daughter and eventually, the siblings. The functioning of this boundary is guided by the set rules, common beliefs, norms, common goals and to a certain extent, by culture. All of the members in this boundary have different roles that they carry out in their day-to-day lives. The main characteristics of this subsystem are that the behaviour, interrelationship and interconnectedness of each member of the family affect each other and are interrelated (Balswick & Balswick 1994). For example, if there is a problem with one member this will negatively affect the other members, which is influenced by the different roles played by members in the family system. According to Balswick (1994) this sentiment was shared by researchers such as Minuchin (1974), Haley (1976), Bowen (1978), and Jackson (2005) by maintaining that the perspective of the FST is a primary goal of therapy, which

is used to break up patterns of interaction that reinforce and perpetuate problematic behaviour by allowing different non-problematic behaviour to develop. Balswick (1994) further states that Lowman (2002:99), maintains that the family system theory is characterised by different roles played by each member in the parental subsystem; these roles are described in detail below.

2.6.3.1 The Scapegoat

The scapegoat is the family member who is described as being hostile, has anger issues, and is defiant. The scapegoat is also regarded as the truth-telling member and acts on problems hence they are referred to as a problem child. The unacceptable behaviour of the problem child sometimes leads the family towards trying to cover up, defend or deny and or in worst scenarios disown them. In this study, the researcher compares the problem child to the adolescent who abuses drugs and in one way or the other manifests with the effects describing the scapegoat role of family members. The change in behaviour of the scapegoat has a detrimental effect on the family, the consequences of which can lead the family to disintegration and/ or family alienation. It must also be noted that though scapegoats may seem to be angry or rebellious or problematic others can, according to Beckvar (2001:113), Bekcvar, & Becvar (2017:) and Becker, (201:7) be referred to as a picky, weak or a sick child. Either way, these kinds of behavioural changes could have a negative effect on the psychosocial wellbeing of another family member such as siblings leaving their homes and becoming street kids or even indulging in alcohol and drugs, violence amongst siblings and parents, which can eventually lead to family disintegration.

2.6.3.2 The Hero

This is a family member who portrays themselves as a caring member who is always making the family look normal without having problems. They always mask the dysfunctionality of the family. The study will explore the experiences of caregivers who, at some point face the possibility of denial and keeping information about the drug-

abusing adolescent to themselves. The consequences of such actions could aggravate the problem the family is already facing.

2.6.3.3 The Mascot

The role of the mascot in the family is to break the tension and lighten the mood in the family with their humility in order to interrupt tension anger, conflict, violence or any other unpleasant situation within the family. They may also use their sense of humour to communicate and to comfort the family. Hence, it can become very difficult for the family to notice the drug abuse problem of the adolescent in this role and this can have a detrimental psychosocial effect on both the abuser and the caregiver, as mentioned in the literature review.

2.6.3.4 The Lost Child

This child is described as being invisible, quiet most of the time, and mostly a dreamer. This child attempts to avoid the family dynamics by shrinking down dramatically, staying out of the way of issues. The lost child hardly ever gets into trouble and never communicates or interacts freely with other family members, so their behaviour is comparable to that of the Hero. Therefore, this behaviour tends to redu€ce parental and sibling bonding. The negative effects of this role could aggravate the drug problem the adolescent is having because it could go unnoticed for a very long time and subsequently lead to a dysfunctional family and family disintegration and loss of livelihood.

2.6.4 The Environment levels

Jack and Judith Balswick (1994) describe environment level as factors within and outside the boundaries of the family system. They further say that these environment levels influence the functioning and interconnectedness of the parental subsystem level, which constitute wife and husband (father and mother), and siblings (sister or brother). This implies that if the environmental factors negatively affect one or more members of the

family, this will consequently affect other members of the family. The researcher in this study will explore the psychosocial impact such as family disintegration, violence, financial inconvenience, and crime and siblings' violence and in the worst-case scenario fleeing the family home, in this case, the caregiver.

2.6.4.1 Input from the environment

Balswick (1994) defines inputs from the environment as any message or stimuli that come into the boundaries of the system. According to Moradi et al. (2919:134), Groenewald and Bhana (2018:478), Choate (2016:365) and Kalam et al. (2019:438) the negative effects of drug abuse on adolescents could be bullying of siblings and/ or caregivers such as the mother or father or both. This can extend to bullying other peers and schoolmates, neglect of personal hygiene, crime, stealing, weight loss and deterioration in their physical and mental health status. These effects could subsequently lead to negative psychosocial effects that can be experienced by the caregivers and can manifest through loss of hope, a sense of despair, depression, and loss of employment and income on the part of the caregiver. These factors could address the aim and answer the research objectives and research questions of this study.

2.6.4.2 Output to the environment level

According to Balswick (1994:10), any message or response from the family system to the environment is considered an output to the environment. The psychosocial effects of drug abuse on the caregivers who live with the drug-abusing adolescent in this study are used to explain the outputs to the environment. The understanding of this theory is that family members control the pliability of the environmental boundaries, for example, if the family system is open, the information can flow freely in and out the family system. If the family system is closed, the family constructs barriers to limit this interaction (Bekcvar, & Becvar (2017) and Becker (2017). Drug abuse by any family member can result in unbearable consequences, which could eventually lead to limited connectedness and interaction amongst the family members. This can also result in siblings fleeing their homes and or fighting amongst themselves.

Researchers like Moradi et al. (2019), Kalam et al. (2018), and Groenewald (2017) emphasized that the harmful effects of adolescent drug abuse extends beyond the abuser and have a negative impact on the families and caregivers daily functioning as well. It should be noted that these effects extend beyond the drug user to include their family. They went on to say that the effects of the drug-using adolescent on the family and/ or caregivers includes, among other things, a feeling of uncertainty about the abuser's future, feelings of powerlessness and worthlessness by caregivers, and at times they feel like they have failed as caregivers. They start to feel guilty and develop a sense of self-blame, they fear for their safety, have emotional instability, lose income, and in extreme cases, the family or caregiver flees their home. Similarly, Njoki (2020:36) asserts that the FST also focuses on analysing interactions observed by family members by asking and attending to moments when exceptions to the problem happen.

The researcher will explore the interrelationship between the adolescents who are affected by input, messages, or stimulus that come into the system from the environment and how this influences the caregiver's psychosocial and physical wellbeing.

2.6.5 Application of the Theoretical Framework

The researcher used the Jack and Judith Balswick's Family Systems Theory in this study because it was more pertinent to the subject and laid the foundation for examining the phenomenon under investigation. The other reason for using this theory is because FST puts more emphasis on tracking the observable sequence of recurring transgressions, making the nature of self-perpetuating patterns of a problem and behaviour more comprehensible and observable (Balswick 1994:20). The researcher will therefore explain the correlation between the FST and the problem under study by unpacking the interrelationship and connectedness amongst the levels of this theory. The framework will be used to guide the researcher in the formulation of the study objectives and data collection method and subsequently applied in the development of comprehensive and constructive meaning of the analysed data that will give direction to the discussion of findings and recommendations made in the study. Additionally, the application of this theory formed the foundation for the achievement of the objectives of the study according to the following subsystems levels:

The drug abuse problem by adolescents has not only resulted in significant morbidity and mortality among adolescents but has also led to negative psychosocial effects on the caregivers and parents living with them worldwide (Moradi et al. 2019:27). Many of these young people will die from drug use, and many more will probably develop into problem drug users, as they get older. Although the drug abuse issue is complicated and serious, there is a wealth of evidence-based research that can be used by doctors, local authorities, and educational institutions to implement interventions that can lower the rate of adolescent substance abuse. Unfortunately, the same cannot be said about the caregivers' experiences of living with those adolescents who abuse drugs. It is further acknowledged that government and individual interventions in the fight against drug abuse by adolescent and its effects on caregivers might not always be successful because this problem is not unique to any one specific community or culture. The emphasise must therefore be based on the South African Institute for Drug Abuse (NIDA) strategy of focusing on modifiable risk factors and enhancing protective factors through family, school, and community prevention programmes as a generalized framework for healthcare and community activists to use when identifying the programs and strategies that are most appropriate for their community (CDC:2020).

2.7 CHAPTER SUMMARY

This chapter presented the pertinent factors acquired from the reviewed literature revealing the extent of drug problem amongst adolescents and the devastating effects it has on both the users and the caregivers globally, regionally and locally. The FST by Jack and Judith Balswick was used as the framework of this study and the system provided a foundation for the development of the research aim and objectives if this study. The methodology used to collect data in this study is discussed in full in Chapter three.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 INTRODUCTION

The preceding chapter provided a detailed account of the reviewed literature perspectives and scholarship concerning the phenomenon of drug abuse amongst adolescents and the negative effects this problem has on their caregivers. In the current chapter, the researcher provides an overview of the research methodology. Research methodology is the method that is used to structure a research study, gather, and analyse relevant data in response to a research question. It consists of several steps and is carried out in a particular order (Polit & Beck 2021:801).

This chapter includes a detailed description of the methodological proponents of the study. It discussed the research approach, design, research setting, and the target population. The recruitment of participants, sampling and sample size, research technique, inclusion and exclusion criteria, data collection process and instruments, data analysis, the principles of trustworthiness and research ethics. This research explored the experiences of caregivers living with adolescents who abuse drugs. The research sub-objectives of the study were to:

i. Determine the effects experienced by caregivers of adolescents who abuse drugs.
ii. Describe the coping strategies used by caregivers living with the adolescent who abuse drugs.
iii. Identify programmes available in the community to support the caregivers of adolescents who abuse drugs

3.2 RESEARCH DESIGN AND APPROACH

A qualitative, descriptive, and contextual with a phenomenological approach was adopted to explore caregivers' experiences living with adolescents who abuse drugs. According to Polit and Beck (2021:471), phenomenological research is a method of study that seeks to examine a phenomenon from the point of view of those who have experienced it to describe its essence. In addition, descriptive phenomenological research emphasizes the conscious description of human experiences of "things", which include hearing, seeing, believing, feeling, deciding, remembering and acting.

The two acts of descriptive phenomenological studies are; bracketing and reduction. According to Polit and Beck (2021:478), bracketing is the process by which a researcher suspends or maintains their hypothesis, theory or prior experience to understand and describe a particular phenomenon. At the same time, reduction is an act of mediation and release. Researchers gain a more focused openness by continually questioning the meaning of experiences. The researcher used the descriptive phenomenological design (approaches) because it was necessary to understand the general nature of the problem identified, which was the caregiver's experiences of living and taking care of adolescents who abused drugs. This approach was also used to identify possible alternatives to the solution, and to identify relevant variables that needed to be considered.

In this study, the researcher sought to explore and describe the lived experiences of the sampled participants by using the bracketing approach because it was deemed the most appropriate method to address the aim of the study. This methodology acknowledges how individuals within a social and personal world construct meaning. Polit and Beck (2021:477) asserted that the goal of descriptive phenomenological studies is to understand lived experiences and the perceptions to which they give rise. Additionally, a phenomenological research paradigm is grounded in personal knowledge, subjectivity and emphasises the importance of personal perspective and interpretation (Polit & Beck 2021:477). In this particular study, the experiences of caregivers looking after adolescents who abused drugs were unpacked.

The qualitative research method was used in this study. According to Polit and Beck (2021:471), qualitative research involves collecting and analysing non-numerical data from sources such as text, video, or audio recordings from interviews to understand concepts, opinions, and experiences. Qualitative research design can be used to gain deeper insight into a problem or generate new ideas for research. This study design is contrary to quantitative studies, where numerical data is collected and analysed for statistical analysis. Polit and Beck (2021) also point out that qualitative research designs are more flexible and can adapt to new information during the data collection process. Another feature of qualitative design is integrating different data collection strategies, developing subsequent strategies based on continuous data analysis, and deciding when to stop collecting data.

3.3 RESEARCH SETTING

The study was conducted at four purposively chosen Non-Governmental Organizations (NGOs) rehabilitation institutions situated in the Sol Plaatjie Municipality in Kimberly in the Northern Cape Province. (Appendices B3, B4, B5 and B6). This Province is vast and arid. It is the largest Province in South Africa, taking up nearly a third of the country's land area. It covers an area of 372 889km ^{2} and has a population of 2.4-million, the least populous of South Africa's Provinces. It is bordered by Namibia and Botswana to the north. Sol Plaatjie is one of the five district municipalities in the Northern Cape Province. The major economic activities in this Province are farming and mining, yet people still live in poverty. The Province is also characterised by a high unemployment rate of 28.78% (Northern Cape Socioeconomic Report 2021:24). There are currently six rehabilitation centres in the Sol Plaatjie municipal area from one government and one private psychiatric hospital These two hospitals also offer drug abuse rehabilitation services and are referral centres for Northern Cape Province and the four NGOs. The NGOs offer primitive, preventive, curative and substance abuse rehabilitation services.

3.4 STUDY POPULATION AND SAMPLING

The population is defined by Polit and Beck (2021) as a particular group of individuals or elements also called participants that are of interest to the researcher to conduct a study, these individuals should meet the criteria that the researcher intends to study. The population of this study were the caregivers who lived with drugs abusing adolescents who are attending counselling and collecting treatment at the selected rehabilitation institutions in the Sol Plaatjie municipal area.

3.5 RECRUITMENT OF PARTICIPANTS

Participants were recruited from selected rehabilitation government institutions and NGOs in the Sol Plaatjie Municipal area after full ethics approval was obtained from the DUT Institutional Research Ethics Committee (IREC). The recruitment process unfolded

at the selected institutions at the reception area where the caregivers accompanied the adolescents who abuse drugs and who attend as day patients, for services such as counselling and collection of treatment. It was noted that caregivers came with the adolescents from 08h30 to 13h00. The researcher facilitated the recruitment session on the day and time that was agreed upon with the healthcare professionals who manage the facilities. Participants were met in the waiting area, where the researcher verbally explained the purpose of the study, the ethical principles of confidentiality, the right to privacy, the right to agree or not to the participants and, finally, how they will be expected to participate. The participant information letters (Appendix C1 to C4), as described in the data collection process, were given to the participants to read, and the researcher availed herself to answer questions that the participants had and provide clarity about the study.

The potential participants were then given seven days to consider if they were still willing to participate in the study. This process gave the participants ample time to consider their involvement and provided them with an explanation of the process throughout, with the opportunity to seek clarification on any concerns that arose. All who met the selection criteria and agreed to participate were required to sign a consent form (Appendix D) before the commencement of the interviews, and the appointment schedule was communicated to them.

Information letters written in English attached as Appendix C1 were translated into Afrikaans (C2), IsiXhosa (C3) and Setswana (C4). This included consent forms also written in English attached as Appendix D1, Afrikaans (D2), IsiXhosa (D3) and Setswana (D4) were obtained from the participants and signed by both the researcher and the participant in the presence of a witness who signed as a witness.

3.6 SAMPLING

Polit and Beck (2021:892) define sampling as the process by which a researcher selects a subset of a population to represent the entire population under investigation which was to explore the experiences of caregivers who were living and taking care of the adolescents who abused drugs. The populace was concentrated on incorporated caregivers living with adolescents who abuse drugs, and the objective populace were

parental figures of adolescents who are misusing drugs and receiving treatment at the selected rehabilitation institutions.

The estimated number of participants who met the selection criteria was 15 (three per each selected institution). It is of note that the participants were caregivers who live with the adolescents. They also normally and routinely accompany the adolescents who abuse drugs to the health institution to collect their medication and counselling.

3.6.1 Sampling technique

A non-probability purposive sampling, also known as the judgment sampling method, was used in this study. Purposive sampling occurs when elements selected for the sample are chosen by the researcher's judgment as guided by the inclusion and exclusion criteria. (Polit & Beck 2021:499). This sampling method saves time and cost and is based on the population's characteristics and the objectives of the study. The other reason for using the purposive sampling method in this study was that it has proven to be effective when only limited numbers of people can serve as primary data sources due to the nature of the research design (Polit & Beck 2021:499). Through permission from the gatekeepers, the researcher made a presentation to the prospective participants. Participants voluntarily indicated their interest in participating in this study. The researcher distributed information letters to those participants who met the selection criteria. The appointment schedule was arranged, and the participants were reminded of the interview's session date, time and venue five days before the date set for the session. It was noted that the participants honoured their appointments as scheduled, and the process unfolded without problems.

3.6.2 Sample size

Sample size is defined as the number of people who participate in a study (Polit & Beck 2021:261). The sample size was determined by data saturation, which is when no new information is coming forth from participants. According to Polit and Beck (2021:502), a sample size of 10 to 15 participants is adequate in phenomenological studies. Hennink,

Hunter and Bailey (2020:113) assert that the focus in qualitative studies is more on the richness of data, rather than on the number of participants providing the data itself. The latter authors further indicate that a large sample was not necessarily required to meet the predetermined goals of a qualitative study.

In this study, the sample size consisted of a total sample of fifteen participants. The researcher's primary objective was on obtaining information and which was rich in data and saturation was reached and established as a factor of data redundancy or saturation. This number was reached from all selected institutions where the number varied between three to five per institutions.

3.6.2.1 Inclusion criteria

i. Caregivers 18 years and above who live with adolescents who abuse drugs and are receiving services from the selected rehabilitation centres in the Sol Plaatjie district.

3.6.2.2 Exclusion criteria

i. Anybody who lives with a drug abusing adolescent who is younger than 10 years and older than 19 years of age and is not a caregiver for that adolescent.
ii. Caregivers. younger than 18 years of age, living with adolescent who abuse drugs.

3.7 DATA COLLECTION

Data collection is the process of gathering and measuring information on variables of interest, in an established systematic fashion that enables one to answer stated research objectives, questions, and evaluate outcomes (Polit & Beck 2021:510). The purpose of data collection in this research was to familiarise oneself with specific experience of identifying the phenomena that was perceived as important by the researcher in a

particular situation. According to Polit and Beck (2021) the emphasis is on subjectivity and personal knowledge in perceiving and interpreting the phenomena from the research participant point of view and this is done through in-depth interview of participants.

3.7.1 Data collection tool

Phenomenological studies are qualitative in nature; therefore, data collection was done through semi-structured interviews whereby an interview guide (Appendix E) was developed by the researcher from the existing literature, which also considered the study's objectives. The interview guide comprised a list of questions the researcher used to gather in-depth data about the research topic. The interview guide helped the researcher focus and organize their line of thinking and pose relevant questions. The interview guide was prepared in English (Appendix E1) and included three other languages, commonly used in the Sol Plaatjie Municipal area. The interview guide was translated into Afrikaans and attached as Appendix (E2), isiXhosa (E3) and Setswana (E4). Fortunately, the researcher is proficient in all four languages. The interview guide comprised of two sections; Section A, which enquired about the demographic information of the participants, and Section B consisted of a grand tour question on the caregivers experiences of living with an adolescent drug addict.

In addition, an audio recorder was used upon permission by the participants to capture the participant's narratives. The researcher made field notes by writing down the participants' nonverbal observations, such as facial expressions or mannerisms, during the interview sessions. These notes were kept as points to remember during the analysis of data.

3.7.2 Data collection process

Data collection commenced after the researcher received full ethical clearance (IREC306/22) from the DUT Institutional Research Ethics Committee (IREC) (Appendix A). The approved research proposal was submitted to the Provincial Departments of Health (Appendices B1 and B2) (both appendices contained the letters of request for

permission to conduct a study and response from gatekeepers) and Social Development (Appendix B2) as well as from the Chief Executive Officers of the four NGOs selected for this study as well as from the New Mental Hospital (Appendices B3 to B7).

An unutilized office, which was conducive, quiet and adhered to the principles of privacy was arranged with the managing directors of the institution selected was used for the interview sessions. A “no disturbance” notice was put on the door of the office used for those sessions. No other person was allowed in the room during the interviewing process. The office had good lighting and ventilation for the comfort of both the interviewer and interviewee. In-depth face-to-face interviews were conducted with caregivers, who met the selection criteria, and the interview was audio recorded after obtaining permission to record the proceedings from the participant to allow the interviewees to express their experiences and to make sense of their responses through interaction and follow-up questions by the researcher. The duration of the semi-structured interview was between 45-60 minutes. However, the researcher did not limit the participants in cases where the session exceeded one hour or more and did allow the participant to continue with the session when the participant seemed to be exhausted because there was a possibility of unnecessary repetition of information sharing by the participant.

The principles of confidentiality and privacy were strictly adhered to. The signed copy of the consent forms was secured and filed in the researcher’s office, which at all times were, kept under lock and key and no access was allowed to them. The researcher ensured that no other person was allowed in the room where the interviews were being conducted. A counsellor was arranged with the institution selected for attending to any emotional reactions, which may arise from the participants during the interview. The researcher is a professional nurse who counselled the participants to a certain extent thereafter referring the participants to the counsellor for further management. Different interviewing skills which included listening, encouraging, reflecting and writing whilst summarising with grand tour questioning followed by probing questions were used. Data was collected every week from Tuesday to Thursday between 8:30 to 13:00 for a period of two weeks. The reason for using those scheduled days and time were because, those were the week days that the patients (drug abusers) attended the clinics with caregivers for counselling and collecting medication; the visiting doctor conducted the sessions and/ or social worker from Tuesday to Thursday at specified times as indicated in the letter of invitation sent to the selected participants. Some participants had to be interviewed more

than once because they became tired or became too emotional on the first day. In the circumstances where the interview process passed lunchtime, the researcher provided a juice and a fruit to the participants. Water and tissue papers were always available for as and when needed.

3.8 DATA ANALYSIS

Polit and Beck (2021:534) define data analysis as a systemic organization and synthesis of data and occurs concurrently with data collection in qualitative studies. They further described the purpose of data analysis as that of organizing, analysing, and interpreting non–numeric qualitative data, conceptual information and user feedback to capture themes and patterns, answer research questions, and identify actions to take and make improvements (Polit & Beck 2021:535). Qualitative data analysis therefore aims to make sense of the abundant, varied, mostly non-numeric forms of information that accrue during interviews. As qualitative researchers, we reflect not only on each piece of data by itself but also on all the data as an integrated, blended, composite package (Polit & Beck 2021:5). Data analysis in qualitative research involves data reduction, data display, and the drawing of conclusions. In summary, data analysis addressed and it was applied in the following three components of conducting qualitative research: selecting participants, performing data analysis, and assuring research rigor and quality.

Thematic data analysis method was used to analyse data obtained from the interviews. The researcher first listened to the audio recording several times, and translated data which was in other languages for example in Afrikaans, IsiXhosa and Setswana in English verbatim and read the transcript several times. This enabled the researcher to get a full understanding and make sense of data that was collected. The researcher developed codes and categories and from those developed themes. This preferred method provided an easy interpretable and concise description of the emerging themes and patterns within a data set usually as the foundation phase of interpretation. Therefore, the thematic analysis involved the identification of the common and recurring interview-based verbatim statements or responses of the participants. The researcher made sure that she understood the meaning that individuals ascribed to their lived experiences and which the

researcher attempted to interpret this meaning in the context of the research. Creswell's six steps of data analysis was also used for a thematic data analysis.

