COPYRIGHT AND CITATION CONSIDERATIONS FOR THIS THESIS/ DISSERTATION

- Attribution — You must give appropriate credit, provide a link to the license, and indicate if changes were made. You may do so in any reasonable manner, but not in any way that suggests the licensor endorses you or your use.

- NonCommercial — You may not use the material for commercial purposes.

- ShareAlike — If you remix, transform, or build upon the material, you must distribute your contributions under the same license as the original.

How to cite this thesis
THE EXPERIENCES OF PARENTS LIVING WITH MENTAL HEALTH CARE USERS SMOKING CANNABIS

BY

GRANNY MONDLANA

Minor dissertation in partial fulfilment of the requirements for the degree

MAGISTER CURATIONIS

In the

DEPARTMENT OF NURSING SCIENCE

FACULTY OF HEALTH SCIENCES

At the

UNIVERSITY OF JOHANNESBURG

SUPERVISOR : PROF M POGGENPOEL
CO-SUPERVISOR : PROF CPH MYBURGH
MRS V VAN NIEKERK

NOVEMBER 2013
DEDICATION

I dedicate this study to my mother, the late Miss Lucky Martha Ndlovu. Your unconditional love, your nurturance, warmth, kindness, your support, guidance and determination has made me to be who I am today; I will always love and miss you.

I wish you were here …
ACKNOWLEDGEMENTS

From the bottom of my heart, I would like to express my sincere gratitude and appreciation to all the following people:

- To God be the glory

- To my siblings, Evelyn Mondlana, Amelia Mondlana and Dion Mondlana; your support, understanding and love sustained me throughout this research study.

- To my supervisors, Mrs Van Niekerk and co-supervisors, Professor M Poggenpoel and Professor CPH Myburgh: if it was not for your unconditional love, your continuous support and guidance, your advice and caring, patience and emotional support, I would not have made it. May God bless you.

- To all the managers of the mental health facility, for allowing me to conduct this research and for the study permission you granted me.

- To all my participants, thank you, for you made this study a success by being unselfish and sharing your personal experiences with me.

- To my friends and colleagues, Ayanda Mda, Tsholofelo Makamo, Siskana Nkome, Andile Mokoena, Tshepo Mohajane, Naniki Motswane, Khensani Maluleke and Muriel Nkosi: your words of encouragement, your team spirit and your support were more than enough to me.
ABSTRACT

In local communities, young people use different substances for reasons known to them alone. This research study is about young people who are aged between 18 and 30 years, who smoke cannabis and are mentally ill. Mostly the parents of these young people, as well as other members of the family, the neighbours and the community at large experience many challenges resulting from cannabis smoking.

The objectives of this study were to explore and describe the experiences of parents living with mental health care users smoking cannabis and to issue guidelines for the advanced psychiatric nurse practitioner to facilitate the mental health of parents living with mental health care users smoking cannabis in the context under study.

A qualitative research design that was exploratory, descriptive and contextual was followed to achieve the aim and objectives of the study. Purposive sampling was used for sample selection based on inclusion criteria. The number of participants selected for this study was guided by data saturation. The total number of participants selected for this study was seven.

The data collection methods used were phenomenological interviews, observation and field notes. In the phenomenological interview, the participant was asked: “How is it for you living with a mental health care user smoking cannabis?”

The phenomenological interviews were audiotaped and transcribed. The researcher and an independent coder analysed the transcribed phenomenological interviews and field notes. The researcher used Tesch’s method of data analysis (Creswell, 2007:157) in analysing the data. The measures to ensure trustworthiness in this study include credibility, dependability, confirmability, transferability and authenticity. The seven ethical principles of competence of the researcher, right to self-determination, right to privacy, right to autonomy and confidentiality, right to protection from exploitation and obtaining informed consent guided this study.
Five themes emerged: experiences of unfulfilled parental expectations linked to the behaviour of the child, the chronic nature of cannabis or “dagga” use and a sense of failing self; experiences of strained interpersonal relationships contributing to an unsupportive environment for both child and parent; experiences of a sense of loss related to the pervasive changes in child’s ways of being; experiences of living in an unsafe home environment by parents culminating in a sense of betrayal; and experiences of emotional turmoil by parents expressed as feelings of helplessness, hopelessness and despair, triggering a death wish.

It is evident from the results obtained from the study that parents of children smoking cannabis are challenged by the behaviour of their children who smoke cannabis and then perform poorly academically; they drop out of school and have multiple relapses due to non-adherence to prescribed treatment. As if this is not enough, the behaviour of these children also causes strained interpersonal relationships between the child smoking cannabis and the siblings, between the child and the relatives, and between the child and the community at large. The parents also experience personality changes in their children, which include aggression and violence, as well as antisocial and criminal behaviour, resulting in parents perceiving their homes as a jail; hence they feel helpless, hopeless and filled with despair.

Based on the findings and literature control, recommendations were proposed for mental health nursing practice, mental health education and mental health research. The recommendations were guided by the Theory for Health Promotion in Nursing from the University of Johannesburg (2009:1). These recommendations served as a frame of reference to enable the professional nurse practitioner to facilitate the mental health of parents living with mental health care users smoking cannabis.

The advanced mental health nurse practitioner has both a developmental and consultative role to implement in the mental health unit. In implementing the roles, the professional nurse practitioner is assisted by the advanced mental health nurse practitioner to mobilise resources to meet both the parents and their children’s needs at a holistic level. A psychiatric nursing qualification for professional nurse practitioners treating mental health care users smoking cannabis is recommended to
assist and support the parents living with mental health care users smoking cannabis.

KEY WORDS

Experiences
Living with
Parents
Mental health care users
Cannabis
OPSOMMING

Die jong mense in plaaslike gemeenskappe gebruik verskillende middels om redes wat aan slegs hulleself bekend is. Hierdie navorsingstudie handel oor jong mense tussen die ouderdomme van 18 en 30 jaar wat cannabis rook en geestelik gestrem is. Meesal ervaar die ouers van hierdie jong mense, sowel as ander gesinslede, die bure en die groter gemeenskap, baie uitdagings as gevolg van die cannabis-rokery.

Die doel van hierdie studie was om die ervarings van ouers wat saam met geestesgesondheidgebruikers wat cannabis rook, woon, te ondersoek en te beskryf en om riglyne neer te lê vir gevorderde verpleegpraktisyns om die geestesgesondheid van die ouers wat saam met geestesgesondheidgebruikers wat cannabis rook, woon, in die konteks van hierdie studie te fasiliteer.

'n Kwalitatiewe navorsingsontwerp wat verkennend, beskrywend en kontekstueel was, is gevolg ten einde die doel en mikpunte van die studie te bereik. Doelbewuste steekproefneming, gegrond op insluitingskriteria, is as steekproefmetode gebruik. Die hoeveelheid deelnemers wat vir hierdie studie gekies is, is deur dataversadiging bepaal. Die totale aantal deelnemers wat vir die studie gekies is, was sewe.

Die dataversamelingsmetodes wat gebruik is, is fenomenologiese onderhoude, waarnemings- en veldnotas. In die fenomenologiese onderhou is die deelnemer gevra: "Hoe is dit vir jou om saam 'n met geestesgesondheidgebruiker wat cannabis rook, te woon?"

Die fenomenologiese onderhou is op band geneem en getranskribeer. Die navorser en 'n onafhanklike kodeerder het die getranskribeerde fenomenologiese onderhoude en die veldnotas geanaliseer. Die navorser het Tesch se metode van data-analise (Creswell, 2007:157) in die analisering van die data gebruik. Die maatreëls om betroubaarheid in hierdie studie te verseker, sluit geloofwaardigheid, betroubaarheid, bevestigbaarheid oordraagbaarheid en egtheid in. Die sewe etiese beginsels rakende die bevoegdheid van die navorser, naamlik die reg tot selfbeskikking, die reg tot privaatheid, die reg tot selfstandigheid en vertroulikheid,
die reg tot beskerming teen uitbuiting en die verkryging van ingeligte toestemming, het die studie geleit.