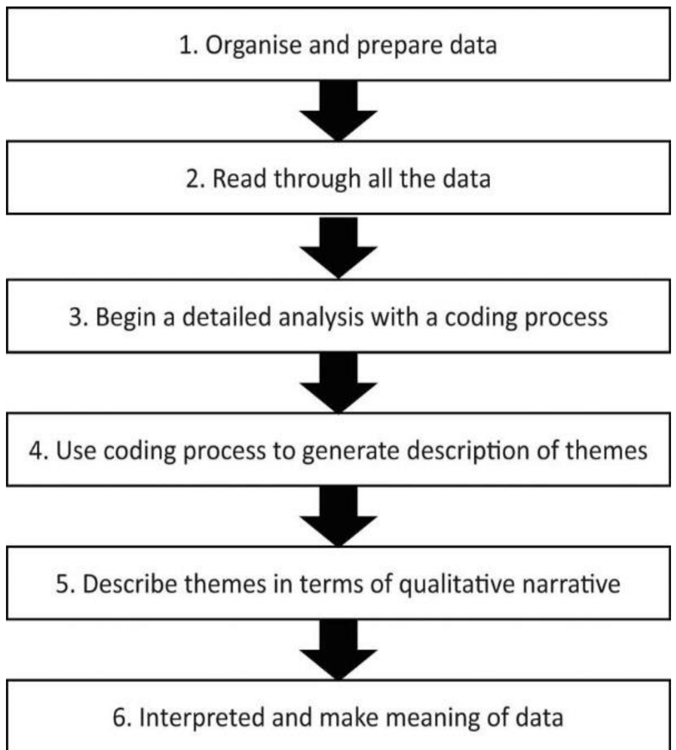


Figure 3.1: Creswell Data analysis steps Source: Creswell 2013

Step 1: Familiarization of Data

It is important that the researcher familiarise themselves with the data before attempting analysis, therefore the researcher embarked on this process by repeatedly listening to voice audios recorded during data collection, reading the field notes and mapping and organizing the narratives of the participants. Reading and re-reading the transcripts was done thoroughly and this was coupled with taking notes to highlight interesting information and to make sense out of the collected data.

Step 2: Preparation and organization of data

The researcher transcribed all data from the recordings and used field notes and other material used in the study to compile a record of data collected during the interviews. This aided in being familiarised with the data from an early stage by being actively engaged in

the data and transcribing the interactions and then reading the transcripts and listening to the recordings several times. Initial ideas were noted down. The researcher also kept notes about any thoughts, ideas or any questions she had by writing them down in her notes. The researcher read all transcribed data over and over in order to understand and start making meaning of data at an early stage, the following steps of analysing data then unfolded:

Step 3: Coding

Coding was done by the researcher Coding commenced after the researcher had transcribed and checked the interviews notes. The field notes compiled during interviews were used to complement sources of information gathered during the interview. The field notes were used because the gap in time between an interview, transcribing and coding can result in memory bias regarding non-verbal or environmental context issues that may affect interpretation of data. Any recurring or similar categories were put together and coded. Codes were then reviewed, revised and combined into themes. The transcribed data was reviewed thoroughly to make sense of what they contained. Key findings were highlighted and noted down and elimination of unnecessary or repeated words such as “I mean”, “you know” were done. Transcripts were examined for their major themes by checking the relationship between the categories and analysing them and then linked them into themes. In order to ensure quality of data collected and analysed the researcher solicited the services of an independent secondary code and transcriber.

Step 4: Development of the Themes

In concurring with Polit and Beck (2021:478), theming refers to the gathering of symbols from one or more texts to show the findings of self-examination in a coherent and tangible way. Examples might be events related to participant’s stories about how they experienced life with adolescent drug users such as feelings of hopelessness or fear of living with a sober abuser. The importance of addressing this obstacle was that it was conceivable to show data from the interviews by using quotations from the individual’s text to determine the source of the researcher’s explanation at the end of the data analysis. Possible themes and sub-themes were identified in the information. Ongoing analysis was done to further enhance the identified themes and clear working definitions that captured the essence of each theme.

Step 5: Presenting themes in a comprehensive manner

This is the last step during which the researcher produced a report by transforming the analysed data into an interpretable content using compelling extracts examples that related to the themes, research objectives, question, and literature.

Step 6: Presentation of the Report and findings

A comprehensive report of the findings and recommendations was compiled and submitted for examination to the DUT faculty research ethics committee through my supervisors. The report was presented to the provincial departments of health and social development upon approval by the DUT IREC.

3.9 DATA MANAGEMENT AND STORAGE

The researcher was responsible for entering and checking the completeness of data collected on the research notes. The recorded audio responses were transcribed verbatim and directly translated into English by the researcher. This was done when the participants used any other language besides English when responding to questions asked by the researcher during the interview session. The language preferences of the participants were therefore considered. The research documents were collected and stored in a manner that ensured that participants' confidentiality was maintained throughout the research process and the reporting of results. The researcher ensured that participants' details and NGOs were not recorded or written into the notes. Instead, codes were allocated to the participants and the four NGOs. The researcher called out the assigned code for it to be audio recorded.

All written notes taken during the interview sessions and any equipment used in this study, such as the audio recordings, were removed from the audio tape, encrypted and saved on a password-protected laptop, which will only be accessible to the researcher. Data backup was stored in a password protected external hard drive. Hard copies, such as consent forms, were kept in a locked cupboard, and the researcher only accessed the key. All data will be kept for a duration of five years and in line with the relevant research policy of the Durban University of Technology and in compliance with the provisions of the Protection of Personal Information Act (POPIA). The retention of research documents

is also a resource for information for further research on a field of interest by the researcher. Those kept records will be destroyed by deletion and shredding by the researcher after five years.

3.10 TRUSTWORTHINESS AND RIGOR OF THE STUDY

According to Polit and Beck (2021:562) trustworthiness refers to the dimension in which the credibility and objectivity of a qualitative research is achieved whereas research rigor is defined as the strength of the research design and the appropriateness of the method to answer the research questions. It is expected that qualitative studies be conducted with extreme rigor because of the potential of subjectivity that is inherent in this type of research. The goal of rigor in qualitative research can be described as ensuring that the research design, method, and conclusions are explicit, public, replicable, and open to review, and is free of bias. Trustworthiness in qualitative research is used to maintain the consistency of a result of measure across researchers. Trustworthiness in this research study was achieved by the application of Lincoln and Guba's framework of credibility, dependability, conformability and, transferability and it is explained below as criteria to evaluate the study's quality.

3.10.1 Credibility

According to Polit and Beck (2021:154), credibility is a dimension of trustworthiness that is attained when the research procedures inspire faith in the veracity of the findings and interpretations. Credibility is a measure of the truth-value of qualitative research, or whether the study findings are correct and accurate. To preserve the study credibility, the researcher always took into account any personal biases that might have affected the results. The researcher did not use her personal experiences or knowledge of the phenomenon in any way throughout this research study. To ensure that data that has been gathered and analysed and it is sufficiently deep and relevant, the researcher also acknowledged sampling biases and ongoing critical reflection of the methodologies. The researcher maintained and safely kept a record of the information gathered and the use

of audio recordings during interviews. Credibility also maintained by means of member checking, extended engagements with participants, as well as peer debriefing.

Peer debriefing comprises of having an individual present to assess the researcher's explanation of the findings, conclusions, and suggestions and to pose inquiries that check its accuracy (Leedy & Ormrod, 2019:200). Considering this, a list of the findings was presented to the research supervisors as well as experts from the researcher's place of employment. The researcher also provided a summary of her findings for both her supervisor and co-supervisor and took heed of their suggestions and recommendations for improvement by applying them throughout the study.

3.10.2 Transferability

This is when the researcher uses multiple sources or references to conclude what constitutes the truth (Polit & Beck 2021:154). For this study, transferability was attained by ensuring that a detailed research report was produced outlining the research context and the assumptions central to the study. This was done to enable other researchers who wish to transfer the result to a different context to take the responsibility of making the judgement of how sensible the transfer is.

3.10.3 Conformability

Polit and Beck (2021:154) defines conformability as the degree of neutrality in the findings of the research study. This meant that the researcher ensured that the findings were based on participants' responses and not any potential bias or personal motivations of the researcher. The researcher made sure that the findings of the research study would accurately portray the participant's expressions of their experiences. The researcher manually transcribed and translated data collected during the interviews. The professional editor also checked the research study in order to conform to this principle of trustworthiness. The researcher did not report her personal opinion on the use of the direct quotes by the participants.

3.10.4 Dependability

Dependability is the degree to which the study could be carried out again by another researcher with the same results. Polit and Beck (2021:154) suggest that in order to increase dependability, an audit trail of all the documents generated during the research process must be kept in a safe place. An audit trail was maintained throughout the study for safekeeping of raw data of each participant's interview for future reference. The researcher made sure that she strived to deliver a well-written, thorough report at the conclusion of her findings. The researcher also applied dependability by ensuring that she asked the same questions to all participants without making any alterations. This was done to ensure that the findings are consistent and comparable to those of this study in the event that other researchers decide to replicate it.

3.11 ETHICAL CONSIDERATIONS

Polit and Beck (2021:131) contend that the planning and execution of research must consider ethical considerations. A code of conduct or accepted social norm for behaviour while conducting research is referred to as ethics in research. It is further stated that standards of ethical conduct are based on three general principles: beneficence, respect for human dignity, and justice.

3.11.1 Permission

Permission to use personal data or information was solicited within the moral framework of maintaining autonomy, confidentiality and anonymity, providing informed consent, telling the truth and guaranteeing non-coercion and non-exploitation of the individual's consent. The researcher ensured that appropriate permission was obtained from individual participants, relevant gatekeepers that is department of Social Development provincial and their relevant provincial administrative offices.

The proposal was presented to the Faculty Research Committee (FRC) of the Durban University of Technology (DUT), for review prior and preparation of a complete and

corrected proposal which was then submitted to IREC to obtain permission and ethical clearance that the study has met the Ethical standards of the University for obtaining ethical clearance prior to commencement with the study. This was further followed by obtaining approval from the gate keepers of the selected institution were the study was conducted.

3.11.2 Beneficence.

According to Polit and Beck (2021:139) researchers have a responsibility to minimize harm and maximize benefits. It should be the goal of human research to benefit either the subjects or other people. The participants in this study did not suffer any harm because of this study, and the researcher always adhered to the principle of confidentiality and obtained informed consent from all participants.

3.11.3 Human rights

According to Polit and Beck (2021:131 the responsibility of recognising and protecting the rights of human research objects must always be maintained. They further state that the human rights that requires protection in research include the right to:

i. Self-determination. The right to self-determination is based on the ethical principle of respect for persons. The researcher respected the opinion and rights of the participant who were caregivers selected in this study.
ii. Privacy. The freedom an individual has to determine the time, extent, and general circumstances under which information will be shared with or withheld from others. The researcher was at all times sensitive and respectful to the participants' rights to privacy, which included among others the right to refuse or agree to take part in the study. It was therefore imperative to guard against any ethical dilemma by adhering to this principle.
iii. Fair treatment. Every individual has the right to fair treatment and this is based on the ethical principles of justice. The selection of participants and their treatment

during the study was fair and the participants were treated equally with no favours or any prejudices and were protected from discomfort and harm.

3.11.4 Confidentiality

Polit and Beck (2021:781) assert that confidentiality is about safeguarding the study participants to ensure that the information they provide is never made public. The researcher took care to protect the information obtained from the participants by keeping it confidential and only using it for this research study. Participants' names and addresses will not be listed in any documents. Each participant received a code for this study, such as P002 if they are the second participant to be interviewed. The researcher was dedicated in upholding, adhering to, and preventing any violations of these principles.

3.12 CHAPTER SUMMARY

Chapter three outlined the methodology, which was followed, and which lead to data collection and data analysis and the research rigor used in this study. In depth application and adherence to research ethics was explained. The presentation of the findings and the discussions of the study findings and recommendations are elaborated on in the chapters that follow.

CHAPTER FOUR: PRESENTATION OF FINDINGS

4.1 INTRODUCTION

Chapter four presents the findings of the analysed data of this research study. Findings are presented in two main sections. The first section the demographic data and the second section the research findings obtained from interviews. The presentation of research findings was linked to the achievement of the main objective of the study:

i. To describe the experiences of caregivers living with adolescents who abuse drugs.
ii. The Family Systems Theory formed the framework and foundation for presenting and discussing the findings. The findings were further aligned with the following sub-objectives of the study.
iii. To determine the effects experienced by caregivers of adolescents who abuse drugs.
iv. To describe the coping strategies used by caregivers living with adolescents who abuse drugs.
v. To identify programmes available in the community to support the caregivers of adolescents who abuse drugs

4.2 DEMOGRAPHICS CHARACTERISTICS OF PARTICIPANTS

The demographic characteristics of the 15 caregivers who participated in this study were nine females and six males, and their ages varied between 37 and 63 years old. It should be noted that the planned number of participants was 15, although three of them enabled the researcher to reach saturation point. Most of the participants were employed, married and stayed in the townships. Most participants achieved high school education, with only one with a secondary level of education. Both confidentiality and anonymity were secured concerning participants using codes such as P01, as seen in Table 4.1.

Table 4.1: Demographics characteristics of the Participants (n=15):

Participant	Age in years	Race	Gender	Marital Status	Residential Area	Education	Employment
P01	42	Black	Male	Single	Township	Diploma	Employed
P02	55	Black	Female	Widowed	Town	Diploma	Employed
P03	44	Black	Male	Single	Township	Secondary	Unemployed
P04	40	White	Male	Married	Town	Grade 12	Unemployed
P05	45	Black	Male	Single	Township	Grade 12	Contract work
P06	55	Coloured	Female	Married	Township	Grade 12	Employed
P07	47	White	Male	Divorced	Township	Grade 12	Employed
P08	63	Black	Female	Widowed	Township	Secondary	Employed
P09	48	Black	Female	Married	Township	Grade 12	Employed
P10	48	Black	Female	Married	Township	Grade 12	Contract
P11	56	Coloured	Female	Married	Township	Grade 12	Employed
P12	53	Coloured	Male	Divorced	Informal Settlement	Secondary	Self-employed
P13	38	Black	Female	Single	Township	Grade 12	Contract work
P14	37	Coloured	Female	Married	Town	Diploma	Contract work
P15	63	Coloured	Female	Widowed	Town	Secondary	Pensioner

4.3 PRESENTATION OF FINDINGS

This section presents the overview of themes and sub-themes that emerged from the data analysis related to caregivers' experiences living with an adolescent who abuses drugs. The following four broad themes were formed from the codes and categories that emerged from the data obtained from the in-depth interviews and were considered when the data was analysed, as shown in Table 4.2:

i. Theme 4.1: Environmental effects experienced by caregivers
ii. Theme 4.2: Biopsychosocial effects experienced by caregivers
iii. Theme 4.3: Effect of coping strategies
iv. Theme 4.4: A need for support services.

Table 4.2: Identified themes, sub-themes and categories

Theme	Sub-theme	Category
4.1 Environmental effects experienced by caregivers	4.1.1 Altered behaviour experienced by the caregivers	4.1.1.1 Neglected Personal Hygiene 4.1.1.2 Loss of interest in entertainment 4.1.1.3 Stealing from family and the community 4.1.1.4 Financial Burden 4.1.1.5 Poor performance at school and dropping out of school 4.1.1.6 Violence and disruptive behaviour
	4.1.2 Effects on other siblings	4.1.2.1 Bullying of siblings 4.1.2.2 Psychosocial abuse of siblings
4.2 Biopsychosocial effects experienced by caregivers	4.2.1 Psychological effects	4.2.1.1 Shame 4.2.1.2 Embarrassment and guilt 4.2.1.3 Psychological pain 4.2.1.4 Depression
	4.2.2 Social effects	4.2.2.1 Family disruptions and conflicts 4.2.2.2 Social exclusion 4.2.2.3 Stigma
	4.2.3 Biological effects	4.2.3.1 Physical Illnesses
	4.2.4 Emotional effects	4.2.4.1 Hopelessness & despair 4.2.4.2 Fear
4.3 Effects of coping strategies	4.3.1 Altered mental health	4.3.1.1 Wish for the recovery 4.3.1.2 Becoming more spiritual: Seeking God 4.3.1.3 Self-isolation 4.3.1.4 Seeking answers
	4.3.2 Altered lifestyle	4.3.2.1 Excessive alcohol and smoking 4.3.2.2 New hobbies
4.4 A need for support services	4.4.1 A need for support services	4.4.1.1 Seeking answers 4.4.1.2 Information about drug abuse 4.4.1.3 Inadequate services 4.4.1.4 Alternative Support services
	4.4.2 Availability of support services for caregivers	4.4.2.1 Human and financial resources 4.4.2.2 Infrastructural resources
	4.4.3 Access to caregiver support services	4.4.3.1 Finance /Funding

4.3.1 Theme: Environmental effects experienced by caregivers

From the environmental effects experienced by caregivers, two sub-themes emerged: altered behaviour experienced by the caregivers and effects on other siblings. These were derived from participant narratives and quotations. The theme explains the caregiver's experiences of the patterns of behavioural changes in those adolescents who abused drugs. The participants explained how the behaviour of the adolescents who abused drugs affected their living environment in different ways. The sub-theme: altered behaviour and activities emerged and this was further explained in different headings as presented below. The sub-themes and categories in Theme 4.1 are presented in Table 4.3 below.

Table 4.3: Theme 1 - Environmental effects experienced by caregivers

Theme	Sub-theme	Category
4.1 Environmental effects experienced by caregivers	4.1.1 Altered behaviour experienced by the caregivers	4.1.1.1 Neglected Personal Hygiene 4.1.1.2 Loss of interest in entertainment 4.1.1.3 Stealing from family and the community 4.1.1.4 Financial Burden 4.1.1.5 Poor performance at school 4.1.1.6 Violent and disruptive behaviour
	4.1.2 Effects on other siblings	4.1.2.1 Bullying of siblings 4.1.2.2 Psychosocial abuse of siblings

4.3.1.1 Sub-theme: Altered behaviour experienced by the caregivers

Most of the participants indicated that neglected personal hygiene, loss of interest in entertainment, stealing from family and the community, financial burden, poor performance at school, and violent and disruptive behaviour were the common altered behaviour they experienced as caregivers.

4.3.1.1.1 Category: Neglected Personal Hygiene

Most participants explained that they initially noticed changes in the habits of their adolescents, such as poor personal hygiene, losing interest in doing school work, poor

performance at school, violence and theft. This was the beginning of discovering that something was wrong with their adolescents. However, they thought their child was either sick or they were going through adolescent crises. They described the appearances of their adolescents as terrible. Other caregivers described this altered behaviour as finding out that their adolescent had started neglecting their personal hygiene, did not change clothing, and were wearing dirty torn clothes and were always seen among friends who looked the same as them. One of the participants said his son was seen roaming around with street kids and eating from dustbins during the day. They further explained that these friends of their adolescents were known to be sniffing glue, and it was then that they realised that their adolescents were using the substance. Some participants reported that the neglect in their adolescent's personal hygiene was a frustrating situation and that these adolescents became very aggressive when told to go and have a bath. They further said their adolescents would even threaten to kill them if they ever asked them to have a bath. Nevertheless, other participants said that they relied on calling some neighbours to come and assist in putting them in a bathtub, whilst others said they sometimes threatened that they were going to call the police. Most participants reported that they felt embarrassed by their adolescent's terrible personal hygiene and that the community looked down upon them as failed parents. They also reported that these children were forever chased away from the streets and yards in the neighbourhood because they are regarded as trouble makers.

"He looked terrible, walking like a zombie "(P07).

"He looks like a hobo" (P12).

"My child hated cleanliness he hated to bath always had excuses and he will swear at us just for asking him to take a bath" (P13).

"My child does not want to have a bath he looks like a hobo he is unable to take care of himself/herself. I do not know what to do anymore" (P02)

"I sometimes call neighbours to come and help me to put him in a bath" (P05)

4.3.1.1.2 Category: Loss of interest in entertainment

Most participants reported that the affected adolescent would often talk less, and make themselves busy by doing household chores, walking around the house and sometimes

cooking. Interestingly, some caregivers reported this behaviour as a contrast and their children did not want to get involved in the household activities and chaos and that they were rebellious and stubborn. They further revealed that their adolescents lost interest in entertainment, which started by not watching TV with the rest of the family and not joining the family when they sat together, something that was common practice prior to that adolescent's involvement with drugs. He lost interest in sports, playing cards and games with their peers and their siblings. Overall most of the participants said that they started noticing that the adolescent who was abusing drugs was forever isolating himself from other family members.

Many caregivers reported that the adolescent's relationship with peers had changed and that those who played an important role in their lives before they used drugs began to disappear, and new influencers, for example those peers who were already abusing drugs, started to appear. The caregivers explained that the actions by their children was that of idolising the peers who were also abusing drugs. They further said that their children lost interest in doing the right things and their morals were very undesirable.

Caregivers noticed that their adolescents often engaged in bizarre habits, such as doing things they did not do before. For instance, they voluntarily cleaned the house, especially their bedroom, prayed and read the Bible, reported transgressions of other siblings and talked about the violations of other friends.

Most caregivers reported that they noticed behavioural changes related to how they spoke to their parents, which was described as being rude, manifesting in mood swings and isolating themselves. Some adolescents were reported to be exhibiting a form of withdrawal symptoms such as sudden quietness and loss of interest in many of the activities they used to do, such as watching TV, playing soccer or talking to other siblings. Some participants expressed this change of behaviour and experience as worrisome, keeping them waiting and wondering what will happen next.

> *"My child is so uncontrollable he has, lost interest in watching TV or being around family. became stubborn and started to behave strangely. He dresses in weird many and even changed the way he walks. Started to talk alone" (P02)*

> *"This antisocial behaviour was a wakeup call to me. I started making enquiries from other family members." (P05).*

> *"He lost interest in everything I say everything "(P06)*

"I started to see a new person, talking less and isolating himself and playing a good boy" (P05)

"He used to love soccer and I saw an opportunity of him to be a star all is now gone due to drugs" (P13).

4.3.1.1.3 Category: Stealing from family and the community

Several participants indicated that the change in their adolescent's behaviour was a problem towards their psychosocial well-being as caregivers. According to these participants, criminal activities such as breaking into houses and stealing household items were a major cause of socioeconomic changes for their households. Caregivers reported that the adolescents started stealing from their homes first, before they stole from their neighbours and the community around them. They further said that the adolescents were arrested due to the thefts they committed, and the victims of these crimes opened criminal cases against their children. Some participants feared that their children could be killed by community members when they stole from them. The caregivers also explained their experiences with having to find money to pay bail for those adolescents who were arrested, and some said they are losing money because they have to, from time to time, pay for and replace the stolen goods of the community members who reported the crime to them. They expressed their frustrations about this behaviour as being helpless. This stealing behaviour by the adolescents abusing drugs resulted in a heavy financial burden for the caregivers.

Most participants reported that the stealing behaviour of their children is mainly done to buy more drugs for their addiction. They said these adolescents do not worry about their parents and other siblings' wellbeing. Few participants said that the adolescents only steal from those who are taking care of them. This, they said, is worrisome and has created a big fear because they do not what they are thinking.

Participants also reported that their children have aggressive episodes. They described these as erratic, violent and scaring. They further said that they do not feel safe when they are left alone with these adolescents. Other participants described this situation as a life-threatening situation because they never know what fuelled the type of behaviour

these adolescents present with at any given time, they said that that they no longer felt safe and protected in their own houses.

> *"He is always involved in house breaking and was arrested and release to the care of the parents because he was under age" (P11).*

> *"He is stealing from us and the community. Money started to disappear at first it was small amount and he eventually broke his uncle's door to steal his clothes and a R2000 we are now hiding valuables and always keeping door under lock and key because we do not trust him" (P13).*

> *"What worries me a lot is that he only steals my belongings such as jewellery, tekkies and other accessories and does not steal from other family members who stay with us in the house "(P07).*

> *"I am the only one he screams at and even told me that he will spit on my grave if I die" (P06)*

> *"This scares me a lot. I am always thinking of what he will do to me if this aggressive behaviour spikes" (P05)*

4.3.1.1.4 Category: Financial Burden

This sub-heading was described as the caregiver's experiences of losing money and income as a result of their adolescent's drug abuse problem. The caregivers reported that they encountered serious financial setbacks as a result of their adolescent's behaviour. Apparent in the experiences of the caregivers was financial burden associated with their children's behaviour. Some of the participants explained that their children's stealing had affected their financial situation so much that they ended up borrowing money from people to feed themselves. This created huge debts for themselves because they had from time to time have to pay back people for the stolen goods or replace items the child stole from the home, neighbours and the community.