Vyf temas het te voorskyn gekom: die ervarings van onvervulde ouerlike verwagting met betrekking tot die gedrag van die kind; die chroniese aard van “dagga”-gebruik en ’n sin van teleurstelling in die self; ervarings van gespanne interpersoonlike verhoudings wat vir beide ouer en kind tot ’n nie-ondersteunende omgewing bydra; ervarings van ’n sin van verlies wat met die deurdringende veranderinge in die kind se manier van wees verband hou; ouers se ervarings van om te leef in ’n onveilige huisomgewing wat in ’n sin van verraad kulmineer; en ervarings van emosionele verwarring onder ouers, uitgedruk as gevoelens van hulpeloosheid, hopeloosheid en wanhoop, wat tot ’n doodswens lei.

Dit blyk duidelik uit die resultate van die studie dat die ouers van kinders wat cannabis rook, uitgedaag voel deur die gedrag van die kinders wat cannabis rook en dan akademies sleg presteer; hulle verlaat skool en het menige terugslae omdat hulle nie by die voorgeskrewe behandeling bly nie. Asof hierdie nie genoeg is nie, veroorsaak die gedrag van hierdie kinders ook gespanne interpersoonlike verhoudings tussen die kind wat cannabis rook en die broers en/of susters, tussen die kind en familielede, en tussen die kind en die breër gemeenskap. Die ouers ervaar ook persoonlikheidveranderings in hul kinders wat aggressie en geweld, asook antisosiale en kriminelle gedrag insluit, wat daartoe lei dat ouers hul huise as ’n tronk beleef; daarom voel hulle hulpeloos, hopeloos en vol wanhoop.

Gebaseer op die bevindings en literatuurkontrole, is aanbevelings vir die geestesgesondheidsverpleegspraktyk, geestesgesondheidsopvoedig en geestesgesondheidsnavorsing voorgestel. Die aanbevelings is deur die Teorie vir Gesondheidsbevordering van die Universiteit van Johannesburg (2009:1) geleit. Hierdie aanbevelings het as ’n verwysingsraamwerk gedien om die professionele verpleegspraktisyn in staat te stel om die geestesgesondheid van ouers wat saam met geestesgesondheidgebruikers wat cannabis rook, woon, te fasiliteer.

Die gevorderde geestesgesondheidsverpleegpraktisyn het beide ’n ontwikkelende en konsulerende rol om in die geestesgesondheidseenheid in werking te stel. In die
inwerkingstelling van die rolle word die professionele verpleegpraktisyn deur die gevorderde geestesgesondheidsverpleegpraktisyn ondersteun om hulpbronne te mobiliseer ten einde beide ouers en kinders se behoeftes op 'n holistiese vlak te bevredig. 'n Psigiatriese verpleegskwalifikasie vir professionele verpleegpraktisyns wat geestesgesondheidgebruikers wat cannabis rook, behandelt, word aanbeveel ten einde die ouers wat saam met geestesgesondheidgebruikers wat cannabis rook, woon, te help en te ondersteun.

SLEUTELWOORDE

Ervarings
Woon saam met
Ouers
Geestesgesondheidgebruikers
Cannabis
# TABLE OF CONTENTS

DEDICATION .................................................................................................................................................. ii
ACKNOWLEDGEMENTS ................................................................................................................................. iii
ABSTRACT ......................................................................................................................................................... iv
OPSOMMING ..................................................................................................................................................... vii

CHAPTER 1: OVERVIEW OF THE STUDY ................................................................................................. 1
1.1 BACKGROUND AND RATIONALE ................................................................................................. 1
   1.1.1 Crime, Violence and Aggressive Behaviour ............................................................................ 1
   1.1.2 Risky Sexual Behaviour .......................................................................................................... 2
   1.1.3 Scholastic Problems ................................................................................................................. 3
   1.1.4 Mental and Physical Health Problems .................................................................................... 3
1.2 PROBLEM STATEMENT ................................................................................................................. 4
1.3 RESEARCH AIM AND OBJECTIVES ............................................................................................. 6
   1.3.1 Aim of the Study ...................................................................................................................... 6
   1.3.2 Objectives of the Study ........................................................................................................... 6
1.4 PARADIGMATIC PERSPECTIVE .................................................................................................... 7
   1.4.1 Meta-theoretical Assumptions ............................................................................................... 7
       1.4.1.1 Person ............................................................................................................................... 7
       1.4.1.2 Psychiatric nursing ....................................................................................................... 8
       1.4.1.3 Environment ................................................................................................................ 8
       1.4.1.4 Mental health ................................................................................................................ 8
   1.4.2 Theoretical Assumptions ......................................................................................................... 8
   1.4.3 Methodological Assumption ................................................................................................. 9
1.5 DEFINITION OF CENTRAL CONCEPTS ...................................................................................... 10
   1.5.1 Experience ............................................................................................................................. 10
   1.5.2 Parents .................................................................................................................................... 11
   1.5.3 Living with ............................................................................................................................. 11
   1.5.4 Mental health care user ....................................................................................................... 11
   1.5.5 Cannabis ............................................................................................................................... 11
1.6 RESEARCH DESIGN AND METHOD ............................................................................................ 11
   1.6.1 Research Design ................................................................................................................... 12
1.6.2 Research Methods................................................................. 12
  1.6.2.1 Phase 1: The experiences of parents living with mental health
care users smoking cannabis ................................................. 12
    1.6.2.1.1 Phenomenological approach .................................... 12
  1.6.2.2 Phase 2: Issuing of guidelines ........................................ 14
  1.6.2.3 Measures to ensure trustworthiness ................................ 14
  1.6.2.4 Ethical considerations .................................................. 14
1.7 DIVISION OF CHAPTERS .......................................................... 16
1.8 SUMMARY.................................................................................. 17

CHAPTER 2: RESEARCH DESIGN AND METHOD ..................................... 18
2.1 INTRODUCTION.............................................................................. 18
2.2 RESEARCH DESIGN .................................................................... 18
  2.2.1 Qualitative Design ................................................................ 18
  2.2.2 Exploratory Design ............................................................... 19
  2.2.3 Descriptive Design ............................................................... 20
  2.2.4 Contextual Design ............................................................... 21
2.3 RESEARCH METHOD ................................................................. 21
  2.3.1 Phase 1: The Experiences of Parents Living with Mental Health Care
      Users Smoking Cannabis ....................................................... 22
    2.3.1.1 Population and sampling ............................................... 22
    2.3.1.2 Sampling criteria ......................................................... 23
    2.3.1.2.1 Inclusion criteria ..................................................... 23
    2.3.1.2.2 Exclusion criteria .................................................... 23
    2.3.1.3 Data collection .............................................................. 24
    2.3.1.4 Data analysis .............................................................. 28
    2.3.1.5 Literature control ........................................................ 29
  2.3.2 PHASE 2: Description of Guidelines that can be Used by the Psychiatric
      Nurses to Assist Parents to Mobilise Resources to Facilitate their Mental
      Health .......................................................................................... 30
  2.3.3 Ethical Measures .................................................................... 30
  2.3.4 Trustworthiness .................................................................... 30
CHAPTER 3: EXPERIENCES OF PARENTS LIVING WITH MENTAL HEALTH CARE USERS SMOKING CANNABIS

3.1 INTRODUCTION............................................................................................................. 37
3.2 ANALYSIS OF INTERVIEWS .......................................................................................... 37
3.3 DESCRIPTION OF THE ENVIRONMENT IN WHICH THE RESEARCH WAS CONDUCTED .......................................................................................................................... 38
3.4 DESCRIPTION OF THE SAMPLE ..................................................................................... 38
3.5 ANALYSIS OF THE FIELD NOTES .................................................................................. 39
  3.5.1 The Researcher's Observation During the Interview Process................................. 39
3.6 DISCUSSION OF THE RESULTS .................................................................................... 40
  3.6.1 Theme 1: Experiences of Unfulfilled Parental Expectations Linked to the Behaviour of the Child, the Chronic Nature of “Dagga” Use and a Sense of Failing the Self ........................................................................................................... 43
    3.6.1.1 Experiences of unfulfilled parental expectations linked to the behaviour of the child, the chronic nature of “dagga” use and a sense of failing the self ........................................................................................................... 43
    3.6.1.2 Experiences unfulfilled parental expectations with regard to recovery from “dagga” use .......................................................................................................................... 45
    3.6.1.3 Experiences unfulfilled parental expectations linked to a sense of failure as a parent .......................................................................................................................... 46
  3.6.2 Theme 2: Experiences Strained Interpersonal Relationships Contributing to an Unsupportive Environment for both Child and Parents ............... 47
    3.6.2.1 Experience of strained interpersonal relationships between the parent and the child .......................................................................................................................... 47
    3.6.2.2 Experience of strained interpersonal relationships between the
siblings and the child ................................................................. 48

3.6.2.3 Experience of strained interpersonal relationships between the
other relatives and the child ..................................................... 49

3.6.2.4 Experiences of strained interpersonal relationships between the
wider community, including the police and the child .............. 50

3.6.3 Theme 3: Experiences Sense of Loss of Parents Related to the
Pervasive Changes in the Child’s Ways of Being ............... 53

3.6.3.1 Experiences perceived personality changes by parents ....... 53

3.6.3.2 Experiences of aggression and violence by parents .......... 54

3.6.3.3 Experiences anti-social and criminal behaviour by parents .... 55

3.6.4 Theme 4: Experiences of Living in an Unsafe Home Environment by
Parents Culminating in a Sense of Betrayal ......................... 57

3.6.5 Theme 5: Experiences Emotional Turmoil by Parents Expressed as
Feelings of Helplessness, Hopeless and Despair Triggering a Death
Wish ......................................................................................... 58

3.6.5.1 Experience feelings of helplessness, hopelessness and despair 58

3.6.5.2 Experience desiring an extreme resolution to an untenable
situation – a coping mechanism .............................................. 60

3.6 CONCLUSION ........................................................................ 61

CHAPTER 4: GUIDELINES AND RECOMMENDATIONS .................. 62

4.1 INTRODUCTION .................................................................... 63

4.2 GUIDELINE 1: EVIDENCE-BASED PREVENTION PROGRAMMES IN
SCHOOLS, FAMILY AND COMMUNITY AND THE PREVENTION OF
RELAPSE ...................................................................................... 64

4.2.1 Facilitation of School-based Programmes ....................... 65

4.2.2 The Importance of Psycho-education .......................... 65

4.2.3 Implementation of Support Groups .............................. 66

4.3 GUIDELINE 2: THE USE OF FAMILY-FOCUSED APPROACHES FOR
STRAINED INTERPERSONAL RELATIONSHIPS ....................... 66

4.3.1 Implementation of Functional Family Therapy, Brief Strategic Family
Therapy and Multidimensional Family Therapy .................... 67
4.3.2 Implementation of Functional Family Therapy, Brief Strategic Family Therapy and Multidimensional Family Therapy ................................................. 68
4.3.3 Implementation of Functional Family Therapy, Brief Strategic Family Therapy and Multidimensional Family Therapy ................................................. 69
4.3.4 Utilisation of Environmental Approaches .......................................................... 69
  4.3.4.1 Environmental approaches.............................................................................. 69
  4.3.4.2 Alternative activities and youth groups ......................................................... 70
  4.3.4.3 Attachments .................................................................................................. 70
  4.3.4.4 Resources ..................................................................................................... 70
  4.3.4.5 The family ..................................................................................................... 70
  4.3.4.6 Local community ......................................................................................... 71

4.4 GUIDELINE 3: DEALING WITH CHANGE IN PERSONALITY, PREVENTION OF AGGRESSION AND VIOLENCE, AND REDUCING ANTI-SOCIAL AND PREVENTING CRIMINAL BEHAVIOUR ............................................................................. 71
  4.4.1 Implementation of Functional Family Therapy, Brief Strategic Family Therapy and Multidimensional Family Therapy; and Implementation of Cognitive Behaviour Therapy, Dialectic Behaviour Therapy and Schema-focused Therapy for the Child ................................................................. 72
    4.4.1.1 Cognitive behavioural therapy (CBT) ......................................................... 72
    4.4.1.2 Dialectical behaviour therapy (DBT) ......................................................... 72
    4.4.1.3 Schema-focused therapy ......................................................................... 72
  4.4.2 Prevention of Aggression and Violence .............................................................. 73
  4.4.3 Reducing and Preventing anti-social Criminal Behaviour ................................ 73

4.5 GUIDELINE 4: INTERVENTIONS FOR FEELING UNSAFE IN THEIR HOME ENVIRONMENT ............................................................................................................. 74
  4.5.1 Community Participation, Involvement of Local Government and the Police to Promote Safety ................................................................................. 74

4.6 GUIDELINE 5: MANAGEMENT OF NEGATIVE EMOTIONS, CHARACTERISED BY HELPLESSNESS, HOPELESSNESS, DESPAIR, AS WELL AS SEEKING AN EXTREME RESOLUTION TO AN UNTENABLE SITUATION ................................................................................................................. 76
  4.6.1 Implementation of Cognitive Behaviour Therapy (CBT) .................................. 76

4.7 EVALUATION OF THE STUDY .............................................................................. 77
4.7.1 Strengths ........................................................................................................ 77
4.7.2 Limitations................................................................................................... 78
4.8 RECOMMENDATIONS .................................................................................... 78
  4.8.1 Mental Health Nursing Practice ................................................................. 78
  4.8.2 Mental Health Nursing Research ............................................................... 79
  4.8.3 Mental Health Nursing Education .............................................................. 79

4.9 CONCLUSION .................................................................................................. 80

LIST OF REFERENCES ............................................................................................ 81

ANNEXURE 1: ETHICAL CLEARANCE FROM THE UNIVERSITY
OF JOHANNESBURG AND PRETORIA ................................................................. 92

ANNEXURE 2: REQUEST FOR PARTICIPANTS’ CONSENT ............................. 95

ANNEXURE 3: REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT THE
MENTAL HEALTH CARE FACILITY ................................................................. 98

ANNEXURE 4: INFORMATION LEAFLET AND PARTICIPANT INFORMED
CONSENT ............................................................................................................... 102

ANNEXURE 5: PERMISSION TO PARTICIPATE IN THE RESEARCH STUDY AND
PERMISSION TO INTERVIEW AND AUDIOTAPE ............................................. 107

ANNEXURE 6: CONFIDENTIALITY CLAUSE CODING CERTIFICATE ............ 110

ANNEXURE 7: CODING CERTIFICATE ................................................................. 112

ANNEXURE 8: EXAMPLE OF A SEMI-STRUCTURED INTERVIEW WITH A
TABLE OF TABLES

Table 3.1 - Experiences of parents living with mental health care users smoking cannabis... 42
Table 4.1 - Challenges and possible corresponding guidelines to address the challenges of parents of mental health care users smoking cannabis .......... 63
CHAPTER 1: OVERVIEW OF THE STUDY

1.1 BACKGROUND AND RATIONALE

Substance use among young people is of major concern in South Africa. Alcohol, tobacco and cannabis (dagga) are the most commonly used substances. Most of those who use illegal drugs, such as cannabis, usually first used alcohol and tobacco (South African Demographic and Health Survey, 2003:46). Cannabis, dagga and marijuana are similar substances and therefore will be used interchangeably in this study. Among learners in a high school survey conducted in 2002, about half, 49.1%, reported ever having drunk alcohol, one third, 30.5% ever having smoked cigarettes and 12.8% ever having used cannabis in their lifetime. Just under one quarter, namely, 23%, indicated having engaged in binge drinking (drank five or more drinks on one occasion), during the preceding one-month period (South African Demographic and Health Survey, 2003:48). The most recent Demographic and Health Survey (2003:50) found that among adolescents aged between 15 and 19 years, 19.9% of the males and 10.2% of the females had used tobacco products, and 31.9% of the males and 17.2% of the females reported having ever consumed alcohol (South African Demographic and Health Survey, 2003: 55).