Additionally, participants reported that they needed to pay money to bail out these adolescents from custody following their arrest for crimes they have committed because they feared what could happen to them in the police cells. Some participants said that they paid and waisted a lot of money on private rehabilitation centres and their children

are just not recovering. Others however reported that they wished to take their children to those rehabilitation institutions but they cannot afford to. Other participants explained the financial burden they were experiencing as result of the drug abuse by their children as being hard and tough and that they were unable to make ends meet; that money was borrowed from friends and relative and working siblings from time to time.

This constituted another dimension of changed roles and of altered responsibilities for caregivers and other working families who offered to support them financially. This situation was described as a huge financial burden, stressful and painful by most of the caregivers who participated in this study.

Many of the participants described the financial burden as the most stressing situation. Others also reported this situation as trying times where they are living with fear of not knowing what the adolescent will do next and most importantly the family conflicts which arose due to this situation. Few of the participants described how they will from time to time, just give the adolescent money to go and buy their "fix", not that they wanted to, but just to get rid of the adolescent so that the caregiver can have some peace. They further reported that they perceive this as an enabling action from their side and felt guilty at times but they have reached the point of not knowing what to do anymore.

> *"The private rehabilitation centre costed us R15 000.00 per month now we are penniless because of his behaviour "(P09)*
>
> *"I now owe "machinisa "a lot of money" (P02)*
>
> *"It is also financially tough; our dreams are shattered" (P04)*
>
> *"The money we have paid was a waste, he is back on drugs" (P11)*
>
> *"My child is always involved in house breaking and was arrested and released to the care of the parents because he was under age, my family is experiencing a huge financial loss" (P08).*
>
> *"He is costing us a lot of money. He is just a burden to the family. He steals, commit crimes and we have to pay" (P13)*
>
> *'I give him the money to go and buy the "fix" just to get rid of him, this child is a nuisance" (P07)*

4.3.1.1.5 Category: Poor performance at school and dropping out of school

This behavioural change was explained by most caregivers as a drop in school performance and the grade previously obtained by the adolescents who abuse drugs. Some caregivers identified a drop in the adolescent's school marks as one of the effects of drug abuse by adolescents. The following caregiver’s comments drawn from the transcripts explained the negative experiences of the participants. Most of the participants were worried about their adolescents’s future when they described that those children dropped from school. The shared experiences were that they started receiving warnings of absenteeism of their children from school which was followed by poor grades and eventually the child dropped o€ut from school. Participants expressed their wish to see their children having a brighter future; completing and graduating from universities just like other children in their neighbourhood. Most parents reported that they stopped seeing the child that they had known before they indulged in drug abuse. At the same time, as things got worse, confrontation, yelling and screaming became part of family life. When asked how her daughter had been treating her, one mother:

> *“There was a sudden change in her interest in school work and was always complaining that the school work is too much for her” (P14)*
>
> *“The results of his first term assessments were very poor. Little did we know that she was not going to classes and was reportedly seen rooming the streets during school hours. She ended up disappearing from home and coming late at home just to sleep “(P007)*
>
> *"My son’s behaviour changed drastically at school he was forever reported to be violent and stubborn and not doing his homework and never took responsibility for his wrong doing. It was a painful situation to see his peers progressing and attending school” (P13).*
>
> *“He completely lost interest in school. I started calling for help and was he sent for counselling by the social worker and that is how we found out that he was on drugs.” (P 14).*
>
> *"He has dropped out of school; he was in grade seven it’s been two years now and I have been trying to encourage him to go back to school because I also*

believe that he needs to be responsible and be able to assist me in caring for his younger siblings" (P12).

"All I wish for is to see my children succeeding in life like other children. I am a good parent and have done my best to give them what they need" (P08)

4.3.1.1.6 Category: Violence and disruptive behaviour

Violence by adolescents who abuse drugs was described in various ways. Some participants described it as erratic behaviour, others as bullying everyone in the house but not harming them, whilst some portrayed it as temper tantrums, throwing things all over the house, breaking and destroying household furniture. Nevertheless, most caregivers described their adolescents as embroiled in fighting at home and at school. One parent explained that she was forever calling the police, who most of the time did not turn up or sometimes came the next day. Some caregivers admitted not calling law enforcement but rather gave them what they wanted such as money to go and buy the "fix". This way they felt relief because the teenager would stop and go and buy the drugs. It was just a way of looking for peace and relief.

Caregivers reported that they suffered both physical, psychological and emotional abuse due to drug abuse by their adolescents. Some revealed that they sometimes felt that they were becoming enablers because they are giving their adolescent money to go and buy the drugs. Not that they had a choice but because they wanted peace and to be left alone by those adolescents. They reported that those adolescents would cause a fight and make noise and make everybody uncomfortable in the house, even threatening to kill them, just to be given money to go and buy a "fix".

Some participants also highlighted that they gave their adplescents money to buy drugs just to be spared the embarrassment they caused when they wanted money, even if they had to go and borrow money from other people. Most participants reported that the humiliating and manipulative behaviour of their adolescents had made them become enablers. This behaviour resulted in fights and disruption in the family and in the community.

"I will just give him money to get rid of him" (P09)

"I wanted peace that is why I gave him money" (P15)

"When he has the withdrawal symptoms he makes a "scene", he acts and cause unnecessary disruptions in the house especially when he sees that we have visitors, I cannot take it anymore" (P02).

"He acts and cause unnecessary disruptions in the house especially when he sees that we have visitors, I cannot take it anymore" (P03).

"I am not working but I will go as far as borrowing money to give to him, I was actually bribe him to leave the house" (P13).

"My son physically attacked me in the presence of my colleagues at my place of work, that was my worst experience and led me to wishing that he should have died whilst he was a baby "(P05).

'I give him the money to go and buy the "fix" just to get rid of him, this child is a nuisance" (P07).

4.3.1.2 Sub-theme: Effects on other siblings

This sub-theme explained the effects of the behavioural changes of the adolescent who abuse drugs on other siblings in the household as experienced by the participants. It had one category which was the bullying of siblings and psychosocial abuse of siblings.

4.3.1.2.1 Category: Bullying of siblings

Most participant said that their children who dropped out of school became a thorn in the family especially to the other siblings who were still attending school. They said that the drug abusing adolescents were for ever complaining that the other siblings were treated better than them, that they were given the attention and everything they wanted. They said they complained that these adolescents who are not abusing drugs were given special treatment and were more loved by the family than they were. This resulted in the drug abuser bullying the other siblings and in worst case scenario threatening to kill the

non-abusing sibling and always fighting with because they believed that the non-abusing adolescents were always getting what they wanted.

The bullying manifested in different ways for example the abuser started to steal the other sibling's clothes and anything that belonged to them and then sold the stolen items to buy drugs. Most participants revealed that the drug abuser would always be angry and threw temper tantrums in the house just to provoke the other siblings and sometimes would not even speak to them. Some participants felt that the drug abuser hated them and that this bullying of other siblings was a way of retaliating because they felt that they were not loved.

> *"He is now bullying his younger sister and claims she is the most favoured and getting everything she wants. He is lying and very manipulative" (P14).*
>
> *"He hates me and throw object to her little sister when I speak" (P02).*
>
> *"It is a matter of time that I will die due to this accident "(P05).*

4.3.1.2.2 Category: Psychosocial abuse of siblings

The adolescents drug abuse problem manifested in different social effect on caregivers. This sub-theme was described in a different dimension by caregivers. Participants described their experiences as one that ended up affecting other siblings in the household. They said that there were times where they felt that they were completely neglecting their other non-drug abusing children.

Caregivers often spoke about the effects of drug abuse on other siblings. These could be direct effects; such as being stolen from or assaulted by the drug abuser. Indirect effects included the other children's needs being neglected because the caregivers shifted their focus more and more to the youth with the problem, leaving other siblings to fend for themselves. In many instances, the sibling being drawn into the personal pattern of living of the sibling who abuses drugs. This was described as non-user sibling being afraid of what the user could do to them if they found out that they had divulged information about their habits to the parents. One participant who is a father described that his daughter was keeping many secrets about drug abuse problem by her brother.

Other participants said that, once in a while his daughter, a non-user, would accidentally let a secret out, then she would be terrified that he will be angry and could give the drug abusing brother a whipping or punishment that could be more traumatic to the brother. The sister was also scared that the revelation could jeopardise her relationship with the user.

Siblings are conflicted between not knowing whether to report the problem to the caregivers or hold the secret to themselves. The father pointed out that his teens had been afraid and scared of what he would do to them should the secret come out. At this stage they only wanted to protect their brother not realising that they were making things worse through keeping it to themselves.

> *"He is terrorising my other kids" (P09)*
>
> *"Volatility, screaming and yelling became the norm of the relationships between all but a few parents and their youth" (P04)*
>
> *"Our oldest daughter would kind of disassociate herself by doing a lot of activities and having a lot of friendships and pouring herself into the things that she was doing" (P13)*
>
> *"My elder son who is working does not speak to him anymore (the abuser). He is irritated by his behaviour and he is spending most of his with friends and only comes home to sleep we seldom see him or talk to him; this also pains me" (P14)*

4.3.2 Theme: Biopsychosocial effects experienced by caregiver

In this theme, four sub-themes emerged, namely psychological effects, social effects, biological effects, and emotional effects. This theme was described as characteristics or facets that influenced the biopsychosocial wellbeing of caregivers who were interviewed. Such factors described the caregiver's experiences in relation to their social environment and how these affected them. The identified sub-themes and categories are presented in Table 4.4 below.

Table 4.4: Theme 4.2: Biopsychosocial effects experienced by caregiver

Theme	Sub-theme	Category
4.2 Biopsychosocial effects experienced by caregivers	4.2.1 Psychological effects	4.2.1.1 Shame 4.2.1.2 Embarrassment and guilt 4.2.1.3 Psychological pain 4.2.1.4 Depression
	4.2.2 Social effects	4.2.2.1 Family disruptions and conflicts 4.2.2.2 Social exclusion 4.2.2.3 Stigma 4.2.2.4 Ridicule & Shame
	4.2.3 Biological effects	4.2.3.1 Physical Illnesses
	4.2.4 Emotional effects	4.2.4.1 Hopelessness & despair 4.2.4.2 Fear

4.3.2.1 Sub-theme: Psychological effects

This sub-theme was explained under several headings to reflect the meaning of the narratives of the participants; shame, embarrassment and guilt, psychological pain, and depression.

4.3.2.1.1 Category: Shame

The psychological effects experienced by the participants were described under different dimensions, for example shame in one dimension was caused by the behaviour of the adolescents who abused drugs whilst in the other dimension it was described as shame as experienced by the participants due to their feelings of failed parenting.

Most of the participants described shame as a very painful experience; believing that they might have sinned and therefore were unworthy of caring or providing for their children. They portrayed a sense of feeling inadequate and ambivalence despite all the efforts they put into caring for their children. They felt that they might not be giving enough love to their adolescents. They felt guilty for what was happening to their adolescents especially the unacceptable behaviour and the person these children had become. On the other hand, participants felt ashamed because they considered that they were doing more than what was expected in caring for their adolescents hence they were being judged and ridiculed for their parental skills. Some even described that they were incapable of

practising tough love and thought that by giving them protection was in a way of making the adolescent feel better. Others revealed that it was out of shame that they delayed seeking for help. Some participants blamed themselves for the conditions of their adolescents. They revealed that they have given their children a good life, gave them what they wanted, enrolled them in good schools but ultimately have to deal with a devastating problem they never imagined will happen to them.

Some participants said they delayed seeking for help even if they noticed that their children were abusing drugs. They said it was because of shame that they kept those situations for themselves. Some even said they were hoping that the problem would disappear in time. They also said they were actually afraid of being judged and named as a failed parent by family and the community. Caregivers often spoke of how they recognised that their adolescents might be abusing drugs but pretended that there was nothing wrong with them because they were ashamed and in denial

> *"I could not believe that my child was abusing drugs, something is wrong with him" (P03)*
>
> *"I did everything possible that a parent can do. I gave him everything and this is what he is doing to us. He must just go away" (P04)*
>
> *"I delayed crying for help and wasted time because of the shame, embarrassment and stigma associated with this problem. The thought of being judged as a failed parent led to the problem getting out of hand "(P11)*
>
> *"I could not believe that my child was abusing drugs, something is wrong with him" (P03)*

4.3.2.1.2 Category: Embarrassment and Guilt

Most of the caregivers reported that it took them time to admit that their adolescents were indeed hooked on drugs. Some highlighted that they did not acknowledge the change in behaviour even if the signs were there, such as sudden stubbornness, laziness and refusing to do household chores. They reported that they thought that this was just an adolescent stage. Others admitted that they ignored rumours from community members about their children's involvement with drugs.

Another dimension was that most of the participants reported that they delayed seeking professional help because of denial, embarrassment and shame they suffered because of their children's behaviour. Some kept this concealed and even instructing other family members not to talk about family secrets. Most of the participants felt that they should have acted earlier but because they were ashamed of their children's behaviour they delayed seeking help.

Some participants revealed that they were themselves recovered addicts and that is how they ended up working at the rehabilitation centres. They further said that they felt guilty that the environment their adolescents were exposed to, could have created a monster they now had to face and deal with on daily basis. They were hands on in supporting these children because they knew and understood what drugs could do to a person. They also reflected on elements of guilt and shame they had to go through after finding out about the habit of their adolescents. Though remorseful they find it difficult to reverse the situation and they described it as a long painful journey but they were determined to go through it with their adolescents.

Other explanations offered caregivers with a sense of hope, believing that, if this other issue could be addressed, then the drug use would diminish or disappear. One of the participants described his personal experience as a drug addict himself as the most devastating time of his life. He described his loss of his house, his wife through the divorce and his life in a rehabilitation institution. He even said that by the time he realised that he has destroyed his life it was already late and he feels guilty that his son is going through the same route but he is determined to protect him and support him.

> *"The thought of being judged as a failed is embarrassing "(P06)*
>
> *"I delayed crying for help and wasted time because of the shame, embarrassment and stigma associated with this problem" (P05)*
>
> *"I sometimes think I should have acted earlier and saved my son from this monster. I am angry towards them and to myself" (P11)*
>
> *"I did everything possible that a parent can do. I gave him everything and this is what he is doing to us. He must just go away" (P04)*

"I thought I was the best mother providing for my kids but now I am a failure. It is better that I could die and this child could see what he has lost, maybe he will come around" (P12)

"I have seen it all, I nearly destroyed my life, and I almost lost everything I worked hard for and I cannot allow it to happen to my child" (P09)

"It was painful to see him destroying his life he was doing. I cried I knew I had to do something but I could not. (P010)

4.3.2.1.3 Category: Psychological Pain

The pain which the participants experienced was described in different ways. They explain the pain as not physical but feeling it and that sometimes they had to ask themselves if they were still alive. The pain was also described as causing irritability. Panic attacks, inner pain and nervousness are heightened due to the caregivers' inability to seek help or talk to others about their problems. Some of participants said that there are times where they felt hopeless, helpless and powerless. However, some caregivers expressed the thought of the existence of their other children who also still need care as one that gave them hope and support to live.

Fear of being on the receiving end of any bad news related to the sons' abuse and the safety of other children were found in the participants' narratives. The anticipation of adverse information due to their sons' misbehaviour has been a traumatising experience for some caregivers. One participant reported that she has started to be nervous and forgetful. She is experiencing blackouts and this has led to her being involved in two car accidents and she is now afraid to drive alone

Other participants reported that their adolescents blamed them for their reliance on drugs. This made the caregivers feel guilty and others described this behaviour as manipulative and an attempt by their children to give them what they wanted or as just being spiteful to them and deliberate inflicting pain on the caregiver. The caregivers also reported being constantly blackmailed, manipulated and blamed by the adolescent.

This resulted in self-blame by the caregivers. They attributed this to the fact that they might have given their children too much of what they required. The use of words such

as “spoiled him” and “I am to be blamed” expresses the extent to which self-blame and guilt for their adolescents’ behaviour was communicated. What was clear from the participants’ narratives was that, not only did they question their parenting skills but that they also wished they had done something different, and perhaps that they had set a better model for the younger children in the family.

“I must be strong for my other children; they need me “(P08)

“it’s because you are always screaming, shouting at me and you hate me that is why I am using drugs” (P06)

“I can’t take it anymore” (P07)

“What worries me a lot is that he only steals my belongings such as jewellery, “tekkies “and other accessories and does not steal from others in the house? I am the only one he screams at and even told me that he will spit on my grave if I die. This scares me a lot. I am always thinking of what he will do to me if this aggressive behaviour spikes” (P07)

“It is painful and I am stressed” (P01, P05 & P06)

“I think he will recover because I have noticed that he is now putting me in his profile picture and kept on saying I love your mom” (P12)

They judge me and criticise my parenting skills and make me feel guilty of failing my child” (P01)

4.3.2.1.4 Category: Depression

Most participants reported that they felt trapped in a role of caregiving but also being vulnerable to criticism and feelings of inadequacy as caregivers. They expressed that the denial they had was because of shame and guilt they were experiencing. They did not believe that their children were involved in drug abuse. Most of them said that they did not see it coming and it came as a shock and they were in denial and disbelief that their adolescebts were abusing drugs especially at such a very young age. All these deep emotional feeling eventually led to depression and made them delay seeking help. One participant even said she was hoping for a miracle.

Some of participants revealed that they are experiencing high altered mental wellbeing. They explained their experience of depression as being distinctly depressed or irritable moods, loss of interest or pleasure in things previously enjoyed, feeling worthless or guilty, poor concentration or indecisiveness, decreased or increased weight or appetite decrease, increased sleep fatigue and loss of energy and, thoughts of death, or suicide plans or attempts. Most of the participants reported that the combination of all these feelings resulted in them being involved in various car accidents. One mother said that the spell of dizziness, loss of concentration made her drive in an opposite direction of the road and she drove into three cars.

Other participants believed that strong emotional support helps in a quick recovery and that it can be managed through regular exercise, yoga, and meditation. They further indicated that they are receiving great support from some of their families while others got support from their colleagues at work.

> *"It is a matter of time that I will die due to this accidents "(P005)*
>
> *"I was with my little daughter and I nearly killed her" (P13)*
>
> *"It is painful and depressed" (P05)*
>
> *"I sometimes feel like committing suicide so that he must be happy that I am not here anymore. I feel like I am punished for the sins I did not commit oh my God I lost hope" (P14)*
>
> *"It was painful to see him destroying his life he was doing. I cried I knew I had to do something but I could not" (P10)*

4.3.2.2 Sub-theme: Social effects

This sub-theme explained the social effects of drug abuse by adolescents as experienced by the caregivers. This sub-theme emerged from the theme; psychosocial effects and it was discussed under the following categories: family disruptions and conflicts, social exclusion, stigma, and ridicule and shame.

4.3.2.2.1 Category: Family disruptions and conflicts

Another effect this problem had on caregivers was the breakdown of family relationships. This disruption of family relationships affected all key members of the nuclear family (i.e. mother, father and/ or stepfathers and other siblings). For certain people involved, these strained family connections were the result of a lack of understanding of the consequences of substance abuse to the person. For some participants, maybe the way their husbands worked to make sure that the family had a good relationship was the beginning of the problems in their marriages. One female participant reported that she is the disciplinarian in the house whilst the husband thought that she was overdoing it and that it was aggravating the problem their son was having. She further revealed that the misunderstanding and the conflict between the two of them nearly resulted in divorce.

One participant described how her husband made her feel uncomfortable and guilty by forever blaming her for the adolescent's behaviour. She even said that there was a time when she wanted to divorce her husband but because she could not because she is a Christian and her church does not allow its members to divorce

The other participant reported that the relationship they have with their husband was becoming toxic. Their husbands are even telling them that they must stop supporting the trouble adolescent and concentrate on the non-abusing children and their marriage. One participant said her husband told her to choose between their marriage and her brother and this has caused her more stress and pain.

Some caregivers also indicated that their personal and social relationships with friends and family have been estranged leading to the loss of close friends who used to support them. The severity of these strained relationships left some caregivers feeling frustrated and ashamed resulting in self-isolation. Some felt that they have been deserted by their families and close friend who did not want to be associated with them. Other participants reported that this also resulted being in conflicts with family and some community members. Few of the participants reported that they have suffered ridicule, discrimination and blame from their families and communities.

> *"My husband was forever blaming me for the child's behaviour, I wanted to divorce my husband but because I am a Christian and my church does not allow that I could not. The thought of divorcing my husband did not materialised" (P06).*

"The thought of divorcing my husband did not materialised" (P06).

"My marriage is now rocky, my husband pushed me to bad habits He wants me to choose between my brother and him he will say your hobo brother and starts to scream at me" (P15).

"I was ridiculed by both my family and my community and I became a laughing stock and labelled as a failed parent" (P14).

"His behaviour became uncontrollable, always screaming and back chatting to us swearing and always embroiled in fights with siblings and peers in the street" (P05).

"I felt ganged from my daughters" (P11).

4.3.2.2.2 Category: Social Exclusion

This sub-theme was explained by participants as effects of all the ridicule, stigma, and judgment by the community they experienced due to their adolescent's drug abuse behaviour. They often felt that they were discriminated against by the community and other family members and this resulted in them removing themselves from social activities and gatherings. The majority of participants described how they sometimes isolated themselves from social engagements and community events because of their children's persistent unacceptable behaviour. Some caregivers also indicated that their personal and social relationships with friends and family have become estranged leading to the loss of close friends who used to support them. The severity of these strained relationships left some caregivers feeling frustrated and ashamed. Some felt that they have been deserted by their families and close friends who no longer wanted to be associated with them. Other participants reported that this also resulted being in conflicts with family and some community members.

"I was ridiculed by both my family and my community and I became a laughing stock and labelled as a failed parent" (P14).

"I have dissociated myself from social gatherings. I only go to work and church and I seldom go to funerals. I am ashamed of the ridiculed and judged as a failed parent get from some of my community members" (P09).

"I feel good when I am out of crowds" (P02).

"I am tired of being judged" (P13).

4.3.2.2.3 Category: Stigma

The psychological effects of this problem were described by most participants as unbearable and made them feel and see themselves as failed parents. However, others felt that disowning their children was the only solution to the problem. The experience of being judged by their families and communities was described as a painful situation which made them feel worthless and shameful. Some participants described it as a devastating situation which makes one afraid of facing the world.

The majority of participants reported that their adolescents' drug abuse had exacerbated their relationship and problems within the family, as the mothers found themselves constantly in conflict with their husbands. Other family members and siblings primarily argued about their adolescent's drug abuse.

For some participants, their adolescents' aggressive behaviour was found to be unacceptable, leading to unpleasant altercations and strained relationships within the family, which has effects on other children in the family. Some participants reported that they have developed erratic behaviour which manifests as being irritable, oversensitive scolding, screaming, forgetfulness and not paying attention to other family member's needs.

"My family is now referenced of a failed family, ill-disciplined with no order. We are being judged as a failed family by our community I can't even try to talk to other children in our street who has this behaviour because they will always make reference to what my brother is doing. We are living with this stigma "(P01).

"I have dissociated myself from social gatherings. I only go to work and church and I seldom go to funerals. I am ashamed of the ridiculed and judged as a failed parent get from some of my community members" (P04).