With regard to all young people, not only does substance abuse carry significant health risks, but it can also be associated with serious – and often devastating – social problems. These include crime, violence and aggressive behaviour, risky and sexual behaviour, scholastic problems, and mental and physical symptoms.

1.1.1 Crime, Violence and Aggressive Behaviour

Adolescents who use substances, such as tobacco, alcohol and cannabis, are frequently more likely than those who rarely or never use them to get involved in multiple violent acts. Young people who are involved in criminal activities seem to be disproportionately involved in using substances. Another study found that younger
arrestees were more likely than their adult counterparts to test positive for the use of various drugs such as cannabis, mandrax and cocaine (Parry, Plüddemann, Louw & Leggett, 2004c: 167-185). Parry, Plüddemann, Louw & Leggett (2004c:167-185) found that, among a sample of 1 000 arrestees in three major cities in South Africa, 39% tested positive for cannabis. (Stuart, Moore, Kahler & Ramsey, 2003:107), the authors of the review, concluded that marijuana use can trigger violent behaviour in a number of ways. Firstly, cannabis intoxication causes cognitive impairments that can decrease the ability of a person to understand complex interpersonal conflicted interactions; it can also increase the likelihood of aggressive responses to conflict. Also, intoxication increases heart rate, panic reactions and paranoid feelings associated with violent behaviour. Secondly, withdrawal can also produce irritability and anger that can lead to aggressive behaviour (Stuart, Moore, Kahler & Ramsey, 2003:110).

1.1.2 Risky Sexual Behaviour

Adolescents who drink alcohol and/or use other drugs are more likely to be sexually active than are those who do not. They are also more likely to engage in unprotected sex, which is associated with having unplanned pregnancies and contracting sexually transmitted infections including HIV (Plüddemann, Flisher, Mathews, Carney & Lombard, 2008:1-6). The use of substances is reported to decrease adolescents’ inhibitions and safer sex negotiation skills, thereby increasing their already-present vulnerability to engage in risky sexual behaviour (Morojele, Brook, & Kachieng’a, 2006:215-219). Cannabis use is associated with unprotected sexual intercourse, especially in adolescents. A survey of a large inner-city sample of students, for example, found that cannabis use in early adolescence increased the risk five years later of having multiple sexual partners and not always using condoms. Unprotected sexual behaviour puts people at high risk of contracting HIV and AIDS, hepatitis C and other sexually transmitted infections. Furthermore, females run the risk of unplanned pregnancy (Morojele & Brook, 2006: 1163-1176).
1.1.3 Scholastic Problems

A longitudinal study among high school learners in Cape Town found a strong association between binge drinking, school drop-out and low academic aspirations over a period of two years (Morojele, Parry, Ziervogel & Robertson, 2001b:110-124). Cannabis also has been found to have a negative impact on school performance. Cannabis use in early adolescence decreases the likelihood of graduating from high school and is associated with problems at school (Morojele & Brook, 2006: 1163-1176).

1.1.4 Mental and Physical Health Problems

Research found that having symptoms of depression, for example, disturbed sleep, appetite and pleasure, is associated with adolescents’ use of alcohol, cannabis and cigarettes (Brook, Morojele, Brook & Rosen, 2005:207-217). International research also established links between cannabis use and schizophrenia, as well as between methamphetamine use and various psychiatric disorders (Yen & Chong, 2006:215-220).

Substance abuse or dependence is a common problem among the general population; evidence indicates that the incidence is even higher in individuals suffering from mental health problems. In South Africa, the exact prevalence of cannabis use or abuse among the general population, as well as among individuals suffering from mental disorders, has not been formally studied; however, it is generally believed to be high. Peltzer and Ramlagan (2007:126-131) recently reviewed cannabis use trends in the South African population over a period of 12 years by sourcing data from surveys, specialised alcohol and drug treatment centres, cannabis-related trauma unit admissions and arrestee studies. They concluded that cannabis was the most common illicit substance used, with current self-reported cannabis use of 5% to 10% among adolescents and 2% among adults. Furthermore, it was higher among men than women, higher in urban than rural areas, higher in the urban provinces of Western Cape and Gauteng than the other provinces, and higher
among so-called coloureds and whites than other racial groups (Koen, Jonathan & Niehaus, 2009:8).

1.2 PROBLEM STATEMENT

In August 2007, doctor Zola Skweyiya, the Social Development Minister, stated that substance abuse in South Africa is reaching crisis proportions, as the following statistics reveal: At least 7% of the inhabitants are alcohol dependent, whereas 31% are at risk of developing serious drinking problems. More than 800 000 South Africans use 123 metric tons of cannabis each year, whereas 265 000 consume five metric tons of cocaine each annum. An estimated 1.2 million citizens furthermore abuse amphetamines (Hosken, 2007:1). These alarming statistics emphasise not only the need for effective rehabilitation programmes, but also the necessity that addicts successfully complete treatment. Premature treatment termination is, however, a major problem at drug addiction treatment centres and has serious prognostic and financial implications (King & Canada, 2004:189).

Gillmore, Lash, Foster and Blosser (2001:524) found that on average 50% of patients drop out of rehabilitation programmes within the first five weeks of admission. Regular substance users who drop out have a poorer prognosis than those who complete treatment programmes. In this regard, Gillmore, et al. (2001:525) state that treating persons who quitted school has the same treatment outcomes as untreated regular substance users. The same authors furthermore found that interventions aimed at improving adherence to rehabilitation programmes reduced readmission by 66% over a six-month period (Gillmore, et al., 2001:537).

Identifying factors that contribute to treatment non-adherence can therefore guide the clinician to design special interventions in order to prevent patient attrition. In this regard, an article by Beuster and Arnott (2007:54) intends to give an overview of factors leading to treatment drop-out and then to explore the role of five possible factors that contribute to this problem. To add to the existing body of knowledge, the authors (Beuster & Arnott, 2007:54) investigated patterns of supplementary psychiatric and general scheduled medication use, legal history, and DSM-IV-TR
Axis I and II co-morbidity as predictors of non-adherence in rehabilitation programmes (Beuster & Arnott, 2007:54).

Some people who smoke cannabis display anti-social behaviour (McAtamney & Morgan, 2009:1). The term “anti-social behaviour” incorporates a range of behaviours from minor offensive or harmful acts to more serious criminal activity (McAtamney & Morgan, 2009:1). Anti-social behaviour is a serious concern to Government, non-government organisations, the private sector, communities, as well as families and individuals, for several reasons: Anti-social behaviour can have a negative impact on community perceptions of safety and people’s quality of life. Anti-social behaviour threatens the establishment and maintenance of a safe and secure community, which is an important prerequisite for community well-being and cohesion as well as sound economic growth by way of continuing business activity and investment. Individuals who engage in anti-social behaviour risk becoming excluded from important support mechanisms such as school, their families and service providers. They also risk coming into contact with the criminal justice system. Involvement in anti-social behaviour can persist throughout adolescence into adulthood, becoming a more significant social issue with long-term negative consequences for the individuals, their family and the wider community (Armitage, 2002:89-103).