"It has caused troubles in our family "(P05).

"My biggest problem is thinking about what could happen to him whilst I am at work. You see, I cannot stop working. Work keeps me sane and receiving lots of support from my colleagues "(P06).

"They judge me and criticize my parenting skills and make me feel guilty of failing my child" (P01).

4.3.2.2.4 Category: Ridicule & shame

The psychological effects experienced by the participants were described under different dimensions, for example shame in one dimension was caused by the behaviour of the adolescents who abused drugs whilst in the other dimension it was described as shame as experienced by the participants due to their feelings of failed parenting. Most of the participants described shame as a very painful experience of believing that they might have sinned and therefore unworthy of caring or providing for their adolescents. They portrayed a sense of feeling inadequate and ambivalent despite all the efforts they were putting into caring for their adolescents. They felt that they might not be giving enough love to their children. They felt guilty for what was happening to their children especially the unacceptable behaviour and the person these children had become. On the other hand, participants were feeling ashamed because they felt that they did more than what was expected in caring for their children, hence they were being judged and ridiculed for their parental skills. Some even described that they were incapable of practising tough love and thought that by giving them all the protection was in a way of making the child feel better. Others revealed that it was out of shame that they delayed seeking for help. Some participants blamed themselves for the conditions of their adolescents. They revealed that they have given their adoleswcents a good life, gave them what they wanted, enrolled them in good schools but at the end they have to deal with the devastating problem they have ever imagined will happen to them

"I did everything possible that a parent can do. I gave him everything and this is what he is doing to us. He must just go away" (P04).

"I delayed crying for help and wasted time because of the shame, embarrassment and stigma associated with this problem. The thought of being judged as a failed parent led to the problem getting out of hand "(P11).

"I could not believe that my child was abusing drugs, something is wrong with him" (P03).

4.3.2.3 Sub-theme: Biological effects

This sub-theme explained the physical effects experienced by the caregivers which manifested in different health ailments.

4.3.2.3.1 Category: Physical Illness

Several participants reported that they have developed chronic illnesses such as diabetes, hypertension and arthritis because of the mentally straining situation they are experiencing. Some participants said that they are experiencing constant fatigue, blackouts, irritability and sometimes disorientation due to this problem. One participant reported that she never had hypertension and diabetes before but has developed these conditions as a direct effect of this problem whereas other participants reported that their diabetes and hypertension is uncontrollable due to this problem.

The physical effects experienced by most participants was explained through different manifestations. Some participants said that they feel sick but could not explain what was wrong with their bodies. They said that the exhaustion they were experiencing due to the stress of taking care of the adolescent who abuses drugs makes them very sick

"Oh I am very sick; my diabetes and high blood pressure is uncontrollable end I take my treatment regularly. I have now developed arthritis and I feel continuously tired" (P03).

"I sometimes feel a heavy mass in my stomach but the doctors' day there is nothing wrong with me" (P07).

"I do not have energy for anything" (P05).

4.3.2.4 Sub-theme: Emotional effects

This subtheme explained the emotional effects experienced and endured by the caregivers who live with adolescents who abused drugs The subtheme was further explained in the following categories: hopelessness and despair and fear.

4.3.2.4.1 Category: hopelessness & despair

Deep emotional feelings were described by most participants as a heavy mental burden and that they have reached a point of not knowing what to do anymore. They experienced conflicting feelings of whether to continue supporting and taking care of the child or fleeing their home or disowning the problem child. In the other dimension some participants experienced a sense of guilt and they blamed themselves for the problem their children were having.

This dimension of fear has made one participant to be in conflict with herself because she cannot take a decision to leave work and be home to take care of her husband and on the other she has to face and experience the possibility of spending time with her son whose condition is deteriorating.

Most of the participants reflected on the perception that one's own behaviour cannot control the occurrence of personal and social outcomes. They believed that there was some control over their lives that emerged from external powerful forces. They felt that losing control of the situation they were in, has become chronic and has repeated occurrence and persistent feelings of powerlessness. The feelings they experienced led them to feel afraid to express their needs, loose confidence and hope that things will become better. The feelings of helplessness were described by some of these caregivers as feelings of overburdened or continuous worry, feeling of fatigue and sleeping too much or too little.

> "*My son went to rehabilitation institution for six weeks but he is worse than he was before he left, he is just seventeen but he is becoming a "hobo" this frustrate me more because he is not listening to any one he has no remorse" (P13).*
>
> *"I can't take it anymore" (P07).*

"My biggest fear is that I don't know how my child's condition will be if, let's say I die. This is because I don't have any sister, mother, or father who can take care of my child in that condition maybe I die now, I don't think he will be in a better condition I am loosing hope" (P03).

4.3.3 Theme: Effects of coping strategies

4.3.3.1 Sub-theme: Altered mental state

Caregivers experienced an altered mental state due to all the challenges they faced whilst trying to take care of their child. Three sub-categories were formed which included: wishing for a recovery, becoming more spiritual - seeking God, and self-isolation as presented in Table 4.5

Table 4.5: Theme 4.3: Effects of coping strategies

Theme	Sub-theme	Category
4.3 Effects of coping strategies	4.3.1 Altered mental health	4.3.1.1 Wishing for a recovery 4.3.1.2 Becoming more spiritual: Seeking God 4.3.1.3 Self-isolation 4.3.1.4 Seeking answers
	4.3.2 Altered lifestyle	4.3.2.1 Excessive alcohol and smoking 4.3.2.2 New hobbies

4.3.3.1.1 Category: Wish for a recovery

Most of the participants narrated their experience of the coping strategies in a way that reflected their wish for their adolescents' recovery. They said that they had tried everything in their power to work towards the recovery of their children. This includes being there and continuously supporting their children throughout the process. Most participants said that they accompany their children to rehabilitation institutions even though they are not included in the counselling of these children. This was noted by a participant who is a caregiver to his younger brother. The involvement of these caregivers

in this process included giving them treatments as prescribed and ensuring they received all the parental support they needed. Many said they felt delighted which made them feel better. Some participants reflected that they are sometimes frustrated by the fact that this has resulted in them neglecting other children. Other participants also reported that they are being mistreated by other family members who, from time to time, said they are spoiling the children.

Several parents spoke of coping by withdrawing and seeking ways not to be at home and having to deal with the chaos. For the other parent, this meant a heavier parenting burden, which they resented. No matter how much they tried to manage, they were not coping and, the strain continued to increase.

'All I wish for is that my brother must recover "(P01).

"It gives me a sense of life and hope that he will recover" (P14).

"I think he will recover because I have noticed that he is now putting me in his profile picture and kept on saying I love your mom" (P12).

"I was a mess. I was in a terrible state of mind and I felt like a failure" (P14).

4.3.3.1.2 Category: Becoming more spiritual: Seeking God

The majority of the participants reported that prayer was the only weapon that they were using as the coping strategy as explained below., many parents reported that they find refuge in prayer. Some indicated that they have also joined different prayer groups in the community in quest for a relief and a miracle to happen. The participants also said that they are being supported by the church congregation and the pastors and that they often visit their homes for prayers.

Other participants said they were thankful to the family support in all kinds including financial support and that they were always willing to help.

"Prayer gives me hope" (P06).

"I spent most of my time in church and in prayer meetings" (P13).

"I have hope and my faith keeps me going. I am praying for a miracle "(P05).

"What can I do God knows my pain "(P06).

"There was a stage where my aunt offered to take my son to go and stay with her and my son refused" (P07).

"He said that I wanted to give him away because I have always hated him" (P10).

4.3.3.1.3 Category: Self-isolation

Most participants indicated that they just felt like spending time alone away from other people, including their family. However, others felt that the kind of self-isolation they found for themselves was only for them to spend time with their children in a way of giving them attention. They said they actually self-isolate themselves from crowds of people and the community because they do not like to be given pity comments because of their trying times. Others felt that they could not face the world and sometimes locked themselves in their bedrooms and cried alone.

Some of the participants described the experience of isolating themselves as loneliness. They described the fear of being around people who look down upon them made them go into self-isolation and this was the other dimension of describing this sub-theme. Most of them described this experience as a depressing situation where they felt worthless, hopeless and a feeling of disappearing or dying.

"I have dissociated myself from social gatherings. I only go to work and church and I seldom go to funerals. I am ashamed of the ridicule and judged as a failed parent get from some of my community members" (P09).

"I spend most of my time at home with my family and talk just about anything" (P02).

"The service we are getting is very poor. We are not taken care of" (P07) .

"There was a time when I felt lonely and suicidal" (P08).

4.3.3.1.4 Category: Seeking Answers

Other caregivers tried to cope by being more and more in control of themselves by reading books, updating their diaries, Facebook, phone messages and hunting down their children in the hope of saving them, often at significant risk to the parent. Some participants reported using open communication with all of their children, they talked about all social ills, achievements and challenges they experienced. They always encouraged their children to talk about their feelings whether negative or positive and they played games with them like snake and ladders, chess, cards and would involve the affected child who will sometimes not want to be involved. They said this strategy was an attempt to find answers to what could have led the adolescent to drug abuse.

> *"I thought I was the best mother providing for my kids but now I am a failure. It is better that I could die and this child could see what he has lost, maybe he will come around" (P07).*
>
> *"Reading books keeps me busy and I don't need to be in a crowd of people" (P14).*
>
> *"Praying and having faith keeps me live" (P07).*

4.3.3.2 Sub-theme: Altered lifestyle

Participants reported having a change in lifestyle. The findings are listed under two categories, namely; excessive alcohol drinking and smoking and new hobbies.

4.3.3.2.1 Category: Excessive alcohol drinking and smoking

Two participants explained how they resorted to destructive behaviour such as abusing alcohol to ease the pain of seeing their children destroying themselves and not showing remorse and their behaviour becoming more toxic. Caregivers saw their lives beginning to fall into a pattern of chaos. The whole of the family system was affected. Their adolescent's behaviour became a high risk to their well-being and the family connections grew steadily weaker and fell apart. As these changes occurred, which resulted in caregivers feeling that they were powerless and more out of control. They would reach out for help to other family members, to professionals, or both. Caregivers reported a

growing desperation and an increased inability to effectively cope, but they found that reaching out for help could be less than useful at times, adding to the pressures to cope.

Most parents spoke about the increased stress that made it harder to manage. Simultaneously, the majority of participants reported a weakening of the co-parenting relationship. Anger crept into relationships, which negatively affected the family functioning. One father describes that, as a result of his anger.

Several caregivers talked about finding ways to withdraw, be at home and deal with the chaos. For the other parent, it meant carrying a heavier burden of parenting, which they resented. No matter how hard they tried to survive, they could not and the pressure kept mounting. Caregivers also discussed using strategies they thought were "crazy" in retrospect.

> *"I was drinking alcohol so much that I was not even sleeping at home. My whole life was centred on booze and friends spending money until I realised that I was causing chaos in the family and wasting money and destroying my life" (P01).*
>
> *"I however changed my behaviour and concentrated on supporting my brother and that is why I am taking care of him" (P10).*
>
> *" Thanks to that effort because I am now working in the institution that is treating him and I am beginning to know more about this drug addiction" (P12).*
>
> *"I started to smoke my husband does not know about it I am taking care of myself Nobody cares they only ask about how the boy is feeling nothing about me" (P05).*
>
> *"I was confused. I was horrified and then tried to call my family and tell them about what was going on" (P04).*
>
> *"It was painful to see him destroying his life, I cried I knew I had to do something but I could not" (P10).*

4.3.3.2.2 Category: New Hobbies

Some participants reported that besides praying they keep themselves busy by doing things they never did before like reading, cooking, baking, gardening and jogging and exercise just to occupy their minds.

"I discovered a new hobby I never thought I could read the book in a day. To them it is a positive effect of dealing with the stress they are enduring in this situation (P08).

"I have discovered that I have energy of doing things like excessive household chores, cooking, baking and exercising a lot. I feel healthier" (P03).

4.3.4 Theme: Need for professional support services

This theme relates to the caregivers' need for support services and the challenges they faced to obtain support and assistance for the problems they were experiencing. Some of the participants became very emotional when they tried to explain the frustrations and bad treatment they received from the family, community and health and social development professionals. However other participants acknowledged the assistance they received from professionals with respect to the treatment of their children though they themselves did not receive any support. The themes consisted of three sub-themes as shown in Table 4.6 below.

Table 4.6: Need for support services

Theme	**Sub-theme**	**Category**
4.4 A need for caregivers support services	4.4.1 Need for support services	4.4.1.1 Seeking answers 4.4.1.2 Information about drug abuse 4.4.1.3 Inadequate services 4.4.1.4 Alternative Support services
	4.4.2 Availability and access to support services for caregivers	4.4.2.1 Human and financial resources 4.4.2.2 Infrastructural resources 4.4.2.3 Finance /Funding

4.3.4.1 Sub-theme: Need for caregivers support services

This theme was derived from the caregiver's narratives of how they struggled to obtain support and assistance for the problem they were experiencing. Some of the participants

became very emotional when they tried to explain the frustrations and bad treatment they received from the family, community and health and social development professionals. However other participants acknowledged the assistance they received from professional with regard to the treatment of their children though they themselves did not receive any support. This theme consisted of four categories; seeking answers, information about drug abuse, inadequate services, and alternative support services

4.3.4.1.1 Category: Seeking answers

Most caregivers tried to cope by being more and more in control of themselves by reading books, updating their diaries, Facebook, phone messages and hunting down their children in the hope of saving them, often at significant risk to the parent. Some participants reported using open communication with all of their children, they talked about all social ills, achievements and challenges they experienced. They always encouraged their children to talk about their feelings whether negative or positive and they played games with them like snake and ladders, chess, cards and would involve the affected child who will sometimes not want to be involved. They said this strategy was an attempt to find answers to what could have led the adolescent to drug abuse.

> *"I thought I was the best mother providing for my kids but now I am a failure" (P12).*
>
> *"It is better that I could die and this child could see what he has lost, maybe he will come around" (P07).*
>
> *"Reading books keeps me busy and I don't need to be in a crowd of people" (P14).*

4.3.4.1.2 Category: Information about drug abuse

As one mother noted, her family was already traumatized through other events especially those which were related to the adolescent's bad behaviour and they suggested that she should throw the child out of the home, which according to her could have caused more damage. They were frustrated that the professionals frequently held back information

about their adolescent's situation due to issues of confidentiality. Given the fact that the ages of some of the adolescents were between 17 and 18, therapists were hampered when the adolescent would not give disempowered permission for information to be shared with caregivers. Most caregivers spoke about how this made them feel that the health professionals were not supporting them and instead they were acting in favour of their children. Many participants described the confidentiality barriers as enabling secrets to be kept, thus making it harder to understand what the adolescent's issues were and how to help. The majority of caregivers spoke about wanting information that would allow them to make sense of what was happening and how they could effectively respond to the problems they were facing. One mother said that it would have made a significant difference. Most participants reported that they do not have adequate access to information about drug abuse in general,

> *"if someone sat down and counselled us and talked to me face-to-face, like you have a sick kid and the sickness that they have is addiction. They're a drug addict, you know" (P14).*
>
> *"it would have been helpful if the therapist had just said it out and told her that her child might be having a drug abuse problem" (P05).*
>
> *"We are not getting proper help" (P13).*

4.3.4.1.3 Category: Inadequate services

Caregivers typically reached out for help when they felt that the pressure arising from the adolescent's behaviours were now far beyond their abilities and capabilities to cope. Most caregivers expressed feelings of powerlessness and that nothing they were trying to do seemed effective. When they crossed that barrier, reaching out made sense and they spoke about trying almost everything and anything to find a solution. Reaching out for help was a major step, and one that caregivers often described as disappointing and which failed to make a difference. In various ways, caregivers often felt that some of the professionals and agencies did not understand the concept of drug abuse and its devastating effects on caregivers. They also felt that some of the professionals were exceedingly reluctant to use terms like dependency and addiction. Some of the professionals offered solutions, which were at odds with family values or needs. Most of

the participants reported that they had lost family support and trust due to their children's behaviour as a result of drug abuse. They revealed that they had been deserted by their own families and friends and this was the most stressful and painful situation. Very often, they said that they were blamed for their poor parenting and that they enabled their children to behave the way they are behaving.

Caregivers were often ambivalent about reaching out to family for support. Some felt it could be useful, while many did not wish to do so. Those who did not share this problem with their families said that they did not want to burden them with their problems because those families might have their own life challenges and dynamics while others expressed guilt, embarrassment and shame regarding the problems they were experiencing with their children. They were worried that they would be judged for failing in the parental role Those who did reach out to family, reported not finding any joy and the family was not supportive and that the exercise was not always helpful. It could be met with family members becoming enmeshed and enabling the child. Participants reported that they tried to get some formal assistance for their children through public and private resources. One participant, a father, reflected on how he once realized that his tolerance for the chaos had been exceeded and now he had to act and started calling law enforcement officials, social services and police to apprehend his unruly child

> *"I was just trying to get help because we realised that things had got out of control and very quickly" (P10).*
>
> *"You have spoilt him and gave him everything he wanted"(P12).*
>
> *"It would have been better if he was admitted here in Kimberly. Now he is worse, he is destroyed" (P13).*
>
> "it would have been helpful if the therapist had just said it out and told me that her child might be having a drug abuse problem. I was not informed about my child's condition" (P12).

4.3.4.1.4 Category: Alternative support services

Most caregivers reported that they decided to seek their own therapeutic support which subsequently allowed them to both validate the challenges and get coaching on various

ways to respond to the behaviours of the adolescents with problems of drug abuse. One resource that was seen as helpful was police officers because they tended to tell the parents bluntly that the cause of their children's behaviour might be substance abuse. According to them the police became involved in a variety of ways, ranging from picking up the problem adolescents for public intoxication and arresting them. Caregivers also found help through their own peers who had children with serious substance abuse or dependency problems. They spoke openly and frankly about their own experiences and offered insights which confirmed what they had been going through. Connecting to these peers occurred through informal meetings, attending self-help programs or by calling addiction treatment centres that offered connections to parents of former clients. Some caregivers said they solicited private services for their peace, sanity but it was costly for them. They further said that it takes too long for the social worker to come to their homes for the assessment and referral of the children to the rehabilitation centre which is in Bloemfontein (Free State Province) and the waiting list was too long.

> *"We use to have an NGO in the township that provided care for us and it has been closed due to lack of funding" (P01).*
>
> *"I feel much better today because I had an opportunity of talking to someone neutral and who listened to me. Am relieved" (P09).*
>
> *"We do not have recreation facilities" (P07)*.

4.3.4.2 Sub-theme: Availability and access to support services for caregivers

This theme was derived from the caregiver's narratives of how they struggled to obtain support and assistance for the problem they were experiencing. Some of the participants explained this experience as one that was stressful, depressing and frustrating. They said it is because they were disempowered and their human right disrespected by the government. This theme consisted of three categories; Human and financial resources, Infrastructural resources and Funding.

4.3.4.2.1 Category: Human and financial resources

All participants reported that there was absence of community programmes which supported caregivers who are experiencing this scourge in the Sol Plaatjie municipal area. Some of the participants also reported that they are still waiting for their children to be admitted at the rehabilitation institutions and feel they have been waiting for a very long time. Four of the caregivers reported that there used to be some NGOs and NPOs which offered support care services for the caregivers in this municipal area but they have unfortunately been closed for a very long time for reasons unknown to them. Participants further reported that there was lack of relevant professionals equipped to deal with their problem in Sol Plaatjie municipal area. They said that the long waiting period and the list that is applied in order to accommodate their adolescents was due to insufficient human resources and financial resources. They further said that it takes too long for the social worker to come to their homes for the assessment and referral of the children to the rehabilitation centre which is in Bloemfontein (Free State Provence) and the waiting list is too long These experiences confirmed that there is no government service provision for caregivers' support services.

> *"We do not have professional care" (P15).*
>
> *"It takes time for a child to be admitted to the government rehabilitation institution. I cannot afford the private rehabilitation institution" (P14).*
>
> *"Government is failing us we are not getting help and support" (P13).*

4.3.4.2.2 Category: Infrastructural resources

The data obtained from the participants revealed that there were no facilities which provide caregivers support programme in this municipal area, if not in the whole province. Participants felt that even the programmes to support affected children were not enough and those who were there were providing poor services. Most of the participants attributed the lack of caregivers support services to insufficient human resources, infrastructure and lack of funding by both government, business and private sectors within this municipal area. They further said that they have been robbed of the services they use to benefit from. They said they are now struggling because of some selfish people who do not want to see Sol Plaatjie developing. They how ever did not mention names of those people they said they robbed them their lives.

” Thanks to that effort because I am now working in the institution that is treating him and I am beginning to know more about this drug addiction” (P11).

“Support services for caregivers are unavailable we cannot afford the private institutions” (P06).

“We are receiving poor service “(P14).

4.3.4.2.3 Category: Finance /Funding

Most of the participants reported that they were not receiving adequate support from government, private or business sector. They felt that there was inadequate funding for those facilities which were at least trying to help their children. They revealed that this problem cost them peace of mind because all those facilities which used to provide relevant services for them have been closed due to lack of finance or funding.

Most participants reported that they decided to source their own therapeutic support which subsequently allowed them to both validate the challenges and receive coaching on various ways to respond to the behaviours of the adolescents with problems of drug abuse. One resource that was seen as helpful was police officers because they tended to tell the parents bluntly that the cause of their children’s behaviour might be substance abuse. According to the participants the police became involved in a variety of ways, ranging from picking the problematic adolescents up for public intoxication and arrested them.

“We use to have an NGO in the township that provided care for us and it has been closed due to lack of funding” (P01).

“I feel much better today because I had an opportunity of talking to someone neutral and who listened to me. am relieved” (P09).

“Government does not take us serious” (P12).

4.4 CHAPTER SUMMARY

In this chapter, the researcher provided a detailed description of the study findings according to the analysed data. Data obtained from the interviews resulted in the

development of themes which subsequently led to development of sub-themes and categories. These themes and sub-themes were derived from the narratives and quotations made by participants. The findings were presented in line with the study objectives, sub-objectives and addressed the research questions and problem statement of this research study. The findings revealed that the lack of programmes that support the caregivers together with poorly resourced facilities which provide services for the adolescents who abuse drugs was a cause for concern. It was clear from the reports from the participants that the only facility, though private, was facing closure due to lack of funding by both government, the private sector and business. The participants said if this institution closed that would be the saddest story in the Sol Plaatjie municipal area.

The next chapter focuses on the presentation and discussion of the findings, of the current study.

CHAPTER FIVE: DISCUSSION OF FINDINGS

5.1 INTRODUCTION

The preceding chapter described the findings of the research study, the current chapter presents the interpretation and discussion of the findings derived from the data collected during the interviews. The findings and the results provided the basis for the discussion of this research study. This study aimed to explore and describe the caregiver's lived of experiences living with an adolescent abusing drugs and receiving care in the selected drug rehabilitation institutions of Sol Plaatjie municipal area. The discussions were based on the objectives and sub-objectives of this study in order to answer the research questions of this current study:

5.2 INTERPRETATION OF THE RESEARCH FINDINGS

The study's findings were evaluated in relation to various literature-based scholarly viewpoints acquired from a diverse range of academic sources and references on the research study

5.2.1 Demographic data

Most of the participants were female. These findings highlighted the plight of women as being at the forefront of family organisations and systems. The mothers are the hardest hit by the burden of social ills in the family, as reflected in this study. This sentiment was shared by Groenewald and Bhana (2017:152) when they stated that mothers are an important parental figure in the family because in most cases they are the ones who are charged with the care and support of children in most households; this is made worse when they are single parents. They further said that the mothers are the most vulnerable individuals when they are faced with challenges like this and needed support. The employment status of caregivers who were married, which includes widows, was higher

than that of caregivers who were single. This indicates that this problem can affect in the household, irrespective of their socioeconomic status.