The problems that individuals experience due to cannabis use also affect their families. Living with a relative who misuses alcohol or illicit drugs causes great strain on the rest of the family (Arcidiano, Velleman, Procentese, Berti, Albanesi, Sommantico & Coppello, 2010:659). The family’s way of life, their roles, routines, finances and communication system are often primarily disrupted. The substance misuse and its resulting problems often create further difficulties for the family with regard to knowing the best way to cope with either the overt problem, the substance misuse or with the complex situations that inevitably develop as a result (Arcidiano, et al., 2010:660).

Considering the facts stated above, the researcher therefore concluded that parents living with mental health care users smoking cannabis are significant and possibly widely prevailing. The researcher views parents living with mental health care users
smoking cannabis as a setback in that it contributes to poor academic performances by the children, strained interpersonal relationships, relapse and readmissions to a mental institution, as well as aggression, crime and violent behaviour; hence this study. Information obtained from this study will assist the researcher in identifying appropriate interviews that may curb the problem.

The following questions arise from the problem statement:

- How do parents experience living with mental health care users smoking cannabis?
- What can be done to facilitate the mental health of parents living with mental health care users smoking cannabis?

1.3 RESEARCH AIM AND OBJECTIVES

1.3.1 Aim of the Study

The overall aim of this study was to generate an in-depth understanding of the experiences of parents living with mental health care users smoking cannabis.

1.3.2 Objectives of the Study

The research aim was achieved by means of the following objectives:

- to explore and describe the experiences of parents living with mental health care users smoking cannabis in a mental health care facility in Tshwane; and
- to issue guidelines for the advanced psychiatric nurse practitioner to facilitate the mental health of parents living with mental health care users smoking cannabis in the context under study.
1.4 PARADIGMATIC PERSPECTIVE

A paradigm may be viewed as a set of beliefs that deals with principles. It represents a world view that defines the nature of the world, including an individual’s place in the world and the individual’s range of possible relationships with the world (Denzin & Lincoln, 2005:191). The paradigmatic perspective of this study included the Theory of Health Promotion in Nursing (University of Johannesburg, 2009) at a meta-theoretical and theoretical level. Phenomenology represents methodological perspective and will be discussed in more detail in chapter 2.

1.4.1 Meta-theoretical Assumptions

The paradigm, as reflect by the Department of Nursing Science at the University of Johannesburg (2009:4), states that the meta-theoretical component is illustrated by means of strategic work ethics as constituted in the mission and vision statement of the Department and the assumptions according to the Theory for Health Promotion in Nursing. The theoretical component is configured by means of research and theory from the Theory for Health Promotion in Nursing (University of Johannesburg, 2009:4).

The four central components of the theory, namely person, nursing, environment and health, are defined as follows:

1.4.1.1 Person
The whole person embodies dimensions of body, mind and spirit. The person functions in an integrated, interactive manner with the environment (University of Johannesburg, 2009:4).

1.4.1.2 Psychiatric nursing

Psychiatric nursing is an interactive process where the nurse, as a sensitive, therapeutic professional, facilitates the promotion of health by mobilising resources (University of Johannesburg, 2009:4).

1.4.1.3 Environment

Environment includes an internal environment that comprises the dimensions of body, mind and spirit; the environment also includes an external environment that consists of physical, social and spiritual dimensions (University of Johannesburg, 2009:4).

1.4.1.4 Mental health

Mental health is a dynamic interactive process in the patient’s environment. These interactions in the person’s environment reflect the relative health status of the patient. This interaction contributes to or interferes with the promotion of health (University of Johannesburg, 2009:5).

1.4.2 Theoretical Assumptions

In the Theory of Health Promotion in Nursing (University of Johannesburg, 2009:5), the following assumptions are applicable:

- the person is seen holistically in interaction with the environment in an integrated manner;
• the environment includes an internal and an external environment;

• psychiatric nursing is an interactive process that facilitates the promotion of mental health; mental health is an interactive, dynamic process in the patient's environment; and

• the promotion of health implicates the mobilisation of resources.

1.4.3 Methodological Assumption

Stewart and Mickunas (1990:5) describe the four philosophical perspectives in phenomenology that were addressed in this study. The first philosophical perspective is the return to the traditional task of philosophy, namely a search for wisdom. Secondly, phenomenology is a philosophy without presuppositions where the approach is to suspend all judgments about what is real until they are founded on a concrete basis. Suspending judgment is referred to as the “epoch”. The intentionality of consciousness is the third philosophical assumption, where consciousness is always directed towards an object. The reality of the object is related to one’s consciousness of it. Lastly is the refusal of the subject-object dichotomy that flows from the intentionality of consciousness. The reality of an object is perceived only in the meaning of the experience of an individual.

According to Creswell (2007:17), the philosophical assumptions in phenomenology include the epistemological, ontological, rhetorical and methodological assumptions. The epistemological assumption relates to the relationship between the researcher and that which is being researched (Creswell, 2007:17).

The ontological assumption relates to the nature of reality and its characteristics (Creswell, 2007:17). When researchers conduct qualitative research, they embrace the idea of multiple realities. Qualitative researchers conduct a study with the intention of reporting these multiple realities. In this study, the researcher reported on the multiple realities, which were in the form of multiple quotes or statements and
different perspectives of the participants on their experiences of living with mental health care users smoking cannabis.

The axiological assumption refers to the fact that the study is value laden and that biases are present (Creswell, 2007:17). The researcher applied the axiological assumption by recognising the value-laden nature of the study and by attempting to minimise biases in the study, as evidenced by the measures she took to ensure the credibility of the study, as discussed in detail in chapter 2, section 2.3.4.1.

The rhetorical assumption determines the language of the study (Creswell, 2007:17). With reference to the rhetorical assumption, the researcher used qualitative terms and language and engaged in a personal and narrative style.

The methodological assumption determines the research process (Creswell, 2007:17). The researcher used inductive logic, studied the topic in its context and employed a phenomenological research approach. The researcher applied inductive logic, whereby logic is from specific observations to more general rules. In search for knowledge, it was the researcher’s aim in this study to generate an in-depth understanding of the experiences of parents living with mental health care users smoking cannabis. The researcher used “reduction” when entering the world of the participants in order to discover the core of the phenomenon, namely mental health care users smoking cannabis. Reduction is attaching meaning to elements in the data and then classifying the data into categories (Burns & Grove, 2005:548).

1.5 DEFINITION OF CENTRAL CONCEPTS

Certain concepts need to be defined in order that their use in this study is clear.

1.5.1 Experience

The process or fact of personally observing, encountering or undergoing something (The Free Dictionary, 2013).
1.5.2 Parents

A father or mother, one who begets or one who gives birth to or nurtures and raises a child, a relative who plays the role of guardian (The Free Dictionary, 2013).

1.5.3 Living with

To put up to, resign oneself to (The Free Dictionary, 2013).

1.5.4 Mental health care user

A patient who is mentally challenged and is under the care of psychiatric nurses and other members of the mental health care team. In this research, this concept refers to a person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user, state patient and mentally ill prisoner and where the person concerned is below the age of 18 years or is incapable of making decisions (Mental Health Act, Act no. 17, 2002:5).

1.5.5 Cannabis

Also known as dagga, marijuana (sometimes spelled "marihuana") among many other names, refers to any number of preparations of the Cannabis plant intended for use as a psychoactive drug or for medicinal purposes (United Nations Office on Drugs and Crime, 2006:14).

1.6 RESEARCH DESIGN AND METHOD

This section describes the research design and the method followed in conducting this study.
1.6.1 Research Design

A qualitative, descriptive, exploratory and contextual design was used for this study. This research design is described in detail in chapter 2, section 2.2.

1.6.2 Research Methods

Polit and Beck (2008:415) define research methods as “the techniques used to structure a study and to gather and analyze information on a relevant research question in a systematic way.”