The current study's findings also showed that drug abuse by adolescents debilitates caregivers across all racial groups (CDC:2017). It was noted that this problem of drug abuse by adolescents and its effects on caregivers occurs in any racial group, as shown in this study. The participants were mostly blacks and coloureds with a few from the white racial group, it would have been ideal if the study had more numbers of white participants. The researcher noted that this could have been because the white population might have had the privilege of receiving care from the private institutions; the researcher could not obtain access there to due to elements of confidentiality and the policies of the private institution. In addition, the argument by Ashante and Lentoor (2017:5) is that the problem of youth drug abuse is increasing in the white communities and this has affected parents and caregivers physically, mentally and psychologically and has led to many family conflicts. However, this finding warrants more research. This sentiment was also shared by Mulyaningrat (2019:856) when he attested that the effects of drug abuse by adolescents living with their parents has devastating consequences on parents worldwide and across all racial groups. He further said that these parent experienced feelings of failure, worthlessness and hopelessness.

The human settlements of the caregivers were mostly in the townships, showing that the problem of drug abuse by adolescents could be due to external influences such as the environment and even peer group pressure, which is very much consistent with the FST. The researcher noted that many of the participants believed that peer pressure and association with influential peers, especially those who were already abusing drugs themselves could be factors that led their children to abuse drug.

It was noted from the findings that caregivers were trying to support their children even if they gave them what they wanted. For example, some caregivers gave these children money to buy the drugs just to have peace or get rid of them. What caregivers were not aware of was that their actions perpetuated the problem. This sentiment was shared by Hlungwani et al. (2021:21) when they said that the parents experienced feelings of guilt about failing the adolescent, believing that they were responsible for their adolescent’s behaviour. Hlungwani et al. (2020) further said that caregivers reported that they were perhaps absent when their adolescents needed them the most. Self-blame thus came out very strongly as parents experienced guilt and anger at themselves about their

adolescents. Participants thought that neglect might be what led to the adolescent's abuse of substances.

The FST highlights that environmental inputs and outputs can affect the functioning of the family system in either a positive or negative way. In this case, the drug abuse problem by the adolescents brought negative energy to the functioning of the family system. The caregivers' experiences resulted in debilitating biopsychosocial effects, which in most cases resulted in altered roles, lifestyles, and mental health for the caregivers. The findings revealed that most of the caregivers were employed, which is why they could ensure that their children are secured a good life. This confirms that caregivers became overwhelmed by the experiences they had when caring and living with an adolescent who abuses drugs. By giving adolescents money to buy drugs was actually failing to refuse to succumb to the continuous manipulation by those adolescents and this meant that they were unable to practice tough love and enabling the problem. Some participants believed that if they did not give the affected adolescent money to go and buy drugs was not showing that they loved them. Choate (2016:470) corroborates that parents experience that they still love their adolescents, but their experiences make it difficult to live with them; hence, they wish they could die or not be discharged from the hospital. The Centre for Disease Control (CDC:2017) concurs that discipline is the universal prevention strategy within the family that may be employed to reduce incidences and onset of delinquency, including substance abuse in early childhood and adolescence. Caregivers experience not being able to control their adolescent abusing substances through discipline whereas some caregivers experienced a sense of worthlessness and powerlessness in terms of controlling their adolescent abusing substances. Discipline with love and respect in the family is crucial for any individual's upbringing. Some caregivers asserted that peer pressure could be a factor that drove their children to drug abuse (Hlungwani et al. 2020:22)

5.2.2 Discussion of the research findings

The main objective of the study was to describe the lived experiences of caregivers living with adolescents who abuse drugs and the sub-objectives were to determine the effects experienced by caregivers of adolescents who abuse; to describe the coping strategies used by caregivers living with the adolescent who abuse drugs; and to identify programmes available in the community to support the caregivers of adolescents who

abuse drugs.The findings of the study were therefore discussed under the main and sub-objectives as well as the following themes “

v. Theme 4.1: Environmental effects experienced by caregivers
vi. Theme 4.2: Biopsychosocial effects experienced by caregivers
vii. Theme 4.3: Effect of coping strategies
Theme 4.4: A need for support services.
These thenes provided the answers to the research questions of this study.

5.2.2.1 “***Lived”*** Experiences of caregivers living with adolescents who abuse drugs

The findings in this study reflected the broad experiences of caregivers living with adolescents who abuse drugs discussed as follows:

5.2.2.2 Environmental effects experienced by caregivers

The experiences described under this theme describe how the caregivers found out that their adolescent was abusing drugs. This current study confirmed that a drop-in school performance played a key role in alerting the caregivers that the adolescent might be going through a problem. It was eventually discovered that this problem was the abuse of drugs. The more the adolescent got involved in abusing drugs, the more they started losing interest in school resulting in poor school performance and eventually becoming a school dropout. This finding is supported Choate (2016:464) who stated that most adolescents who abuse substances do not do well in school because their lifestyle probably affects their brain functioning. In addition, Kalam et al. (2019:162) reported that challenges with school work are one of the effects of substance abuse, and it is through a decline in school performance that some parents find out about their adolescents' behaviour. Adolescents who drop out of school because they are abusing substances and cannot cope with schoolwork anymore are a challenge to caregivers. These same sentiments were shared by Groenewald and Bhana (2017:426), who pointed out that neglecting school work and dropping out of school were some of the signs indicating that an adolescent is abusing substances. Parents wish to see their children succeed, and seeing their adolescents abuse drugs resulted in irreparable emotional harm to them. The participants mentioned their experiences with stress, which is caused by seeing their adolescents destroy their future by dropping out of school. This affects them very badly because they had dreams and hopes of seeing their children have a brighter future than the one they had. Other caregivers reported that their children dropped out of either

primary or secondary school. Motshoeneng (2018:41) asserted that it is common for parents to discover the adolescents' drug abuse problem while still in primary and secondary school, even before they reach sixteen years of age. Asante and Lentoor (2017:6) state that most adolescents who are abusing substances are not doing well at school as their brain functioning might be affected by their lifestyle. The parents experienced shock, sadness and shame because of the behaviour of their adolescents.

Other studies found out that adolescent learners who abuse drugs use them to cope with difficult situations and deal with their feelings of failure (CDC:2022), Groenewald and Bhana (2017), Takalani and Phashwana (2016:430) Kauri et al. (2021:576) Hlungwani et al. (2020:6), SAENDA (2017)) and Dada et al. (2016:11) reported that marijuana use alters perception and causes hallucinations and that users feel relaxed when consuming lower dosages. On the other hand, high doses can cause nausea and vomiting, feelings of disorientation and paranoia (Kauri et al. 2019:541). In the contrary Njoki et al. (2019:153) said that anxiety and panic attacks were also evident when consuming marijuana. These findings were also corroborated by narrations taken directly from interviews conducted with participants in exploring peer pressure regarding drug abuse amongst adolescent learners in previously disadvantaged township secondary schools

This research study also showed that the caregivers were the victims of theft, violence, and bullying. Theft itself led caregivers in experiencing financial loss due to the adolescent’s drug abuse. These findings resonate with Groenewald and Bhana’s (2018:149) assertion that caregivers became victims of adolescent theft and unacceptable behaviour due to the adolescent's drug abuse problem. These devastating, incalculable experiences of the caregivers being a victim needs to be explored further. Many participants gave narratives about the stealing behaviour of their adolescents and how this was also a factor that made them aware that their adolescent might be abusing drugs. Motshoeneng (2018:46) explained that stealing and petty theft are common among adolescents who abuse drugs. He further attests that society regards such behaviours as unacceptable and dangerous to community safety. It was, therefore, not surprising that some participants reported that their children had sometimes been arrested by the police for such criminal activities. A few of the caregivers reflected on their experiences of how these adolescents started by stealing from home first, for example, money and household items, belongings. And eventually stole from neighbours and the community just to sell goods in order to buy their drugs "fix". This correlates with what Motshoeneng (2018:33)

attested when he said stealing and petty theft are common among adolescents who abuse drugs. He further notes that society regards such behaviours as unacceptable and dangerous to community safety. It was, therefore, not surprising that some participants reported that their children had sometimes been arrested by the police for such criminal activities. Other behavioural changes the caregivers of these adolescents which were revealed in this research are consistent with the findings of Hlungwani et al. (2021:22), Kalam and Mthembu (2018:469) and Kwaku and Antonio (2018:66), who described the effects of this problem on caregivers such as enabling, isolation, denial of self-blame, neglecting family relationships, and being engaged in destructive behaviours, both to the self and other family members. According to Hlungwani et al. (2020:21), adolescents are considered a developmentally vulnerable population, and this pattern is contextually different from when substance dependency is found in an adult.

Findings in this study show that the misbehaviour of adolescents who abuse drugs provides a context that leads to a troubled lifestyle and physical and psychosocial ailments of their caregivers. The findings by Dada et al. (2018:6) suggest that the consequences of the misbehaviour of these children are feelings of shame and embarrassment by the caregivers; as shown in some of the revelations that emerged strongly from the interviews during data collection. Participants also experienced personal challenges, which included emotional problems, fear and self-blame. The findings also revealed that family disruptions, conflicts, and financial drain were other adverse experiences associated with their adolescents’s use of drugs. Several results from this study are consistent with other studies on mothers' experiences of living with adolescents and/ or youth substance abusers both in South Africa and further. For instance, the psychological distress that some participants experienced due to the adolescent's misbehaviour is consistent with other studies that have confirmed that repeated daily exposure to destructive behaviours affects the psychological well-being of caregivers whose adolescents have substance abuse problems. A sense of intense worry could lead to anxiety, and being anxious and nervous in a South African context is a risk factor for depression among caregivers (Kwaku & Antonio 2018:69).

The researcher concluded that the behaviour of the adolescents misusing Nyaope leads to conflict and disintegration of the family as a unit and has the potential to collapse the entire family system. Furthermore, it was concluded that the parents, as the centre and backbone of a family system, require support to save the entire family system from

collapsing as a result of their adolescents' misuse of drugs. In addition, the researchers concluded that the adolescents' misuse of drugs inevitably leads to a breakdown in family relationships as family members spend more time away from home. In response to parents giving misusers money to purchase drugs, it is concluded that there is a need for programmes to educate and support parents of adolescents misusing drugs. Finally, it is concluded that religious institutions such as the church have a significant role to play in supporting parents of adolescents. There is also a need for collaboration between social workers, parents, families, educators, church leaders and law enforcement agencies in combating adolescents' misuse of drugs (Kalam & Mthembu 2018:467).

The financial burden experienced by parents was known to be associated with substance addiction in young adults. In most cases, drug users often tend to steal first from their homes and then from the community selling everything in their possession, including phones and clothes, to pay for their drugs, thus leaving their families with hardly any possessions and huge debts. Additionally, Kwaku & Antonio (2018:9) affirm that having disruptive family relations and financial burdens may further exacerbate the caregivers' psychological functioning, thus adversely impacting the overall well-being of the family. This finding affirms the need for efforts to develop formal support interventions for caregivers of drug abuse-challenged adolescents.

This study has revealed that such behaviour can prevent caregivers or parents of adolescents who abuse drugs from seeking help and support from the broader social network, such as extended families and friends, often leaving them helpless and isolated. It is therefore important for interventions to put greater efforts into public education on the effects of stigma and the psychological distress associated with caregivers for young adults with substance addiction. Such efforts must also be directed at health care providers and formal treatment facilities to understand the challenges faced by parents and how best to provide the support needed. Previous studies have highlighted caregivers' dissatisfaction with such services as they are most often misunderstood or blamed as suggested by Ogunrombi (2018:54).

In this study, the researcher also observed that many caregivers reported or alluded to medical conditions which they experienced such as hypertension and diabetes being exacerbated by their worry and concern over their adolescent's substance abuse. Some participants indicated that the stress of managing an adolescent with drug abuse has caused them to seek medical treatment or find outlets to manage the negative effects of

such stress. The researcher observed that caregivers' perceived and experienced stress appeared to increase exponentially with the complexity of their adolescent's drug problems.

5.2.2.3 Biopsychosocial effects experienced by caregivers

Fear of attack by their adolescnts, should they not be able to give or provide what they want from them, was also reported by most participants. Motshoeneng (2018:47) further reported that other family members protected themselves and stopped further communication with the adolescents who abused drugs by obtaining restraining orders against the drug abuser from law enforcement agencies.

Caregivers attested that they were now a laughing stock in their communities. Ashante & Lentoor (2017:4) said that the consequences of the adolescents' misbehaviour are the shame and embarrassment that the caregivers must endure. This shame and embarrassment stems not only from the adolescent's stealing, but also from close friends and relatives. This research study also showed the common ground between families where the parent or another adult in the home has had substance dependency and families where the adolescent has the issues. Previous studies by researchers such as Motshoeneng (2018:26), Moradi et al. (2019:467), and Hlungwani et al. (2020:4) have shown that conflict in the family increases as the drug abuse problem by adolescents grows, which was undoubtedly the case in this research. Indeed, family conflict grew to the point where family cohesion was damaged, either the parent-child relationship, relationships with the siblings, the caregiver's relationship with the spouse or co-parenting itself. Family relationships were strained across the family system, including the extended family. The shame and embarrassment experienced by caregivers due to the adolescent's loss of interest in cleanliness and grooming were evident enough to conclude that this was a genuine and stressful experience. The behaviour of the adolescent who abuses drugs led to family conflicts and disintegration as shown by the researcher in this study. Furthermore, it is concluded that the caregiver, as the anchor and the backbone of the family system which experiences this problem, requires professional support.

This is consistent with the FST description of a child who is described as a "Hero". This role is likened to an adolescent who abuses drugs because this kind of behaviour always masks the dysfunction experienced by the family. Caregivers also faced the possibility of denial and kept information about drug-abusing adolescents to themselves. The

consequences of such actions aggravated the problem because the family delayed calling for help, and some became hopeless. The change in the adolescent's behaviour made it difficult for the caregiver to address the adolescent drug abuse problem. One participant said that her child's condition deteriorated so rapidly that the damage was already done by the time she noticed it. It was clear from the participants' narratives that there is not enough information related to the awareness of drug abuse and addiction. This is consistent with the experiences of participants who said there are no support programmes for caregivers who live and care for adolescents who abuse drugs in the Sol Plaatjie municipal area. The findings of Moradi et al. (2019:434) and Hlungwani et al. (2020:7) are in line and confirm this experience by caregivers when they also found out that drugs are prevalent in our homes and communities and that many parents are unaare of the risks they pose. Therefore, strategies to inform the parents and caregivers and communities about the risks of drug abuse must be implemented. For most participants, social exclusion led to isolation, feelings of rejection, desertion and loneliness.

5.2.2.3 Coping strategies used by cagergivers who are living with adolescents who abuse drugs

5.2.2.3.1. Effects Coping strategies.

Caregivers developed coping strategies for dealing with the behaviour of the adolescent abusing drugs. These strategies ranged from prayer, reaching out to church, and altered lifestyles, to giving the adolescent money to buy drugs to get rid of them. For example, some caregivers stated that they gave their adolescent money, not that they wanted to, nor that they were enabling this behaviour or problem, but because they found solemnness when these misbehaving adolescents were not around them. A few participants also reported that they could not handle the adolescent's withdrawal symptoms; hence, they gave them money to go and buy the "fix". This resonates with the findings by, Hlungwani et al. (2020:8) who said that when adolescents were given money to buy drugs, this was the parents' way of trying to find peace and trying to get rid of them.

At the parental level, coping became about survival instead of leading the life the parent envisaged. Motshoeneng (2018:112) argued that caregivers were trying to find their way through the chaos, but as they sought meaning for what was going on around them, the confusion and unbearable situation presented a clear understanding of the altered

lifestyle and change in responsibilities and roles caregivers had to face. The research study conducted by Hlungwani et al. (2020:9) affirms that what families had to go through included but not limited to painful, stressful and devastating unmanageable life changes. Therefore, it is psychologically important for a caregiver to receive support that will help them, manage and approach the challenges they are facing (Mulyaningrat et al. 2019:851). This might lead to a different understanding of what is happening and activate earlier interventions. However, parents need very specific support to address their own emotions as the problem of drug abuse by their adolescents and their experiences unfold. These lived experiences demand an understanding because caregivers often felt a sense of failure due to the situation they are facing with their adolescent (Groenewald & Bhana 2018:150)

The process of understanding the drug abuse problem was neither linear nor transparent for these caregivers. On the contrary, they often relied on contradictory information, which led them in diverse directions. For most, the change in the adolescent's behaviour was not clear to them (Kawaka & Antonio (2018:11). Even those participants who reported as having had a history of substance dependency found that responding to the current problem of adolescent's drug abuse problems presented to them with unfamiliar challenges that left them uncertain about how to respond to this scourge. Subsequently, the participants reported that they could see problems emerging but did not know what to make of them. The fact that caregivers carried a belief of their guilt for their children is evident that there was limited information about drug abuse in the Sol Plaatjie municipal area as reported by the participants during the interviews. These findings concur with those in a study conducted by Hlungwani et al. (2020:39) who said that parents shared their feelings of guilt about failing the adolescent, and they believed that they were responsible for their adolescent's behaviour. They also said that they were perhaps absent when their adolescents needed them most. Self-blame thus came out very strongly as parents experienced guilt and anger at themselves about their adolescents.

This finding is also consistent with the findings of Pelzer and Phaswana (2018:171), SAENDA (2017) and Kwaku and Antonio (2018:8) who reported that the picture of the behavioural changes in the adolescents was confusing and misleading to some. A parent has a natural desire to see their children succeed. These caregivers were not blind to what was going on, they simply did not have a good understanding about the problem at hand. Some exceptions were similarly evident and related to the behaviours that were

associated with the problem of adolescent drug abuse (Schultz & Alpaslan 2016:730) Most participants learned in different ways to make sense of what was happening while also trying to manage a growing sense of chaos for themselves and their families. Moreover, experiences of shame relating to criticism, being negatively judged by other people, and having to live according to the expectations of other people were significantly related to depression, ill health, embarrassment and entrapment. Shame was expressed by participants as a feeling of the altered role of having or being connected to someone who has a drug problem and unacceptable behaviour as defined by the society they are a part of.

Caregivers did not deliberately avoid the problem but rather responded to what they "thought" was happening around them. Trying effortlessly as they might, things just got worse, it was happening before their very eyes, no matter what they did. The power of the drugs and the related culture and effects were greater than the interventions the caregivers could bring to bear. Some of these interventions, be it outpatient counselling, school interventions, family therapy, rehabilitation, changes in living situations or various combinations of these efforts, were somehow ineffective in certain cases.

However, there may be cases where drug abuse is more of a concern than dependency. The study revealed that the behaviour of adolescents misusing Nyaope has dire consequences for the affected families, as they cannot function as units. In line with these finding, Schultz and Alpaslan (2016:91) pointed out that substance misuse is not an individual problem only but also affects the family system. Furthermore, Ngantweni (2018:38) argued that the adolescents' misuse of drugs often throws the family into turmoil because of conflicts. Accordingly, parents always find themselves in the middle of friction between these adolescents and other family members. This often poses a challenge as their attempts to maintain peace and normal family functioning are consistently jeopardised by the negative behaviour of the adolescents. In addition, because of theft by the adolescents, parents and other family members are at risk of crime at home (Ngantweni 2018:32).

Regarding coping strategies, parents opt to give the adolescents money to buy substances as a way of saving both the family and the misuser. In concurrence, Liahaugen (2022:9) observed that the practice of giving adolescents money to buy substances is the parents' way of coping and protecting the entire family. Furthermore, parents acknowledge that the support from the church, pastor and prayers enables them

to cope with the challenge. The results also showed that the lifestyle of caregivers of youths who abuse drugs was clouded with shame and embarrassment, which leads to a sense of isolation. Similarly, Moradi et al. (2019:372)) attest that a sense of isolation appeared to facilitate perceived and expressed stigma towards substance users and their caregivers. Globally, studies have shown clearly that stigma and discrimination discourages illicit drug users from obtaining health care due to fear of poor treatment by healthcare providers; this affects the help-seeking behaviours of caregivers of adolescents with substance use problems (WHO:2020). Most caregivers said that they isolated themselves from the family and the community. Researchers such as Moradi et al. (2019:5), Choate (2016:468) and Priyanka (2020:241) found that most parents felt isolated from society because of the stigma that was attached to them due to their children's drug abuse problem.

Regarding this study strengths, it is noteworthy that parents of adolescents misusing drugs are often overlooked and barely feature in research. and supportive cases.

5.2.2.4 Programmes available and accessible in the community that support the caregivers of adolescents who abuse drugs.

5.2.2.4.1 A need for support services.

A dominant theme in this research was that caregivers and/ or parents felt unsupported, helpless and powerless. The caregivers revealed that professionals involved with their children were often constrained by confidentiality rules or a shortage of human res€€ources. This led to them not being involved in the care of their children whilst in the rehabilitation institutions. This left the caregivers quite frustrated and disempowered, with many believing that they failed as caregivers and did not do enough to prevent, take control and manage the problem. They regarded this experience as a counter-action to the interests of themselves as parents and caregivers, and these emphasised feelings of being ineffective or failing in the parenting role. As a result, the need of the other children in the family were often neglected. Groenewald and Bhana (2018:149) found out that this neglect would cause the siblings to look elsewhere for guidance or to isolate and, in many cases, detach from the parental guidance making siblings at risk of also starting to use as they adapted to the substance abuse environment a sentiment shared by Ngantweni (2018:22). Many researchers found out that siblings of substance-dependent youth are

at greater risk for their adverse outcomes, this was confirmed by some of the participants when they indicated that they are also recovering or had recovered from a substance abuse problem. This issue can lead to a recurring and vicious circle in the family problem; therefore, this area warrants further investigation because research on the effects of drug abuse and dependence in the family and on siblings is limited.

Throughout these interviews, the real emotional pain these caregivers experienced was apparent. Thus, it was not surprising that caregivers wanted explanations for this pain they were experiencing in a way that was not a product of substance dependence and was more socially acceptable. This made sense, given that the parents have such a large stake in the youth. They raise their children and invest much of their lives and hopes in their children with no gains; instead, they are burdened with the societal expectation that they have to take control and manage the problem. One parent revealed that she sometimes becomes angry and rude towards people who forever come to complain about her child's behaviour.

The findings showed that participants blamed themselves for their children's misuse of drugs. The finding supports the discourses which hold mothers accountable for their children's behaviour (Groenewald & Bhana 2018:151). In this study, this accountability was illustrated in the ways the caregivers blamed themselves as caregivers for their adolescent's misuse of drugs. This was implicit in the narratives where some caregivers questioned their caregiver' roles, capabilities and approaches to understand why their adolescents abused drugs. In this way, the adolescents' abuse of drugs was inherently associated with the caregivers' happiness and sorrow. It has therefore been argued by Groenewald and Bhana (2018:152) that caregivers of young adults with drug abuse problems often bear the burden of the adolescent's drug abuse and see the children as extensions of their own identity.

The support programmes for the caregivers facing the scourge of living with adolescents who abuse drugs were reported unavailable in the Sol Plaatjie municipal area. Some caregivers reported that there used to be NPOs and NGOs, but they all closed for unknown reasons. They said those institutions were very helpful and accessible to them. Most caregivers expressed their frustrations over the kind of treatment and attitude they are receiving from the professional service providers of the adolescents. Other caregivers whose adolescents were admitted to the government referred rehabilitation institutions described the process as unhelpful and disappointing. They reported that their children

came home from these rehabilitation institutions after six weeks and were worse than before they were sent there. Evidence from the data and literature highlights that a lack of support for caregivers who live with adolescents who abuse drugs is a cause for concern as suggested by Dauber et al. (2018:8).

Most participants reported and requested that their adolescents be admitted to the rehabilitation institution based in the province for three months because they felt that the six-week programme that their adolescents were referred to was not effective enough. The participants further reported that the challenge was that gaining access to that institution is not easy, and they were told admission to the Northern Cape substance abuse rehabilitation only caters for adults. Peltzer and Phaswana-Mafunga (2018:331) concur with this statement when they said that it was evident that the caregivers did not have information regarding the services they could access in order for their adolescents to receive treatment.

It is clear from the narratives of caregivers that the experience of living with than adolescent who abuses drugs was stressful and emotionally draining. This sentiment was shared by Hlungwani et al. (2020:6) when they said that parents experience negative consequences regarding their adolescents abuse of drugs. Groenewald and Bhana (2018:152) and Motshoeneng (2018:44) state that having an adolescent who is dependent on substances can bring about challenges and stress on physical health and well-being of the parents, leaving them overwhelmed. Moradi et al. (2019:455) share the same sentiment when he stated that the individual who abuses drugs runs the risk of compromising and exhausting the relationships in the family setting, which lead to family systems being strained. Dauber et al. (2018:7) also confirm that substance abuse in the family affects the social life of family members and the way they relate to others. Parents moreover experienced negative consequences from the community, although they understood that the community was tired of the adolescents' behaviour. Participants in this study also shared that the community members were treating them as if they were supporting the behaviour of the adolescents; the community did not realise that they were also challenged by this behaviour of their children. Parents shared that the community perceived them as irresponsible parents because their adolescents were abusing substances.

However, the participants demonstrated that they wanted progress in their adolescents' lives. In the study by Choate (2016:467) it was found that despite the emotional

challenges in which parents find themselves, they still hoped that their adolescents will change and respect them.

Among the most common risk factors related to adolescent drug abuse reported by participants were school dropout and consuming gateway drugs such as cigarettes, hubbly and hookah pipes. Numerous studies by researchers such Kwaku and Antonio (2018:12), Hlungwani et al. (2020:8), Ashante and Lentoor (2017:4) and Dada et al. (2018:10) found that there is a relationship between dropout and academic failure with drug use by the adolescents. According to the FST, external environmental factors can negatively affect the connectedness of the family systems, and this is the case in this study. Family bonds were weakened, and control mechanisms for deviant behaviour also became ineffective; therefore, caregivers reacted negatively psychologically and emotionally towards their children's socially unacceptable behaviours.

Finally, most participants reported that their adolescents were admitted at some point to rehabilitation centres and treatment camps for drug abuse treatment; unfortunately, this often led to a return to drug use and also made them familiar with other drugs and various methods of drug abuse. Since those in the addiction treatment institutions have a higher average age and their substance abuse patterns are high-risk, adolescents will likely model this pattern of substance abuse after discharge from the camp. In order to respond to this situation, most caregivers reported that they isolated themselves from the family and the community. Concurring with this finding, most researchers, such as Moradi et al. (2018), Choate (2016) and Priyanka (2020) found out that most parents are isolated from society because of the stigma attached to them due to their children's drug abuse problem. This confirms the findings of the lack of proper education and awareness of drug abuse problems in the family and society, and this was also revealed by the caregivers who were interviewed in this study. A dominant theme in this research was that caregivers and/ or parents felt unsupported, helpless and powerless. The caregivers revealed that professionals involved with their children were often constrained by confidentiality rules or a shortage of human resources. This led to them not being involved in the care of their children whilst in the rehabilitation institutions. This left the caregivers quite frustrated and disempowered, with many believing that they failed as caregivers and did not do enough to prevent, take control and manage the problem. They regarded this experience as a counter-action to the interests of themselves as parents and caregivers, and these emphasised feelings of being ineffective or failing in the parenting role. As a result, the

need of the other children in the family were often neglected. Groenewald and Bhana (2018:149) found out that this neglect would cause the siblings to look elsewhere for guidance or to isolate and, in many cases, detach from the parental guidance making siblings at risk of also starting to use as they adapted to the substance abuse environment a sentiment shared by Ngantweni (2018:22). Many researchers found out that siblings of substance-dependent youth are at greater risk for their adverse outcomes, this was confirmed by some of the participants when they indicated that they are also recovering or had recovered from a substance abuse problem. This issue can lead to a recurring and vicious circle in the family problem; therefore, this area warrants further investigation because research on the effects of drug abuse and dependence in the family and on siblings is limited.

Throughout these interviews, the real emotional pain these caregivers experienced was apparent. Thus, it was not surprising that caregivers wanted explanations for this pain they were experiencing in a way that was not a product of substance dependence and was more socially acceptable. This made sense, given that the parents have such a large stake in the youth. They raise their children and invest much of their lives and hopes in their children with no gains; instead, they are burdened with the societal expectation that they have to take control and manage the problem. One parent revealed that she sometimes becomes angry and rude towards people who forever come to complain about her child's behaviour.

In this study, for example, the researcher observed that while caregivers possessed some levels of resilience and strength in coping with a problem that often appears to have no clear solution, the caregivers appeared to be psychologically overwhelmed, tired, emotionally worn out or "burned out", frustrated and overburdened, frustrated, and depressed. Thus, there is a need for interventions in the form of support groups, therapy, and other forms of assistance that can help caregivers alleviate the stress they encounter daily.

5.3 CHAPTER SUMMARY

The study has revealed that adolescents in the Northern Cape Province commonly used drugs such as dagga, methamphetamine, commonly referred to as "Tik" coke and

mandrax. Compared to previous studies about drug abuse and adolescent perceptions in the Sol Plaatjie municipal area in the Northern Cape by (SAENDA 2017:368), this study contributes towards building evidence on the experiences of caregivers who live and care for adolescents who abuse drugs. This area of study has received limited attention and research in this Province. This study provided insight into the personal and interpersonal experiences of caring for an adolescent who abuses drugs by qualitatively exploring the effect of the drug abuse by adolescents on caregivers' experiences living and taking care of these adolescents.

The findings showed that parents with an adolescent abusing substances faced a number of challenges, as evidenced from their shared experiences. The results displayed were that there was poor social support for these individuals; however, there was no doubt that social support is highly valued by the parents. Participants displayed signs of stress and strain and were employing various coping strategies to try to respond to their situation. There was strong evidence of emotionally burdened experiences by the caregivers / parents because of their adolescent abusing substance. This emphasises the need for further research to be conducted in developing a model for the facilitation of their mental health. It is evident from their nature of challenges and difficulties experienced that these parents need external interventions to facilitate their mental health.

CHAPTER 6: SUMMARY OF FINDINGS, CONCLUSION, LIMITATIONS AND RECOMMENDATIONS OF THE STUDY

6.1 INTRODUCTION

The preceding chapter presented a discussion of the research findings and the application of the FST. This chapter will discuss the summary, recommendations and limitations of this study.

6.2 OVERVIEW OF THE STUDY

The current study focused on one (1) main research question and three (3) sub-research questions which were answered:

Main research question

i. What were the lived experiences of caregivers who are living with an adolescent who is abusing drugs?

Sub-questions

i. What were the psychosocial effects experienced by caregivers of adolescents? who abuse drugs?
ii. What coping strategies did caregivers living with the adolescent who abuse drugs use?
iii. What programs were available in the community to support caregivers and what support do they need?

6.3 SUMMARY OF THE FINDINGS

The researcher used the following research questions of the current study to discuss the summary of the findings of this study.

6.3.1 Biopsychosocial effects experienced by caregivers of adolescents who abuse drugs?

The biopsychosocial effects experienced by caregivers of adolescents who abuse drugs was discussed under the theme: Biopsychosocial effects experienced by caregivers,

subtheme; Psychological effects, Social effects, Biological and emotional effects and the following categories that were subsequently derived from the narratives of participants during the interviews: shame, embarrassment and guilt, psychological pain, depression family disruptions and conflicts, social exclusion, stigma, ridicule, physical Illnesses, hopelessness and despair and fear, all of which were discussed in the previous chapters.

Participants reported that taking care of an adolescent who abuses drugs means never ending work and changing roles from their part which was described as tiring, and potentially threatening to one's mental and physical health. At the beginning of their finding out about the adolescent's drug abuse problem, the caregiver experiences different forms of distress because they did not know where to begin the process of seeking help or assistance. These caregivers also have to struggle with the unpredictability of an adolescent's behaviour which can take more caregivers through a psychological "roller-coaster ride". In turn, this type of a challenges faced by parents and caregivers often leads to not only severe stress, but also mental illness and even substance abuse in caregivers. This also leads to "burn out" which often causes caregivers to give up and want to walk away from their homes.

These parents were pressed to not only care for themselves and manage their own lives and families including other children, but also to maintain vigilance over those adolescents who are actively using different types of substances and the resulting consequences that were usually problematic and dangerous on a daily basis. They were worried about whether their child was going to die because of a drug overdose, be killed or severely injured in an accident, prostitute themselves, steal from home or the community in order to maintain their habit, become drug dealers in order to support their addition, or end up in prison. They were also worried about their adolescent s education, especially if they were no longer attending on a regular basis or if they were about to be expelled. For many parents or caregivers, the toll of parenting this type of adolescent left significant lingering psychological and physical effects. For example, in addition to dealing with the adolescent abuse problem, they also had to deal with other key issues that were part of the adolescent period of development including puberty, identity and sexual development, life and relationship choices, peer associations, etc. Many caregivers eventually needed psychological treatment because the strain of caregiving was overwhelming and emotionally costly. In addition, families, both immediate and extended, were also affected by a family member's drug abuse problems and the family as a system

as a result of many changes, often dysfunctional and pathological. Many families became disjointed, disorganized, and disengaged, while others became highly disintegrated and lost psychological boundaries. Thus, there was a significant “collateral damage” in families with a family member who had drug and/ or alcohol problems, whether the member is an adult or child, Also, in some families, drug abuse by their adolescent could have been intergenerational having begun with parents or grandparents, and thus became a problem over several generations.

Economically, families were also known to have suffered huge financial strain because of a family member actively used drugs. In many families, the abuser often stole from the family, especially if the drug or substance is costly. In other cases, families often incurred debt when trying to assist their family member through specialised mental health and substance abuse treatment. Most families were often left with bills and costs associated with incarceration, harm to others (e.g., restitution), and legal costs. It was not unusual for families to become bankrupt in attempting to seek a “cure” for their adolescent’s drug abuse problems. In other cases, the economic strain parents or caregivers experience affects their own emotional and relationship problems to the point of seeking divorce or trying to commit suicide.

6.3.2 Effects of Coping strategies

Caregivers used different coping strategies as an attempt to escape the suffering they were experiencing as a result of the adolescent’s behaviour. The coping strategies narrated by the participants gave rise to the following theme: effects of coping strategies and two subthemes: altered mental state and altered lifestyle and categories ‘Wishing for the recovery, becoming more spiritual: seeking God, self-isolation, seeking answers excessive alcohol and smoking and new hobbies. These categories were described in Chapter 4.3.

Research studies on the caregivers of children, especially adolescents, with these types of problems suggest that caregivers are overly taxed on an emotional level and often develop their own psychological problems in attempting to cope with the burden of caring for an adolescent with one or more medical and/ or psychiatric problems. While there are many commonalities between among caregivers of adolescents with substance abuse

issues and those with adults with drug and alcohol problems as well as medical problems, there are also many unique differences. For example, in the case of the caregiver for an adolescent with substance abuse problems, they are typically the biological parent or grandparent, while caregivers for adult substance abusers can range from a spouse to an adult child or friend to a government sponsored caretaker. Groenewald and Bhana (2018), Choate (2016) and Mulyaningrat et al. (2019) affirm that there is continued limited research studies on how caregivers effectively cope with the stress of having to parent an adolescent who has such problems, and in which the problems can range in different forms to catastrophes. This stress can manifest itself at different levels of the caregiving process, from initially finding out that an adolescent has problems with substances to having to manage the negative outcomes of substance abuse including poor academic performance, school absence, oppositional and defiant behaviours, criminality, incarceration, gang involvement, and sexual acting-out.

6.3.3 Programs available in the community to support caregivers and what support do they need?

This was explained in Theme 4: A need for support services by caregivers, whereby this themes consisted of three sub-themes and several categories emerged from the narratives presented by participants as shown in Table 4.6. The dominant finding in this part of the research was that there were no programmes which support caregivers of adolescents who abuse drugs and the participants attributed these to lack of funding by government, private and business sectors, inadequate human resources and infrastructure. There was strong evidence of emotionally burdened experiences by the caregivers because of their adolescent's drug abuse. This emphasises the need for further research to develop a model for facilitating their mental health and giving support to caregivers. It is evident from the challenges and difficulties experienced that these parents or caregivers need external interventions to facilitate their mental health. Additionally, this study has indicated that health professionals should be trained to be more vigilant and aware of the need to intervene with the identified client and create supporting interventions for the entire family system.

These interviews also suggest that further research could explore the pre-substance-using period to better understand what it is that leads adolescents onto a trajectory towards dependence. Groenewald and Bhana (2017:463) argue that the research and practice initiatives should consider using a multidimensional perspective of parental coping that recognises the heterogeneity of caregivers "coping responses”.

6.4 LIMITATIONS OF THE STUDY

This study is not without some possible limitations. The researcher interviewed a purposive sample of caregivers living and caring for adolescents who abuse drugs in six selected rehabilitation institutions in Sol Plaatjie municipal area, therefore, these findings may not reflect the experiences of caregivers whose children are addicted to other substances in other rehabilitation institutions. As with all research on subjective experiences, recall bias was also possible. The study was conducted on a small scale therefore findings could not be generalized because it is qualitative in nature. Perhaps knowing the age of the adolescent and interviewing the affected adolescents could also have provided more insight. Additionally, this is a descriptive qualitative study, so the researcher cannot say if the caregivers' experiences in the study resembles those of people with similar problems residing in the Northern Cape or other social and economic groups in the Province. However, the study provides useful insight into the lived experience of caregivers whose adolescents are abusing drugs within the Northern Cape Province.

The researcher faced constraints regarding the scheduling of appointments with the prospective candidates from the private rehabilitation institution in Sol Plaatjie municipal area because access was denied due the confidentiality and policy aspects of the identified institution as advised by their management.

Another limitation that the researcher noted was anxiety; participants were anxious initially but relaxed as the interviews proceeded. The audio recording also added to the participants’ anxiety during interviews. The limitation of lack of sufficient time was addressed by means of prolonged engagement to accommodate the participants’ busy schedules.

6.5 RECOMMENDATIONS FROM DATA

Identifying and responding to the psychosocial needs of caregivers affected by drug-abusing adolescents cannot be overemphasised. Based on the study findings, the following recommendations were made:

6.5.1 Policy reforms in the Department of Health and Social Development

i. Efforts should be directed towards developing more formal methods to provide self-care skills for families and caregivers of adolescents and those at risk of drug addiction. This could be achieved by equipping caregivers and parents with the appropriate skills to identify drug use in their children and how to respond to their children's needs at an early stage of developing this societal problem. These caregivers reveal that many of the services that became involved with their adolescents were not effectively accessible and that they felt that professionals did not seem to show resilience or will in assisting them in dealing with adolescent substance dependency

ii. It would, therefore, be valuable to see how professionals who work with this population start to realise the importance of supporting the caregivers of these adolescents.

iii. There is a need for individual psychotherapy with a cognitive behavioural perspective in light of the feelings, thoughts, opinions, and ideas that the participants shared with these researchers. A review of the comments made across all of the identified themes in this study indicates that feelings of hopelessness and anxiety,

iv. Caregivers need to be involved in family therapy with the identified patient, an adolescent with substance abuse problems, and the rest of the family. This can also include the involvement of extended family. The focus should be on understanding the effects of the identified patient problems in the family system, including the effects on every family member's role, and the anger, disinterest, and disappointment held by individual family members, and faulty communication patterns.

6.5.2 Nursing education and practice

There is a need to incorporate the role of professional nurses in identifying, assessing, and treating substance abuse disorders and other ailments in the communities in the nursing education curriculum across the country. The researcher believes that professional nurses need to continue to examine both the "micro" and "macro" aspects of substance abuse within the context of ethnicity, race, poverty, class, political disenfranchisement, unemployment, and the family.

Healthcare providers must be equipped with knowledge of substance abuse in a holistic approach where special support must be given to caregivers. This must be applied in all nursing care processes.

6.5.3 Recommendation for further research

i. Further research should explore the pre-substance-using period to better understand what leads adolescents toward dependence
ii. The other area for exploration is whether the lived experiences of caregivers may vary according to which strategies become the preferred choice for caregivers. There is a need for a multifaceted approach to the support that needs to be given to caregivers, and this calls for policy reform.
iii. A methodologic – quantitative study will cover more people and a larger area

of caregiving and parenting an adolescent with drug and/ or alcohol problems. As noted in this study, there is a need for both quantitative and qualitative studies on caregivers who have adolescents with substance abuse problems. Quantitative studies should focus on patterns of coping and resilience among large groups of caregivers and employ empirically-based instruments that tap into problems such as depression, hopelessness, and anxiety. In contrast, qualitative studies should focus on the "feelings" and "emotions "of the individual experience.

6.6 CONCLUSION

This research study extends the work on the caregivers' experiences living with adolescents who abuse drugs carried out by other researchers. This research has proven that whilst there is limited research about the caregiver's experiences of living with adolescents who abuse drugs, there are also unique issues and similar experiences by caregivers, and this requires attention from relevant authorities. Parents and caregivers need support to see emerging drug abuse in their adolescents and how they might effectively respond to this scourge before it gets out of hand. Caregivers also need support in helping the other children in the family to timeously control, prevent and manage this societal problem The findings showed that parents with an adolescent who abuses substances faced a number of challenges, as evidenced from their shared experiences.

The results displayed that there was poor social support and professional for those individuals; however, there was no doubt that social support is highly valued by the parents and caregivers. Participants displayed signs of stress and strain and employed various coping strategies to try to respond to their situation. There was strong evidence of emotionally burdened experiences by the parents and caregivers because of their adolescent abusing substances. This emphasises the need for further research to be conducted in developing a model for the facilitation of the parents and caregiver’s mental health. It is evident from their nature of challenges and difficulties experienced that these parents need external interventions to facilitate their mental health.

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APPENDIX A: ETHICS

A1: IREC CONDITIONAL ETHICS CLEARANCE

Institutional Research Ethics Committee
Research and Postgraduate Support Directorate
2nd Floor, Berwyn Court
Gate 1, Steve Biko Campus
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2375
Email: lavishad@dut.ac.za
http://www.dut.ac.za/research/institutional_research_ethics

APPENDIX A1 –IREC ETTHICS CONDITIONAL APPROVAL

14 February 2023

Mrs N P Ditshetelo
P.O. Box 2072
Kutuman
8460

Dear Mrs Ditshetelo

Caregivers' experiences of living with adolescents who abuse drugs in Sol Plaatjie Municipal Area in the Northern Cape Province

I am pleased to inform you that **PROVISIONAL APPROVAL** has been granted to your proposal subject to:

- Obtaining and submitting the necessary gatekeeper permission/s to DUT-Institutional Research Ethics Committee (DUT-IREC).

PLEASE NOTE THAT THIS IS NOT A FINAL APPROVAL LETTER. KINDLY SUBMIT THE ABOVE MENTIONED DOCUMENTS WITHIN THREE MONTHS TO THE DUT-IREC OFFICE. DATA COLLECTION CAN ONLY COMMENCE WHEN DUT-IREC ISSUES FULL APPROVAL

The Proposal has been allocated the following Ethical Clearance number **IREC 306/22**. Please use this number in all communication with this office.

Approval has been granted for a period of **ONE YEAR**, before the expiry of which you are required to apply for safety monitoring and annual recertification. Please use the Safety Monitoring and Annual Recertification Report form which can be found in the Standard Operating Procedures [SOP's] of the DUT-IREC. This form must be submitted to the DUT-IREC at least 3 months before the ethics approval for the study expires.

Yours Sincerely

Prof J K Adam
Chairperson: DUT-IREC

A2: IREC FINAL ETHICS APPROVAL

Gate 1, Steve Biko Campus
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2375
Email: lavishad@dut.ac.za
http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

APPENDIX A2- IREC FINAL ETHICS APPROVAL

23 March 2023

Mrs N P Ditshetelo
P.O. Box 2072
Kutuman
8460

Dear Mrs Ditshetelo

Caregivers' experiences of living with adolescents who abuse drugs in Sol Plaatjie Municipal Area in the Northern Cape Province
Ethical Clearance number IREC 306/22

The DUT-Institutional Research Ethics Committee acknowledges receipt of your gatekeeper permission letters.

Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the DUT-IREC according to the DUT-IREC Standard Operating Procedures (SOP's).

Please note that any deviations from the approved proposal require the approval of the DUT-IREC as outlined in the DUT-IREC SOP's.

It is compulsory for a student or researcher to apply for recertification on an annual basis. The failure to do so will result in withdrawal of ethics clearance. It is the responsibility of the researcher and the supervisor to apply for recertification.

Please note that you are required to submit a Notification of Completion of Study form together with an abstract to the DUT-IREC office on completion of your study.

Yours Sincerely

Prof J K Adam
Chairperson: DUT-IREC

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fairness · professionalism · commitment · compassion · excellence

APPENDIX B: PERMISSION LETTERS

B1: PERMISSION LETTER – DOH

DEPARTMENT OF HEALTH
LEFAPHA LA BOPHELO BO BOTLE
DEPARTEMENT VAN GESONDHEID
ISEBE LEZEMPILO

OFFICE OF THE HOD
Executive Offices
Northern Cape Department of Health
Private Bag X5049
KIMBERLEY, 8300
Tel: 053 830 2134
Email: BMashute@ncpg.gov.za

APPENDIX B1- DoH PERMISSION LETTER

Enquiries: / Imibuzo: / Navrae: Mr. B Ngatwe

Date: / Leshupelo: / Umhla: / Datum: 27 February 2023

Reference: / Tshupelo: / Isalathiso: / Verwysing: NC_202302_004

Mrs. Nomonde Ditshetelo
PO Box 2072
Main Street Kuruman
8460

Title: Caregivers Experiences of living with an adolescent who abuses drugs.

Dear Mrs. Ditshetelo

The application requesting permission to conduct the above-mentioned research study was received and reviewed by the Northern Cape Department of Health.

Decision: Permission is granted to conduct this research project at the Northern Cape New Mental Hospital and Sinothemba Home of Orphans as indicated in the research proposal, in the Northern Cape Province.

The reference number for this research project is NC_202302_004, and please use this reference with all your communication with the Research Coordinator.

Please note the following:

1. This approval is valid for a period of one year from the date of approval.
2. Should this research study need a period more than one year, the researcher must annually submit the progress report to the department and request extension.
3. The researcher is requested to make all the necessary arrangement with each facility/institution CEO/manager prior visiting the facility/institution, so that the provision of healthcare services is not affected by this research project.

Please note the following conditions:

1. This research project must be conducted at no cost to the Northern Cape Department of Health.
2. The approval is limited to the research proposal as submitted on the application.
3. There must be no modification or amendments on the research project.
4. The Research Unit may monitor this research project at any time.
5. At the completion of this research project, a copy of the final report must be submitted to the Research Unit.
6. The Northern Cape Department of Health Senior Management must be briefed on the outcome of the study prior publishing.