The study will be conducted in two phases, which are detailed in the paragraphs that follow. In the first phase, phenomenological interviews will be conducted with parents living with mental health care users smoking cannabis. In the second phase, guidelines will be issued based on the data obtained from the interviews. This involves the issuing of guidelines for psychiatric nurses to assist mental health care users who smoke cannabis and their parents in order to mobilise their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of their overall health.

1.6.2.1 Phase 1: The experiences of parents living with mental health care users smoking cannabis

1.6.2.1.1 Phenomenological approach

A phenomenological study addresses the need to know more about a particular phenomenon and describes the common experiences of individuals experiencing the phenomenon (Creswell, 2007:103).
a) Population and sampling

Purposive sampling (Robson, 2007:99) will be used in this study. Participants will be selected until data saturation is reached (Burns & Grove, 2005:583).

b) Data collection

Parents will be interviewed at the hospital or at their homes at a convenient time. Data will be obtained by means of phenomenological in-depth interviews. A tape recorder will be used to record the interviews (Burns & Grove, 2005:545). The aim of these interviews is to allow these parents to speak freely in a relaxed manner. Each interview will last 30 to 45 minutes. The central question will be: "How is it for you living with child (mental health care user) smoking cannabis?" The researcher will make field and observation notes to describe her observations, reactions and experiences during interviews.

c) Data analysis

The audiotape recording will be transcribed verbatim and then analysed using Tesch’s open coding method (Creswell, 2007:156). Each transcript of an interview, as well as the field notes, will be read through and units of meaning underlined. Units of meaning will be grouped together to form categories. The categories will be grouped together to form themes. A clear set of transcribed interviews and field notes will be provided to an independent coder who is experienced in qualitative research. After the researcher and independent coder have analysed the data, they will meet for a consensus discussion.

d) Literature control

In qualitative research, the literature review provides the rationale for the problem and positions the current study in the ongoing literature about the topic. The findings
of this study were verified by means of a literature control in order to compare the similarities and differences of this study with other research studies concerned with participants’ experiences of the phenomenon. The literature control is presented in chapter 3.

1.6.2.2 Phase 2: Issuing of guidelines

Guidelines will be issued for psychiatric nurses to assist parents living with mental health care users smoking cannabis in order to mobilise resources to facilitate their mental health, based on the results of phase 1. A literature control will be done to justify the validity of the results obtained from interviews.

1.6.2.3 Measures to ensure trustworthiness

Trustworthiness is a term used in the evaluation of qualitative data (Polit & Beck, 2008:539). Lincoln and Guba (in Polit & Beck 2008:539) suggest five criteria for developing the trustworthiness of a qualitative inquiry. The following criteria are identified: credibility, transferability, dependability, confirmability and authenticity. These criteria are discussed in chapter 2, section 2.3.4.

1.6.2.4 Ethical considerations

In this study, humans will be used as the source of information; therefore the researcher must ensure the protection of her information and exercise great care in this regard. The researcher’s information is protected by adhering to the conditions discussed below. A good qualitative study is one conducted in an ethical manner. To a large extent, the validity and reliability of a study depend on the ethics of the researcher (Merriam & Associates, 2002:28).
a) Competence of the researcher

The researcher must display basic knowledge, skills and attitude in executing the research process (Poggenpoel, 2008:7). Since the researcher attended a research methodology course and learnt advanced psychiatric nursing skills, these will enhance the communication skills needed, especially during data collection.

b) Right to self-determination

The principle right to self-determination means that prospective participants have the right to decide voluntarily whether to participate in a study without risking penalty or prejudicial treatment. It also means that people have the right to ask questions, to refuse to give information and to withdraw from the study at any time (Polit & Beck, 2013:84).

c) Right to privacy

Privacy is the right an individual has to determine the time, extent and general circumstances under which personal information will be shared with or withheld from others. Such information consists of one’s beliefs, behaviours, opinions and records (Burns & Grove, 2005:186). The participants will be requested permission to audiotape the interviews.

d) Right to autonomy and confidentiality

On the basis of the right to privacy, the participants have a right to autonomy and a right to assume that data collected will be kept confidential (Burns & Grove, 2005:189). In this study, the researcher will not share the participants’ private information without the authorisation of the participants. Participants will be requested permission to audiotape interviews. The audio taped interviews will be kept under lock and key. Only the researcher and supervisors will have access to them. The audiotapes will be destroyed two years after publication of the study.
e) Right to full disclosure

Respect for human dignity encompasses people’s right to make informed, voluntary decisions about study participation, requiring full disclosure. Full disclosure means that the researcher has fully described the study, the person’s right to refuse participation and possible risks and benefits (Polit & Beck, 2013:84).

f) Right to protection from exploitation

Involvement in a study should not place participants at a disadvantage. Participants need to be assured that their participation, or the information they provide, will not be used against them in any way. For example, people describing their economic situation should not risk the loss of public health benefits; people reporting drug abuse should not fear exposure to criminal authorities (Polit & Beck, 2013:84).

g) Obtaining informed consent

An important procedure for safeguarding participants involved is obtaining their informed consent. Informed consent means that participants have adequate information about the study, comprehend information and have the power of free choice, enabling them to consent to or to decline participating voluntarily (Polit & Beck, 2013:87).

1.7 DIVISION OF CHAPTERS

The structure of the dissertation is set out below.

Chapter 1: Overview and rationale of the study

Chapter 2: Research design and method

Chapter 3: Research results and discussions relating to the experiences of parents living with mental health care users smoking cannabis
Chapter 4: Guidelines, conclusions, limitations, recommendations and summary

1.8 SUMMARY

Chapter 1 served as an introduction to the study. Important factors in executing the research were stated and supported by relevant literature. The research overview and rationale were included. The problem statement was formulated, and the research objectives and applicable paradigmatic perspectives for guiding the study, including the study design and method, were outlined.

In Chapter 2, a more detailed description of the research method and design will be presented.
CHAPTER 2: RESEARCH DESIGN AND METHOD

2.1 INTRODUCTION

In chapter 1, the rationale and overview of the research were discussed. In this chapter, the research design and methods that will be used for the study of the experiences of parents living with mental health care users smoking cannabis will be discussed in order that the researcher clearly reveals the research design and methods appropriate to the study.

2.2 RESEARCH DESIGN

A research design is a plan or a blueprint for a study; it guides an investigator in planning and implementing a study (Gills & Jackson, 2002:713). LoBiondo-Wood and Haber (2006:240) discuss three of the most common and useful purposes of conducting research, namely exploration, description and explanation. In this study, a qualitative, exploratory, descriptive and contextual design was used to meet the aim and objective as set out before.

2.2.1 Qualitative Design

In a qualitative research, the focus is on the quality of the information obtained from the person, situation or event sampled versus the size of the sample (Burns & Grove, 2005:358).

In qualitative research, a researcher often approaches reality from a constructivist position, which allows for multiple meanings of individuals’ experiences (Maree, 2007:257). According to Uys and Basson (2005:50), the term qualitative indicates that these approaches concentrate on the qualities of human experiences and actions. Qualitative research explores attitudes, behaviour and experiences, and
attempts to obtain an in-depth understanding from participants by conducting interviews (Dawson, 2006:14-50). This research is a phenomenological study, as it examines human experience by means of the participants’ thick and rich descriptions concerning their lived experiences (Brink, 2006:124). The researcher chose a qualitative design in order to fully understand the holistic picture of the experiences of parents living with mental health care users smoking cannabis.

Qualitative research is an “inquiry process of understanding based on a distinct methodological tradition of inquiry that explores a social or human problem” (Creswell, 2007:240). Qualitative research involves an “interpretive, naturalistic approach to the world”. It focuses on phenomena that occur in natural settings that are in the “real world”. It also involves studying these phenomena in their complexity to make sense of and to interpret the phenomena in terms of the meanings that people bring to them (Leedy & Ormrod, 2005:133).