Mr. Riaan Strydom
Acting Head of Department
Northern Cape Province
Department of Health

Date

B2: PERMISSION LETTER – DSD

social development

Department:
Social Development
NORTHERN CAPE
REPUBLIC OF SOUTH AFRICA

Private Bag X 5042, KIMBERLEY, 8301. Latlhi Mabilo Complex, Barkly Road, KIMBERLEY
Tel (053) 874 9100, Fax (053) 871 3611

APPENDIX B2 –DsD PERMISSION LETTER

Enquiries : Ms M Kivedo
Dipatlisiso
Navrae
Imibuzo

Date
Letlha : 23 February 2023
Datum
Umhla

Reference
Tshupelo
Verwysings
Isalathiso : L.3.1.12

Monde Ditshetelo
monde.ditshetelo@gmail.com

PERMISSION TO CONDUCT A RESEARCH STUDY

Permission is hereby granted from the Northern Cape Department of Social Development that the research on:" **Caregivers experiences of living with adolescents who abuse drugs in Sol Plaatjie Municipal Area in the Northern Cape Province"**can be conducted and that the Managers at Lerato Place of safety, Northern Cape Substance abuse Treatment Centre and Thlokomelo Office can be contacted to provide the names and contact details of the caregivers of adolescents who received services, if relevant. I am proposing that you first meet with the managers of Lerato and the Treatment Centre to check the relevance of their involvement because the field social workers are the case managers.

The following condition should be adhered to by the social workers involved : **That they first contact the caregivers of the adolescents to obtain their permission to share their particulars with the researcher because of the POPIA Act and the fact that this is a very sensitive matter.**

Attached please find the contact details of the Managers at the mentioned centres and offices:

- ✓ Lerato Place of Safety: Ms Shiela Mothobi: 082 856 1764 email smothobi@ncpg.gov.za
- ✓ Northern Cape Substance abuse Treatment Centre: Ms R . Snyders:
- ✓ 076 440 9997. email esnyders@ncpg.gov.za
- ✓ Thlokomelo Office Ms T Mbetane:060 9787981 email:mbetanethembeka@gmail.com

1

Building a Caring Society. Together.
A Caring and Self-reliant Society.

It will be appreciated if the research findings could be made available to the Department to improve service Delivery.

Best Wishes with your studies.

The Researcher to Comply with Popia Regulation as per guidelines from Legal services!

……………………………

Ms S. Wookey
Acting Head of Department

B3: PERMISSION LETTERS – NEW MENTAL HEALTH HOSPITAL

1

OFFICE OF THE CHIEF EXECUTIVE OFFICER
SPECIALIZED HOSPITAL
MDR TB AND MENTAL HEALTH SERVICES
PRIVATE BAG X 6086
KIMBERLEY
8300
Tel: 053 802 3601/2/3
Fax: 053 861 2873
Cell: 071 323 6781
Email: alinks@ncpg.gov.za

...ION LETTER

TO:	Ms. Nomonde Ditshetelo Masters in Nursing Student
FROM:	Mr A Links CEO-Specialized Hospital Mental Health & DRTB
DATE:	14 March 2023
RE:	**RESPONSE PERTAINING REQUEST ON PERMISSION TO CONDUCT RESEARCH AT THE SPECIALISED HOSPITAL (MENTAL HEALTH & DRTB)**

Dear Madam,

Please be advised that you request is duly approved.

You reminded and requested to conform to the terms and conditions as approved by the Northern Cape Head of Department, Mr. R. Strydom.

I wish you success with your studies.

Yours faithfully,

Mr. A. LINKS
CEO-SPECIALISED HOSPITAL
MENTAL HEALTH AND DRTB

B4: PERMISSION LETTERS – LERATO PLACE OF SAFETY PERMISSION LETTER

APPENDIX B4 – LERATO PLACE OF SAFETY PERMISSION LETTER

Lorato Place of Safety, Ethel Street Galeshewe.
Tel (053) 833 1051

Enquiries :
Dipatlisiso : S. K Mothobi
Navrae :
Imibuzo:

Date :
Letlha :
Datum: 15/03/ 2023
Umhia :

Reference:
Tshupelo :
Verwysings :
Isalathiso :

Attention: Monde Ditshetelo

RE: Subject – Permission granted for Data Collection

The following serves to inform you that permission is granted to collect data at the institution.

Hope the above is in order.

S.K Mothobi
Institutional manager
LPOS

Building a Caring Society.Together.

B5: PERMISSION LETTERS – MOLEFE MAMPE SCC PERMISSION LETTER

APPENDIX B5 – MOLEFE MAMPE SCC PERMISSION LETTER

Private Bag X 5042, KIMBERLEY Mathanzima Street, KIMBERLEY
Tel (053) 872 4000/ 872 4030, Fax (053) 831 1457
e-mail: mmndadza.kbycourt@.gmail.com

EXTERNAL MEMO

TO:	Researcher (Nomonde Ditshetelo)	FROM:	Mr. M.M Ndadza (Acting Institutional Manager: MMSCC)
CC:	Acting District Director (Frances Baard) Corp/Fin Manager (Frances Baard) Labour Relations Division (Provincial Office)		
DATE:	20 March 2023	FILE NR:	

SUBJECT: PERMISSION TO CONDUCT RESEARCH (MMSCC).

This letter confirms the engagement that the undersigned had with the prospective researcher who asked for the permission from the Acting Head of Department of Social Development for planned interview schedules with the Centres Child and Youth Care Workers/Guardians. As the Acting Head of Department has already given permission to the above mentioned researcher; the Centre Management was consulted and also agree that the researcher may schedule appointments with the Child and Youth Care Workers/Guardians and continue with the study as she has planned. The permission to conduct the research is given provided that the researcher follows all the research ethics and also adheres to the conditions outlined by the Acting Head of Department.

Hope you find the above in order.

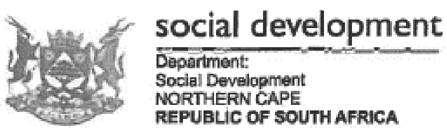
Yours faithfully

....

Mr. Matome Mishack Ndadza

(Acting Institutional Manager: MMSCC)

B6: PERMISSION LETTERS – TLHOKOMELEO PERMISSION LETTER



APPENDIX B6 – TLHOKOMELEO PERMISSION LETTER

Private Bag x 5042
Kimberley
8300
Tel 053 - 872 4000/060 978 7981

Email:TMbetane@ncpg.gov.za

Enquiries: Ms Thembeka Mbetane **Date:** 15 March 2023

Attention: Ms Nomonde Ditshetelo

RE: Permission to Conduct Research Study in Frances Baard (Tlhokomelo Satellite Office)

This letter serves to confirm that your request for permission to conduct research study in the above- mentioned office with the title: **Caregivers experiences of living with adolescents who abuse drugs in Sol Plaatjie Municipality Area in the Northern Cape Province** is granted.

We look forward to seeing you at our offices.

Kind regards

T. Mbetane

Ms T. Mbetane

Social Work Manager

Date: 16/03/2023

B7: PERMISSION LETTERS – AGAPE EC PERMISSION

APPENDIX B7 – AGAPE EC PERMISSION

17 Camp Road
Strandfontein
N.P.O # 157-308

Tel: 081 469 5735
Cell: 081 488 2510
Email:agapefamilylife@webmail.co.za

12.03.2023

Good day Nomonde

This letter is to confirm permission to interview our caregivers at Agape Family Life Centre.

Kind regards

Archibold Seema

Centre Manager

APPENDIX C: PARTICIPANTS INFORMATION LETTERS

C1: PARTICIPANTS INFORMATION LETTERS -ENGLISH

LETTER OF INFORMATION

Title of the Research Study: Caregivers experiences of living with adolescents who abuse drugs in Sol Plaatjie Municipal Area in the Northern Cape Province.

Principal Investigator/s/researcher: Dr DG. Sokhela D Nursing

Co-Investigator/s/supervisor/s: Dr L Hillerman PhD

Brief Introduction and Purpose of the Study: Drug abuse by adolescents especially in schools, is a worldwide societal problem and in this area as well. , which pose a problem for caregivers. The researcher observed that during her employment in the NGOs these caregivers do not receive effective and necessary support from family or at health facilities and these motivated her to conduct a study on this problem. The purpose of this study is to explore and describe the caregiver's experiences of living with an adolescent who is abusing drugs and receiving care in the selected drug rehabilitation institutions of Sol Plaatjie municipal area.

Greeting: Good morning, thank you for considering participating in this study.

Introduce yourself to the participant I am a student at DUT doing research for my Master's Degree in Nursing.

Invitation to the potential participant: I would like to invite you to participate in the research.

What is Research? Research is a systematic search or enquiry for generalized new knowledge.

Outline of the Procedures: Once you have read this letter I will conduct interviews whereby I will take you to a quiet room where we are going to talk more about your experiences of caring for an adolescent who abuses drugs. The interview will last form 20 mins to 45minutes. May I ask your permission to audio record the interview so that I capture everything that we discuss?

Risks or Discomforts to the Participant: No risk is expected from the interviews. However, there may be discomfort when answering during the interview and you become emotional because of your experiences. I am a professional nurse who counsel you to a certain extent. If required I will refer you to the social worker or counsellor in the institution.

Explain to the participant the reasons he/she may be withdraw from the Study: You have the right to decline from participating in the study. Furthermore, you can withdraw from the study at any stage of the interview for any reason and this will not compromise you in any way.

Benefits: You may benefit from the study in that it may influence health care policy reform, to develop policies to assist you and health care workers in dealing with

adolescents who abuse drugs. During data collection, you will find an outlet to talk about your experiences to a neutral person who will be interested in listening to you thus helping you psychologically.

Remuneration: Your participation in the study is voluntary, there is going to be no compensation or payment for participating.

Costs of the Study: There will be no cost for participating in the study as I will meet with you on the day that you are due to come to the facility.

Confidentiality: Your name and contact details will not appear in any research document and all information obtained from the interview will not be shared with any person except my supervisor and the co-supervisor. Your name will not be sued during reporting and dissemination of findings. No one will be allowed access to the office where the interviews will be held.

Results: Findings of the study will be reported to all gatekeepers of institutions from where data was collected, this is where you will hear about the findings.

Research-related Injury: No research related injury is expected since I will only conduct interviews.

Storage of all electronic and hard copies including tape recordings Records and all documents used in this study will be kept safely and under lock and key for a period of five years. They will thereafter be destroyed by shredding and burning. The researcher will be the only person who will have access to the research documents and data collected.

Persons to contact in the Event of Any Problems or Queries: Dr D. Sokhela at 031 373 2292 e mail dudus@dut.ac.za Please contact the researcher Nomonde Ditshetelo

0822320183.email-monde.ditshetelo@gmail.com or the Institutional Research Ethics Administrator on 031 373 2375. Complaints can be reported to the Acting Director: Research and Postgraduate Support .

C2: PARTICIPANTS INFORMATION LETTERS - AFRIKAANS

INLIGTINGS BRIEF

Titel van die Navorsingstudie: Versorgers se ervarings van die lewe met adolessente wat dwelms in Sol Plaatjie Munisipale Area in die Noord-Kaap misbruik.

Hoofondersoeker/Toesighouer/s: Dr. D.G.Sokhela. Verpleegdis

Mede-ondersoeker/s/toesighouer/s: Dr L Hillerman D Verpleegsdiens

Kort inleiding en doel van die studie: Dwelmmisbruik deur adolessente veral in skole, is 'n wêreldwye maatskaplike probleem en ook op hierdie gebied., wat 'n probleem vir versorgers inhou. Die navorser het opgemerk dat hierdie versorgers tydens haar diens in die NRO's nie effektiewe en nodige ondersteuning van familie of by gesondheidsfasiliteite ontvang nie, en dit het haar gemotiveer om 'n studie oor hierdie probleem te doen. Die doel van hierdie studie is om die versorger se ervarings van die lewe met 'n adolessent wat dwelms misbruik en sorg ontvang in die geselekteerde dwelmrehabilitasie-instellings van Sol Plaatjie munisipale gebied, te ondersoek en te beskryf.

Groetnis: Goeiemôre, dankie dat jy dit oorweeg om aan hierdie studie deel te neem.

Stel jouself voor aan die deelnemer: Ek is 'n student aan DUT wat navorsing doen vir my meestersgraad in verpleegkunde.

Uitnodiging aan die potensiële deelnemer: Ek nooi u graag uit om aan die navorsing deel te neem.

Wat is **navorsing**? Navorsing is 'n sistematiese soektog of ondersoek na allemande nuwe kennis.

Uiteensetting van die prosedures: Sodra u hierdie brief gelees het, sal ek onderhoude voer waardeur ek u na 'n stil kamer sal neem waar ons meer gaan praat oor u ervarings met die versorging van 'n adolessent wat dwelms misbruik. Die onderhoud sal 20-minute tot 45 minute duur. Mag ek u toestemming vra om die onderhoud op te neem sodat ek alles vaslê wat ons bespreek?

Risiko's of ongemak vir die deelnemer: Geen risiko word van die onderhoude verwag nie. Daar kan egter ongemak wees wanneer jy tydens die onderhoud antwoord en jy word emosioneel as gevolg van jou ervarings. Ek is 'n professionele verpleegster wat jou tot 'n sekere mate raad gee. Indien nodig sal ek u na die maatskaplike wreaker of berader in die inrigting verwys.

Virdauielik aan die deelnemer die redes waarom hy/sy aan die Studie onttrek kan word: Jy /het die reg om te weier om aan die studie deel te neem. Verder kan u om enige rede aan die studie onttrek op enige stadium van die onderhoud, en dit sal u op geen manier in die gedrang bring nie.

Voordele: U kan baat vind by die studie deurdat dit hervorming van gesondheidsorgbeleid kan beïnvloed, om beleid te ontwikkel om u en gesondheidswerkers te help met die hantering van adolessente wat dwelms misbruik. Tydens data-insameling sal u 'n

uitlaatklep vind om oor u ervarings te praat met 'n neutrale persoon wat belangstel om na u te luister en u sielkundig te help**.**

Vergoeding: Jou deelname aan die studie is vrywillig, daar gaan geen vergoeding of betaling vir deelname wees nie.

Koste van die studie: Daar sal geen koste wees om aan die studie deel te neem nie, aangesien ek met u sal vergader op die dag waarop u na die fasiliteit moet kom.

Vertroulikheid: Jou naam en kontakbesonderhede sal nie in enige navorsingsdokument verskyn nie en alle inligting wat uit die onderhoud verkry is, sal nie met enige persoon behalwe my toesighouer en die medetoesighouer gedeel word nie. U naam sal nie gedagvaar word tydens die rapportering en verspreiding van bevindings nie. Niemand sal toegang kry tot die kantoor waar die onderhoude gehou sal word nie.

Resultate: Bevindinge van die studie sal gerapporteer word aan alle hekwagters van instellings van waar data ingesamel is, dit is waar jy van die bevindinge sal hoor.

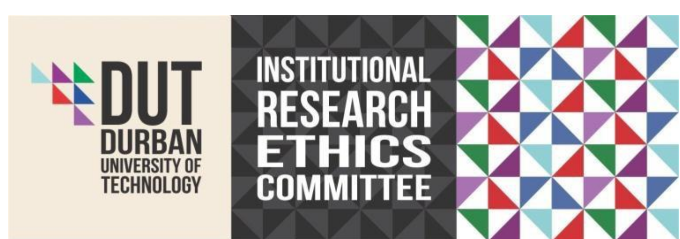
Navorsingsverwante besering: Geen navorsingsverwante beserings word verwag nie, aangesien ek slegs onderhoude sal voer.

Berging van alle elektroniese en harde kopieë, insluitend bandopnames Rekords en alle dokumente wat in hierdie studie gebruik word, sal vir 'n tydperk van vyf jaar veilig en onder slot en grendel gehou word. Hulle sal daarna vernietig word deur versnippering en brand. Die navorser sal die enigste persoon wees wat toegang sal hê tot die navorsingsdokument en data wat ingesamel is.

Persone om te kontak in geval van enige probleme of navrae: Dr. D. Sokhela by 031 373 2292 e-pos dudus@dut.ac.za Kontak asseblief die navorser Nomonde Ditshetelo 0822320183.email-monde.ditshetelo@gmail.com of die Institusionele

Navorsingsetiekadministrateur by 031 373 2375. Klagtes kan by die Waarnemende Direkteur: Navorsing en Nagraadse Ondersteuning, aangemeld word oor TtiDirector@dut.ac.za

C3: PARTICIPANTS INFORMATION LETTERS - SETSWANA



LOKWALO LWA KITSISO

Thitokgang ya Thuto Patlisiso: Go Tlhotlhomisa Maitemogelo a Batlhokomeli ba tshelang le Basha ba dirisang dithethefatsi botlhashwa mo ditikwatikweng tsa tshiamiso ya pholo mo mafelong a mo masepaleng wa Sol Plaatjie mo Kapa Bokone.

Motlhotlhomise/Mookameli o Mogolo: Ngaka. D.G. Sokhela. Ngaka ya dithuto tsa booki.

Motlhotlhomisi mmogo: Dr.L. Snell –Hillerman. – Ngaka ya dithuto tsa booki.

Tumedisho: Madume go motsaakarolo yo o Rategang

Ke moithuti wa dithuto tse dikgolo tsa Masters in Health Sciences ko Yunibesiting ya tekonoloji ya Durban jaanong ke tlile go dira thuto tshekatsheko. Dintlhakgolo tsa thuto tshekatsheko e, ke tse di lateng.

Taletso: Ka boikokobetso ke go laletsa go tsaya karolo mo thutong e elatelang.

Thuto tshekatsheko ke eng? Thuto tshekatsheko kgotsa tlhotlhomiso ke mokgwa oo tsepamisitsweng wa go tlhothlomisa dithuto ka mokgwa oo tseneletseng gore re kgone go iponela dipholo tsa boamaruri. Go tsaya karolo gagago ga se go ya ka kgatelelo, o letlelesegile go ka gana kgotsa go dumalane go nna motsaakarolo. O letlelesegile gape

go botsa dipotso mabapi le thuto e gore o tle o kgone go tlhaloganya sentle pele o ka tsaya karolo.

Ntlha khutswe ya tshekatshekong e: Tiriso ee botlhashwa ya dithethefatsi ke basha bogolo jang mo dikolong ke tlhoka boroko mo bathong ba rona lefatshe ka bophara le mo tikologong e e bile e imetsa le go utlwisa batlhokomedi botlhoko thata.Mosekaseki o itemogetse mathata a gore batlhokomedi ba basha ba ba nang le mathata a tiriso e botlhashwa ya dithethefatsi ga ba bone tlhokomela le keletlhoko e e tsepameng go tswa go ba losika le badiredi ba tsa pholo.Se, se ile sa rotloetsa mosekasiki go tsweletsa dithuto tsa bosikasiki mo morerong ka nako ya fa a ne a dira mo ditheong tse eseng tsa pusho (NGOs). Maikaelelo a thuto e ke go seka seka ditlamorago tsa tiriso e e botlhashwa ya basha mo batlhokomeding ba bona mo masepaleng wa Sol Plaatjie mo Kapa Bokone.

Thuto tlhaloso le tsamaiso ya thuto e.: Morago ga go bala lokwalo lo.ke tla ya le we ne go senang modumo mo go yona e bile e bolokesegilea mo kantorong e kgethegileng, ga go ope yo o tla letlelelwang go tsena mo teng.Ke gona foo ke tla tswelelang ka puisano ya rona mabapi le maitemogelo a gago a go tlhokomela gape o dula le mosha yo o dirisang dithethefatsi botlhashwa.. Puisano e e tla tsaya metsots e ka nna 20 go ya go e 45. An o ka b mpha tetla ya go dirisa segatisa mentswe go rekota puisano e?

Matshosetsi kgotsa dikgoreletsi: Ga gona sekgorekletsi sepe kgotsa kotsi epe e e lebaganeng le dithuto ntlhotlhomiso tse.

Moshola: Di pholo tsa tlhotlhomiso e di tla nna le moshola mo lefapheng la pholo ga mmogo le badiredi ba loago le pholo ka gonne di tla ba rotloetsa go tokafatsa mokgwa wa go neelana ka ditirelo mo bathong Baitse dikwalo ba tsa pholo ba tla rotloetsega go fetola merero ya dipolisi go tokafatsa tsamaiso le dititrelo mo bathihong.Ka nako ya dithlotlhomiso batlhokomedi ba tla itemogela sebaka sa go go ka bua maikutlo a bona ba phuthulugile e bile ba iponela tshegetso e e kgethegileng le go tsepamisa kagoloago le maikutlo a bona.

Kotsi kgotsa go sa nnisege: Ga gona kotsi e pe e o tla itemogelang yona mo thutong. O tla dula o babalesegile**.**

Go ikgogela morago mo thutong e: O kgona go ikgogela morago nako e ngwe le engwe e o ikutlwang o sa babalesega kgotsa o sa ikutlwe monate kgotsa o ikutlwa e ka re ga o a sireletsega. Itse gape gore motlhotlhomise le ene a ka tsaya tshwetso ya go khutlisa tshekatsheko e fa maemo a sa babalesega.

Tuelo: Ga gona tuelo epe ya madi e o tla iponelang yona ka go tsaya karolo mo thutong ntle le moshola o o umakilweng ko godimo.

Dipholo tsa tlhotlhomiso e: Dipholo le tokomane ya thuto e di tla abelwana le lefapha la pholo e bile gape di tla phatlhaladiwa mo di koranteng tsa dithuto lefatshe ka bophara.

Khupamarama: Dithuto tse di tla nna khupamarama e e etsiweng ke motlhotlhomisi le wena fela. Ditlhothlomiso di tla direlwa mo sephiring e bile leina la gago ga le kitla le kwalwa gope .Se se akaretsa kitso e ngwe le ngwe ka ga gago le eseng dinomoro tsa mogala.

Dikotsi tsa thuto e: Ga gona kotsi epe e e sholofetsweng mme fa e ka nna gona ka mokgwa mongwe o tshwanetse wa repota tiragalo e ka mokwalo ko go motlhotlhomisi le motlhotlhomisi Mogolo.

Poloko ya mafatlhtlha le dikwalo le dirokoto tse di dirisitsweng mo thutong e; Mafatlhatlha otlhe a a dirisitsweng mo tlhotlhomisong e go akaretsa le dirokoto le kitso le dikwalo tsotlhe di tla bolokwa mo kantorong e e kgethegileng e bile e dula e lotletswe ka nako tshotlhe morago sengwe le sengwe se fisiwe.

Dipotso, dingongorego kgotsa tlhaloso go ya pele di ka lebisiswa go :

Motlhotlhomisi r- Nomonde Ditshetelo at 0822320183.email-monde.ditshetelo@gmail.com or my Mokaedi Dr Sokhela at 031 3732292 e/mail: dudus@dut.ac.za **Kgotsa**, Institutional Research Ethics Administrator on 031 373 2375. Complaints can be reported to the Acting Director: Research and Postgraduate Support .To: Director@dut.ac.za

C4: PARTICIPANTS INFORMATION LETTERS - ISIXHOSA

ILETA YOLWAZI

Isihloko sophononongo loPhando: Ukuphononongа amava abaNonophelo abaHlala noBantwana abafikisayo abasebenzisa kakubi iziyobisi kwiziko elikhethiweyo lokubuyisela kwisimo sangaphambili kummandla kamasipala weSol Plaatjie.

Umphandi oyiNqununu/uMphathi: uGqr. D.G. Sokhela. D.Phil. uMlungelelanisi woLuleko

Umphandi/s uGqr.L. Snell -Hillerman. D. Phil uMlungelelanisi woLuleko

Intshayelelo emfutshane kunye nenjongo yolu phando

Ukusetyenziswa kakubi kweziyobisi ngabantu abafikisayo ingakumbi ezikolweni, yingxaki yoluntu yehlabathi nakulo mmandla., nto leyo ebangela ingxaki kwabo babanyamekelayo.