Qualitative research allows the researcher to empower individuals to share their stories by voicing their experiences of the phenomenon (Creswell, 2007:40). The participants in this study were communicated to by means of phenomenological interviews and field notes. Qualitative research includes rich narrative descriptions classified in themes and processes to understand the participants’ experiences of the phenomenon (Polit & Beck, 2008:19). According to Creswell (2007:39), qualitative researchers give a holistic account of the issue being studied by reporting on multiple perspectives and identifying the many factors involved in a situation, thereby sketching the larger picture that emerges. The reporting of the phenomenon of interest is done by applying inductive reasoning. Inductive reasoning is the process of reasoning from specific observations to more general rules (Loiselle, McGrath, Polit & Beck, 2010:412).

2.2.2 Exploratory Design

The topic, namely the experiences of parents living with mental health care users smoking cannabis, has not been explored previously from the participants’ point of view. Exploratory qualitative research frequently involves the use of in-depth
interviews, the analysis of case studies and the use of informants (Polit & Beck, 2008:20). Polit and Beck (2008:21) further state that “exploratory qualitative research is designed to shed light on the various ways in which a phenomenon is manifested and on the underlying process”.

Creswell (2007:40) is of the opinion that an exploration of the phenomenon of interest is essential to hearing silent voices. The exploration of the phenomenon of interest gave the researcher an in-depth understanding of the phenomenon. Hence the objective of this study was to explore and describe the experiences of parents living with mental health care users smoking cannabis.

According to Uys and Basson (2005:38), exploratory studies are set out to explore a relatively unknown field. They aim at gaining insight and understanding. The purpose of exploring is to gain new insight into the domain of the phenomenon, to extend a preliminary investigation into a more structured study, to elucidate central concepts and constructs, to determine the priorities for further research and to develop a new hypothesis in respect of an existing phenomenon. The researcher is willing to explore areas that have been relatively neglected by other researchers (Morse & Field, 2002:12). Consequently, by exploring the experiences of parents living with mental health care users smoking cannabis, new knowledge will be generated and, moreover, insight will be gained into how these parents experience living with their children (mental health care users) smoking cannabis.

2.2.3 Descriptive Design

A descriptive study design provides an accurate portrayal of the characteristics of a particular individual for the purpose of discovering new meaning, describing what exists, determining the frequency in which something occurs, and categorizing information. Descriptive designs provide a picture of situations as they naturally happen and problems with current practice, justifying current practice and determining what others in a similar situation are doing (Burns & Grove, 2005:332,335,736).
According to Babbie (2004:89), “descriptive designs involve observations that are deliberate and careful to ensure accuracy and precision”. Descriptive studies seek accurate observations; the research design should focus on the trustworthiness of the observations and the appropriateness of the sampling method. This study focused on parents describing their experiences, including situations and events related to the research phenomenon, in narrative form.

### 2.2.4 Contextual Design

It is Creswell’s (2007:40) opinion that qualitative research is conducted because the researcher wants to understand the contexts or settings in which participants in this study address a problem or issue. In this research study, contextual research design is used in order to investigate into how parents in Tshwane who meet the sampling criteria, experience living with mental health care users smoking cannabis. The contextual nature of a qualitative research indicates that the description and exploration of a particular phenomenon occur in the natural context of the everyday life of the participants under investigation. The phenomenon can best be understood in the unique context in which it occurs (Dowson, 2006:30).

### 2.3 RESEARCH METHOD

This is referred to as the tools used to gather data (Dawson, 2006:14). Blaxter-Hughes and Tight (2006:29) refer to the research method as a key part of the research; the knowledge that the specific method uses depends on the research questions. This study will be conducted in two phases. In phase 1, in-depth interviews will be conducted with parents to explore and describe their experiences of living with mental health care users smoking cannabis. The following will be addressed: sampling data, collection, data analysis and literature control. In phase 2, all collected data from individual interviews, field notes and observations will be analysed. This analysis will lead to the formulation of guidelines by the advanced psychiatric nurse. Psychiatric nurses will then use these guidelines to assist parents
in mobilising resources to facilitate their mental health. A literature control will be done to verify the results obtained from the interviews.

2.3.1 Phase 1: The Experiences of Parents Living with Mental Health Care Users Smoking Cannabis

In this phase, the researcher will address the following: population and sampling, data collection, data analysis and literature.

2.3.1.1 Population and sampling

The population that will be used in this study will be the parents of mental health care users who meet the sampling criteria. The targeted population includes the entire membership of the group in which the researcher is interested and from which information can be collected (Hek, Judd & Moule, 2002:60). Population is the “process of selecting a portion of the population to represent the entire population so that inference about the population can be made” (Polit & Beck, 2008:33). The target population in this study refers to parents living with mental health care users smoking cannabis.

The targeted population in the study will be the parents of mental health care users who have been living with their children smoking cannabis for at least a year or two prior to data collection. The researcher chose purposive sampling, which is selecting participants with known characteristics; these include people who are knowledgeable about a situation (Robson, 2007:99). The concept of purposive sampling is used in qualitative research. This means that the inquirer selects individuals and sites for study because they can purposefully inform and give understanding of the research problem and central phenomenon of the study (Creswell, 2007:127). Purposive sampling involves the researcher’s intentional choice of individuals or groups of people to participate in the study (Creswell, 2007:127).
2.3.1.2 Sampling criteria

According to Polit and Beck (2008:339), researchers specify the characteristics that delimit the study population by implementing the inclusion and exclusion criteria when selecting participants.

2.3.1.2. a Inclusion criteria

Inclusion criteria is the criteria used by the researcher to designate the specific attributes of the target population and by which participants are selected for participation in the study (Polit & Beck, 2008:339). The inclusion criteria for this study are discussed in the paragraph that follows.

Parents of mental health care users smoking cannabis, aged between 18 and 35 years; the mental health care users must have been admitted for a year or more to a mental health care facility in Tshwane. The participants had to be willing to give informed consent and to disclose information regarding their experiences of living with mental health care user smoking cannabis. The time frame was stipulated in order to eliminate any emotional or physical discomfort. The participants had to be conversant in English, SeTswana and IsiZulu.

2.3.1.2. b Exclusion criteria

In line with purposive sampling, those parents who had been living with mental health care users suffering from any other mental health diagnoses except cannabis use or abuse. This also applied to parents living with mental health care users smoking cannabis who were admitted for a period less than a year.

Data collection will now be discussed.
2.3.1.3 Data collection

Data collection is the soul of the study. The validity or truth of all research depends on accurate data (Fink, 2005:106). Data is collected from people immersed in a setting of everyday life in which the study is framed (Maree, 2007:257). In this study, the researcher will be exploring and describing the experiences of parents living with mental health care users smoking cannabis. The researcher serves as an important instrument of data collection and asks the participants to share their views about experiences within the phenomena (Fink, 2005:106). According to O’Leary (2005:150), the first step in collecting data is access. Without access, obtaining credible data becomes impossible. The researcher must gain entry into the setting and develop a rapport with the participants (Burns & Grove, 2005:669). The researcher will use primary data collection techniques as described by Burns and Grove (2005:669) that are said to be reliable.

Data will be collected by means of in-depth phenomenological interviews, observations and field notes (Polit & Beck, 2008:394). Information will be gathered by questioning the individual participants directly. Polit and Beck (2008:396) describe observational notes as objective descriptions of events and conversations. The focus of the observation can be broadly defined events or highly specific behaviours. These include the observation of verbal communication such as tone, pitch and fluency of speech, as well as non-verbal communication such as body language, for instance gestures, eye contact, posture and facial expressions.

Phenomenological in-depth interviews, field notes and observational notes are discussed in detail below.

a) Phenomenological interviews

An interview is a personal conversation by means of which research information is obtained. It is a conversation with a purpose; qualitative research relies quite extensively on in-depth interviewing (Uys & Basson, 2005:58). One can take the stance that interviewing gives one access to a person’s subjective world (Gilham, 2000:93). According to Kumar (2011:160), in-depth interviewing is face-to-face
encounters between the researcher and the informants that are directed towards understanding informants’ perspectives on their lives, experiences or situations as expressed in their own words.