Umphandi uye waqaphela ukuba ngexesha lokuqeshwa kwakhe kwii-NGOs aba bakhathaleli abafumani nkxaso isebenzayo neyimfuneko kusapho okanye kumaziko ezempilo kwaye oku kwamkhuthaza ukuba. Injongo yolu phononongo kukuphononongа nokuchaza amava omkhathaleli wokuhlala nomntwana ofikisayo osebenzisa kakubi iziyobisi kwaye afumane ukhathalelo kumaziko akhethiweyo okubuyisela kwisimo sesiqhelo seziyobisi.

Umbuliso: Molo Mthathi-nxaxheba othandekayo Enkosi ngokuthatha inxaxheba kolu phononongo.

Zazise kuMthathi-nxaxheba Ndingumfundi e-DUT ndenza uphando nge-Master's Degree in Nursing.

Isimemo kumntu onokuba ngumthathi-nxaxheba: Ndingathanda ukukumema ukuba uthathe inxaxheba kuphando.

Yintoni uphando? Uphando luphando olucwangcisiweyo okanye uphando lolwazi olutsha ngokubanzi.

Ulwandlalo lweeNkqubo: Nje ukuba uyifundile le leta ndiya kuqhuba udliwano-ndlebe apho ndiya kukusa kwigumbi elizolileyo apho siza kuthetha ngakumbi ngamava akho okunyamekela i-ado osebenzisa kakubi iziyobisi. Udliwano-ndlebe luya kuhlala kwimizuzu engama-20 ukuya kwimizuzu engama-45. Ndingacela imvume yakho yokurekhoda udliwanondlebe ukuze ndibambe yonke into esiyixoxayo?

Imingcipheko okanye ukungonwabi kuMthathi-nxaxheba: Akukho mngcipheko ulindelekileyo udliwano-ndlebe. Nangona kunjalo, kunokubakho ukungakhululeki xa uphendula ngexesha lodliwano-ndlebe kwaye ube neemvakalelo ngenxa yamava akho

Imingcipheko okanye ukungonwabi kuMthathi-nxaxheba: Akusayi kubakho mngcipheko okanye ukungakhululeki kuwe. Ndingumongikazi oqeqeshiweyo okucebisayo ukusa kumlinganiselo othile. Ukuba kuyimfuneko ndiyakuthumela kunontlalontle okanye umcebisi kwiziko elo.

Chazela umthathi-nxaxheba ngezizathu zokuba arhoxe kuPhononongo: Unelungelo lokwala ekuthatheni inxaxheba kuphononongo. Ngaphaya koko, unokurhoxa kuphononongo ngalo naliphi na inqanaba lodliwano-ndlebe nangasiphi na isizathu kwaye oku akusayi kukubeka esichengeni nangayiphi na indlela.

Izibonelelo: Unokuxhamla kuphononongo kuba lunokuba nefuthe kuhlaziyo lomgaqo-nkqubo wokhathalelo lwempilo, ukuphuhlisa imigaqo-nkqubo yokunceda wena kunye nabasebenzi bezempilo ekujonganeni nolutsha olusebenzisa kakubi iziyobisi. Ngexesha lokuqokelela idatha, uya kufumana i-outlet yokuthetha ngamava akho kumntu ongathathi hlangothi oya kuba nomdla wokukuphulaphula ngaloo ndlela akuncede ngokwasengqondweni.

Umvuzo: Ukuthatha kwakho inxaxheba kuphononongo kungokuzithandela, akusayi kubakho mbuyekezo okanye intlawulo ngokuthatha inxaxheba.

Imingcipheko okanye ukungonwabi kuMthathi-nxaxheba: Akukho mngcipheko obandakanyekayo kolu phononongo kwaye umphandi uya kuhlala ehlonipha ukhetho lwabathathi-nxaxheba kunye nelungelo lokuthatha inxaxheba okanye hayi.

Izizathu zokuba arhoxe kuPhononongo: Ukuba uphando lunokupheliswa kwangoko kwiimeko ezithile ezifana nokungahambelani neemfuno zokuziphatha okanye nayiphi na imeko esongelayo, ukugula okanye ukusabela okubi, njl. Umthathi-nxaxheba unelungelo lokurhoxa ukufunda ngalo naliphi na ixesha ukuba banqwenela ukwenjenjalo yaye basaza kuqhubeka abafumani umgangatho ofanelekileyo wokhathalelo; Ukuba umphandi, phantsi kweemeko ezithile, athathe isigqibo sokurhoxisa umthathi-nxaxheba kuphononongo; Kwiimeko apho abathathi-nxaxheba bakhetha okanye banqumamisa ukuthatha inxaxheba kwakhe abathathi-nxaxheba kufuneka benze ngokubhaliweyo kwaye bazise umphathi.

Ukwenzakala okunxulumene noPhando: Ukuba kukho Ukwenzakala okunxulumene nophando okanye ukusabela kakubi uyacetyiswa ukuba axels ngoko nangoko kumphandi kunye nomphathi ngokubhaliweyo. Lo mba uya kuqwalaselwa ngokweenkqubo zangaphakathi zeYunivesithi.

Umvuzo: Ukuthatha inxaxheba kolu phononongo kungokuzithandela kwaye akukho mvuzo uya kufunyanwa ngokuthatha inxaxheba.

Iindleko zeSifundo: Akuyi kubakho ndleko yokuthatha inxaxheba kuphononongo njengoko ndiya kudibana nawe ngemini ofanele ukuza kweso sibonelelo.

Ubumfihlo: Igama lakho kunye neenkcukacha zoqhagamshelwano aziyi kuvela kulo naluphi na uxwebhu lophando kwaye lonke ulwazi olufunyenwe udliwano-ndlebe aluyi kwabelwana naye nawuphi na umntu ngaphandle komphathi wam kunye

Iindleko zeSifundo: Abathathi-nxaxheba abayi kuhlawula nto malunga nophononongo.

Iziphumo: Inkcazo egqityiweyo kunye neziphumo zeprojekthi. Kya kwabelwana ngokuthi**:**

Inkcazo-ntetho kwiinkomfa zasekhaya nezamazwe ngamazwe.

Ukupapashwa kwiijenali ezivunyiweyo**.**

Ubumfihlo: Igama lakho kunye neenkcukacha zoqhagamshelwano aziyi kuvela kulo naluphi na uxwebhu lophando kwaye yonke ingcaciso efunyenwe kudliwano-ndlebe ayisayi kwabelwana ngayo naye nawuphi na umntu ngaphandle komphathi wam kunye no-co-supervisor. Akukho mntu uya kuvunyelwa ukuba angene kwi-ofisi apho udliwano-ndlebe luya kubanjelwa khona. Igama lakho aliyi kugwetywa ngexesha lokunika ingxelo kunye nokusasazwa kweziphumo. Akukho mntu uya kuvunyelwa ukuba angene kwi-ofisi apho udliwano-ndlebe luya kubanjelwa khona.

Iziphumo: Iziphumo zophando ziya kuxelwa kubo bonke abagcini-masango bamaziko apho bekuqokelelwe khona idatha, kulapho uya kuva khona malunga neziphumo.

Ukugcinwa kwazo zonke iikopi ze-elektroniki kunye neekopi: Ezingamaphepha kubandakanywa neeteyiphu ezirekhodiweyo kunye nawo onke amaxwebhu asetyenziswe kolu phononongo aya kugcinwa ngokukhuselekileyo kwaye ngaphantsi kwetshixo kunye nesitshixo isithuba seminyaka emihlanu. Emva koko ziya kutshatyalaliswa ngokukrazulwa nokutshiswa. Umphandi uya kuba yedwa umntu oya kuba nokufikelela kumaxwebhu ophando kunye neenkcukacha eziqokelelweyo.

Abantu abanokuqhagamshelwana nabo xa kukho naziphi na iingxaki okanye imibuzo: UGqr Dr. Sokhela kule nombolo 031 373 2292 imeyilela dudus@dut.ac.za Nceda uqhagamshelane nomphandi uNomonde Ditshetelo 0822320183.email-monde. ditshetelo@gmai **Okanye** uMlawuli weeNdlela zokuziphatha zoPhando kwiZiko kule nombolo 031 373 2375. Izikhalazo zingaxelwa kwiBambela Mlawuli: iNkxaso yoPhando kunye nesiDanga sezidanga To: Director@dut.ac.za.

APPENDIX D: PARTICIPANTS CONSENT FORMS

D1: PARTICIPANTS CONSENT FORMS - ENGLISH

PARTICIPANT CONSENT FORM

Statement of agreement to participate in the Research Study

I hereby confirm that I have been informed by the researcher Ms Nomonde Ditshetelo about the nature, conduct, benefits and risks of this study- Research Ethics Clearance Number IREC 306/22

have also received, read and understood the above written information 9(Participants information letter) regarding the study.

- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report,

- In view of the requirements of research, I agree that that the data collected during this study can be processed in a computerised system by the researcher.
- I may at any stage, without, prejudice, withdraw my consent and participation in this study.
- I have had sufficient opportunity to ask questions and (of my own free will declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may be related to my participation will be made available to me.

____________________ __________ ______ _______________

FullNameoF of Participant **Date** **Time** **Signature / Right**

Thumbprint

I, Nomonde Patience Ditshetelo herewith confirm that the above participant has been fu informed about the nature, conduct and risks of the above study.

__________________ ___________ ____________________

Full Name of Researcher Date Signature

__________________ ___________ ____________________

Full Name of Witness (If applicable) Date Signature

__________________ __________ ___________________

Full Name of Legal Guardian (If applicable) Date Signature

D2: PARTICIPANTS CONSENT FORMS - AFRIKAANS

VRYWARINGS VORM

Verklaring van ooreenkoms om aan die navorsingstudie deel te neem. Ek bevestig hiermee dat ek deur die navorser, me Nomonde Ditshetelo, ingelig is oor die aard, gedrag, voordele en risiko's van hierdie studie- Navorsingsetiekklaringnommer : IREC306/22

• Ek het ook bogenoemde geskrewe inligting (Deelnemers inligtingsbrief) met betrekking tot die studie ontvang, gelees en verstaan.

- Ek is bewus daarvan dat die resultate van die studie, insluitend persoonlike besonderhede rakende my geslag, ouderdom, geboortedatum, voorletters en diagnose anoniem in 'n studieverslag verwerk sal word.
- In die lig van die vereistes van navorsing, stem ek saam dat die data wat tydens hierdie studie ingesamel is in n gerekenariseer stelsel deur die navorser verwerk word.
- Ek kan op enige stadium, sonder vooroordeel, my toestemming en deelname aan hierdie studie terugtrek.
- Ek het voldoende geleentheid gehad om te vrae te vra en (uit vrye wil verklaar dat ek bereid is om aan die studie deel te neem).
- Ek verstaan dat betekenisvolle nuwe bevindinge wat in die loop van hierdie navorsing ontwikkel is wat met my deelname verband hou, aan my beskikbaar gestel sal word

____________________ __________ ______ _______________

Full Name of Participant **Date** **Time** **Signature / Right**

Thumbprint

I, Nomonde Patience Ditshetelo herewith confirm that the above participant has been fu informed about the nature, conduct and risks of the above study.

________________ ___________ ________________

Full Name of Researcher **Date** **Signature**

________________ ___________ ________________

Full Name of Witness (If applicable) **Date** **Signature**

________________ ___________ ________________

Full Name of Legal Guardian (If applicable) **Date** **Signature**

D3: PARTICIPANTS CONSENT FORMS - ISXHOSA

FOMU YEMVUME

Ingxelo yesivumelwano sokuthatha inxaxheba kuPhando loPhando

Ndiyaqinisekisa ke ngoko ukuba ndazisiwe ngumphandi uma Nomonde Ditshetelo malunga nobume, ukuziphatha, iinzuzo kunye nobungozi bolu phononongo- iNombolo

yokuCoca i-Research Ethics Clearance no. IREC306/22.

• Ndikwafumene, ndafunda kwaye ndaqonda ulwazi olubhaliweyo olungentla (ileta yolwazi lwabathathi-nxaxheba) malunga nophononongo.

• Ndiyazi ukuba iziphumo zophononongo, kubandakanywa neenkcukacha zobuqu malunga nesini sam, ubudala, umhla wokuzalwa, amagama aqalayo kunye noxilongo ziya kuqwalaselwa ngokufihlakeleyo kwingxelo yophononongo,

• Ngokubhekiselele kwiimfuno zophando, ndiyavuma ukuba idatha eqokelelweyo ngexesha lolu phononongo inokusetyenzwa kwinkqubo yekhompyutha ngumphandi.

• Nakweliphi Na inqanaba, ngaphandle kokudlelwla, ndingarhoxisa imvume yam kunye nokuthatha inxaxheba kolu phononongo.

• Ndibe nethuba elaneleyo lokubuza imibuzo kwaye (ngokuzithandela kwam ndizixelele ukuba ndikulungele ukuthatha inxaxheba ku phononongo.

• Ndiyaqonda ukuba izinto ezintsha ezifunyanisiweyo ezibalulekileyo eziphuhliswe ngethuba lolu phando ezinokunxulumana nokuthatha inxaxheba kwam ziya kwenziwa zifumaneke kum.

Full Name

of Participant **Date** **Time** **Signature /**

Thumbprint

I, Nomonde Patience Ditshetelo herewith confirm that the above participant has been fu informed about the nature, conduct and risks of the above study.

Full Name of Researcher **Date** **Signature**

Full Name of Witness (If applicable) **Date** **Signature**

Full Name of Legal Guardian (If applicable) Date **Signature**

D4: PARTICIPANTS CONSENT FORMS - SETSWANA

DUT
DURBAN UNIVERSITY OF TECHNOLOGY
INYUVESI YASETHEKWINI YEZOBUCHWEPHESHE

FOROMO YA TUMALANO

Puisano ya tumalano no ya go tsenela Boithuto ba Dipatlisiso

Ka gona ke tiisa gore ke boleletswe ka tshekathseko e ke Mme Nomonde Ditshetelo ka mofuta, ka boitshwaaro, melemo le dikotsi tsa tshekatsheko e ya Research Ethics

Clearance Number: IREC306/22

- Gape ke amogetse, ka bala le go tlhaloganya dintlha tse di kwadilweng mo lokwalong kitsiso ee mabapi le tshekatsheko e e tlhagisitsweng mogodimo ga tumalano e. (Lengolo la boitsebiso ba barupeluoa) mabapi le thuto.

- Ke a itse gore dipholo tsa dipatlisistso tse, ga mmogo le dintlha tsa botho mabapi le bong ba ka, dilemo, letsatsi la tsoalo, di-initials le tlhatlhobo di tla dirisiwa ka mokgwa wa khupamarama magareng game le Mosekasiki.

- Ka lebaka la litlhoko tsa lipatlisiso, ke lumela hore lintlha tse bokeletsoeng nakong ea phuputso ena li ka sebetsoa ka mokhoa oa khomphutha ke mofuputsi.

- Ke tlhaloganya gore ka nako e ngwe le engwe ke ka ikgogela morago tumalano e ya go tsaya karolo mo tshekatshekong e.

- Ke nale letetla e e lekanyeng ya go botsa dipotso mme ka go rata gaka ke tiisa gore ke maikemisetso a ka a go tsaya karolo mo tshekatshekong e. ka boithatelo ba ka ke bolela hore ke itokiselitse ho nka karolo thutong.

- Ke tlhaloganya gore dipholo tse tsa botlhokwa tse didirilweng mo tshekatshekong ebile di amana le go tsaya karolo game nka difitlhelela.

____________________ __________ ______ _______________

Full Name of Participant Date Time Signature / Thumbprint

I Nomonde Patience Ditshetelo herewith confirm that the above participant has been fu informed about the nature, conduct and risks of the above study.

_________________ __________ ___________________

Full Name of Researcher Date Signature

_________________ __________ ___________________

Full Name of Witness (If applicable) Date Signature

_______________ _________ _________________

Full Name of Legal Guardian (If applicable) Date Signature

APPENDIX E: INTERVIEW GUIDE

E1: INTERVIEW GUIDE - ENGLISH

INTERVIEW GUIDE

SECTION A: DEMOGRAPHIC CHARACTERISTICS

1. Age in years (write actual years)

2. Gender assigned at birth (Tick relevant box)

Male	Female	Other

3. Race

Black	Coloured	Indian	White

4. Residential area

Township	Informal Settlement	Town	Village

5. Marital Status

Married	Divorced	Single	Widowed

6. Level of Education

Degree	Diploma	Grade 12	Secondary	Primary Standard	No Schooling

7. Employment Status

Full- time employment	Part- time employment	Unemployed	Self-employed	Student

Part B: Interview Questions

Grand tour question

What are your experiences of living with an adolescent who is abusing drugs?

Follow up questions

1. What is your most challenging part of living and caring for an adolescent who abuse drugs?

2. What sort of things help you to cope with the challenge of caring for caring for an adolescent who abuse drugs?

3. Are you aware of any programmes are available in the community that support caregivers living with adolescents who abuse drugs?

Probing will be used.

E2: INTERVIEW GUIDE - AFRIKAANS

ONDERHOUD GIDS

AFDELING A: DEMOGRAFIESE EIENSKAPPE

1. Ouderdom in jare (skryf werklike jare)

2. Gender assigned at birth (Tick relevant box)

Male	Female	Other

3. Race

Black	Coloured	Indian	White

4. Residential area

Township	Informal Settlement	Town	Village

5. Huwelikstatus

Getroude	ongetroude	Enkele	Weduwee

6. Vlak van onderwys

Graad	Diploma	Graad 12	Sekondêre	Primêre Standaard	Geen Skoolopleiding

7. Indiensnemingstatus

Voltydse indiensneming	Deeltydse indiensneming	Werkloos	Selfstandige	Student

Deel B: Onderhousdcvrae

Groot toer vraag

Wat is jou ondervindinge om saam met ' n adolessent te lewe wat dwelms misbruik?

Volg vrae op

1. Wat is jou moeilikste deel van die lewe en omgee vir 'n adolessente wat dwelms misbruik?

2. Watter soort dinge help jou om die uitdaging die hoof te bied om na 'n adolessent om te sien wat dwelms misbruik?

3. Is jy bewus van enige programme wat beskikbaar is in die gemeenskap wat versorgers ondersteun wat saam met adolessente woon wat dwelms misbruik?

Proefneming sal gebruik word

E3: INTERVIEW GUIDE - ISIXHOSA

ISIKHOKELO SODLIWANO-NDLEBE

CANDELO A: IIMPAWU ZEDEMOGRAFI

1. Ubudala kwiminyaka (bhala iminyaka eyiyo)

2. Isini esabelwe ukuzalwa (Tikisha ibhokisi efanelekileyo)

Indoda	Ibhinqa	Okunye

3. Ugqatso

Mnyama	Umbala	Indiya	Mhlophe

4. Indawo yokuhlala

Ilokishi	Ukuhlaliswa ngokungekho sikweni	Idolophu	Ilali

5. Ubume obuxela ukuba utshatile okanye awutshatanga

Utshatile	Uqhawule umtshato	Ungatshatanga	Umhlolokazi

6 Inqanaba leMfundo

Isidanga	Idiploma	IBanga le-12	Eyesibini	Umgangatho oPhambili	Akukho sikolo

7. Ubume beNgqesho

Umsebenzi osisigxina	Umsebenzi wesingxungxo	Ukungaphangeli	Uziqeshile	Umfundi

Icandelo B: Imibuzo yodliwano-ndlebe

Umbuzo wokhenketho olukhulu

Athini amava akho okuhlala nomntwana ofikisayo osebenzisa kakubi iziyobisi?

Landela imibuzo

1 Yeyiphi eyona nxalenye ingumceli mngeni yakho yokuphila nokunyamekela abantu abafikisayo abasebenzisa kakubi iziyobisi?

2. Ziziphi izinto ezikuncedayo ukwazi ukuhlangabezana nocelomngeni lokunyamekela umntwana ofikisayo osebenzisa kakubi iziyobisi?

3. Ngaba uyazi naziphi na iinkqubo ezikhoyo kuluntu ezixhasa abakhathaleli abahlala nolutsha olusebenzisa kakubi iziyobisi?

Probing will be used.

E4: INTERVIEW GUIDE - SETSWANA

INTERVIEW GUIDE

KARALO A: DINTLHA TSA LOAGO

1. Dingwaga

2. Bong go tswa tlholegong (Tshwaya go go maleba)

Monna	Mosadi	Go gongwe

3. Lotso

Montsho	Moshweu	Mmala	MoIntia

4. Kwa o Dulang teng

Motsesetoropo	Ko Baipeing	Toropong	Mo Motseng

5. Tsa Kemo

Ke Nyetswe	Ke Tlhadile	Ga ke a nyalwa	Motlholagadi

6. Tsa Thuto

Dekeri	Diploma	Marematlou	Sekontari	Poraemari	Ga ke a tsena sekolo

7. TsaTiro

Tiro ya leruri	Tiro e seng ya le ruri	Botlhoka-tiro	Keaipereka	Moithuti

Karolo B: Dipotso tsa patlisiso

Potso kgolo

Ke maitemogelo a feng a o na leng one a go dula le mosha yo o dirisang diritebatsi?

Dipotsotlaleletso

1. Ke dikgwatlho di feng tse o na leng tsone mabapi le go tshela le go tlhokomela mosha yo o dirisang diritebatsi?

2. Ke dilo di feng tse di go thusetseng go kgotlhelela mo dikgwatlhong tsa go tlhokomela mosha yo o dirisang diritebatsi?

3. A o na le kitso ka mananeo a leng teng mo sechabeng a a thusang batlhokomedi ba ba dulang le basha ba ba dirisang diritebatsi?

Probing will be used.

APPENDIX F: PROJECT PLAN AND BUDGET

F1: PROJECT PLAN

Activities	**Target Dates**
Presentation to DRC	June 2022
Submit proposal to FRC	August 2022
Submit proposal to IREC	September 2022
Data collection	October –November 2022
Data Analysis	March – April 2023
Write up	June 2023
Final submission Of Dissertation	30 October 2023

F2: PROJECT BUDGET

Section A: Budget		**(Motivate below)**	
Consumable Details (Motivate)		Printing paper for information letter and consent forms. External memory drive to keep data.	**R** 1000
Outside Specialist Services (Motivate)		Language Editor.	**R** 4 000
Books/Journal/Documents		Purchase of prescribed and recommended research books and journals	**R** 1 300
Library Charges		N/A	
Equipment (Motivate)		N/A	
6.	**Travel Costs** (Motivate)	Travelling in and around Sol Plaatjie for the purpose of follow-ups with gate keepers, selection of participants and interviews	**R** 3 700
7.	**Other** (Motivate)		**R**
	TOTAL		**R10 000**

APPENDIX G: EDITING CONFIRMATION LETTER

Supplier Database No: MAAA0450241
PostNet Suite #40
Private Bag X04
Menlo Park 0102
Mobile: 060 530 1165
Email: noteworthy@myconnection.co.za /
honey@myconnection.co.za

27 October 2023

TO WHOM IT MAY CONCERN

This serves to confirm that the thesis entitled: *Caregivers experiences of living with an adolescent who abuses drugs in the Sol Plaatjie municipal area in the Northern Cape.*

By: **Nomonde Patience Ditshetelo**, Department of Nursing, Durban University of Technology.

has been professionally edited by one of our accredited English mother-tongue language editors. The accuracy of the content of the final work remains the authors' responsibility.

Dr MC Steyn

Scribing, Proof-reading and Editing Services