O’Leary (2005:162) states that interviewing is a method of data collection that involves researchers asking respondents basically open-ended questions. During this study, the researcher will use interviews, thus aiming at obtaining information about the human being, his or her opinions, attitudes, values and perceptions on his or her environment (Uys & Basson, 2005:59).

Data will be collected at a psychiatric institution in Tshwane by using in-depth semi-structured interviews which, according to O’Leary (2005:164), are flexible interviews. Interviews will generally start with some defined questioning plan, but will pursue a more conversational style of interviewing that may see questions answered in an order more natural to the flow of the conversation. Interviews will be conducted on a one-on-one basis since this allows the researcher to have control over the process and the interviewee freedom to express his or her thoughts (O’Leary, 2005:164).

Each interview will last for about 30 to 45 minutes. The participants will be asked to describe their experiences of the phenomenon (Burns & Grove, 2005:256). The interviewer will be a listener (Gilham, 2000:31). The following central question will be asked, “How is it for you living with a mental health care user smoking cannabis?” When eliciting information from participants, the researcher will use verbal and non-verbal communication skills such as exploring, reflection and open-ended questions. These are useful when seeking specific information because they focus on the topic and allow freedom of response. The researcher will also use clarification, eye contact, posture, gestures, touch and facial expressions (Gilham, 2000:31-50).

b) Field notes

Field notes are an important part of the data collection process, as it provides a written account of what is heard, seen and experienced in the course of collecting data (De Vos, 2005:311). Polit and Beck (2008:754) state that field notes are notes
taken by the researcher to record the unstructured observation made in the field notes as well as the interpretation of those observations. Writing down all that transpires during the interview will ensure that the period between data collection and data storing is minimised; it will also give the researcher time to reflect on the information before starting with the next interview. The researcher’s field notes in this study will include observational, methodological, theoretical and personal notes.

i) Observational notes

Observation is one way to collect primary data. It is a powerful systematic and selective way of watching and listening to an interaction or phenomenon as it takes place; it helps when studying the behaviour and personal traits of an individual (Kumar, 2011:141). Participant observation is when the researcher participates in the activities of the group being observed in the same manner as it members, with or without their knowledge that they are being observed (Kumar, 2011:141). Maree (2007:83-85) states that observation is an essential data-gathering technique. It provides an insider with the perspective of a particular person. It allows the researcher to hear and see, as well as to start experiencing as participants do. Observation enables the researcher to gain a deeper insight into and understanding of the phenomenon being observed.

This method (observation) assumes that behaviour is purposeful and expressive of deeper values and beliefs. The value of observation is that it enables the researcher to discover the recurring patterns of behaviour relationships. Robson (2007:84) refers to observation as watching people in some situation and making a record of what is seen. In this study, the researcher will be able to describe the experiences of parents living with mental health care users smoking cannabis by understanding the deeper perspectives captured through face-to-face interaction (Robson, 2007:84-85).

Participants’ observation is when the researcher is in the same room with the participants who are being observed and carries out his or her observation while participating in the same activity as the subjects (Uys & Basson, 2005:56). The researcher will be a participant observer (Uys & Basson, 2005:56). The researcher will make field notes during and after every interview. Morse and Field (2002:86-98)
state that field notes are a written account of the things that the researcher hears, sees and experiences. The researcher keeps progress notes that document the day-to-day activities (Burns & Grove, 2005:669). Field notes contain descriptions of the researcher’s reflections regarding conversations, interviews, intuition and the stimulation of new ideas during the study. The researcher gains an opportunity to attain a clear view of his or her thoughts (Maree, 2007:295).

ii) Methodological notes

In observational field studies, these are the notes kept by the researcher regarding the methods and strategies used for collecting the data (Polit, Beck & Hungler, 2006:649). Methodological notes are, in fact, notes to researchers themselves regarding the tactics they use to elicit data. In this study, the researcher will make methodological notes as a reminder to, for example, return to a point previously made by a participant where she could use her probing skill to gain more information. She will also continuously evaluate her methodological notes against the design and methodology of the study.

iii) Theoretical notes

The observer’s interpretations of observed activities (Polit, Beck & Hungler, 2006:658) are known as theoretical notes. According to Polit and Beck (2008:470), theoretical notes are used to document the researcher’s thoughts and his or her own interpretation of what is actually going on; what is really meant by what is being said or shown. In this study, the researcher will listen to what a participant is saying and compare it to what others said previously during their interviews. The researcher will then interpret, in her own mind, what had been communicated. In addition, by making eye contact with the individual participants and noticing the reactions they exhibit, for example, the researcher can attach meaning to what the participant is saying.
iv) Personal notes

Polit, et al. (2006:659) explain that personal notes are comments about the researcher’s own feelings during the research process; they are notes about the researcher’s own reaction, reflection and experiences. The researcher in this study will make notes of her own feelings, reactions and reflections during the interviews.

The field notes taken in this study enhanced the data collection process in the following ways: it provided additional information by noting the non-verbal behaviour of the participants, indicated emerging themes and sub-themes and was used to validate the collected data (De Vos, 2005:311). The researcher made field notes during and directly after each interview.

2.3.1.4 Data analysis

Data analysis is a process of bringing order, structure and interpretation to the mass of collected data. All data captured by means of interviews, observations and field notes will be analysed using Tesch’s six steps (Creswell, 2007:158). The steps are as follows:

1. the coder obtains a sense of the whole by reading through the transcriptions independently. Ideas that come to mind are jotted down;

2. the coder then selects one interview and asked, “What is this about?”, thinking about the underlying meaning of the information;

3. when the coder completes this task for several respondents, each interview is coded separately; thereafter a list is to be made of all the topics. Similar topics are clustered together and formed into columns that are arranged into major topics, unique topics and leftovers;
4. the coder takes the list and returns to the data. The coder attempts a preliminary organising scheme to see whether new categories and codes emerge;

5. the coder finds the most descriptive wording for the topics and turns them into categories, then endeavours to reduce the total list of categories by grouping together topics that relate to each other; and

6. the data belonging to each category is assembled in one place and a preliminary analysis performed, followed by a consensus discussion between the researcher and the coder.

2.3.1.5 Literature control

The literature control is an organised critique of the important scholarly literature that supports a study; it is a key step in the research process. Its overall purpose is to present a strong knowledge base for conducting a research project (Lobiondo-Wood & Harber, 2006:79).

Hunt (2005:61-62) states that by doing a literature control, the researcher demonstrates that he or she knows what research exists into his or her topic, gathers and reads subject-specific material, can analyse and comment on existing work, knows how his or her proposed research relates to the existing work and understands to what extent his or her proposed research is unique.

Literature control helps in contextualising the findings of the study, in comparing very systematic findings of the study with those made by other researchers. Quotes from other studies show how a researcher’s findings contradict, confirm or add towards the phenomenon under study. Literature control furthermore places the researcher’s findings in the context of what others have found, providing complete reference in an acceptable format (Kumar, 2011:41).
2.3.2 PHASE 2: Description of Guidelines that can be Used by the Psychiatric Nurses to Assist Parents to Mobilise Resources to Facilitate their Mental Health

In phase 2, guidelines derived from the results of phase one will be recontextualised with literature.

2.3.3 Ethical Measures
See discussion in chapter 1, paragraph 1.6.2.

2.3.4 Trustworthiness

Trustworthiness is a term applied to the evaluation of qualitative data using specific evaluation criteria (Polit & Beck, 2008:539). Lincoln and Guba (1985:289) suggest the following five criteria for developing the trustworthiness of a qualitative inquiry: credibility, transferability, dependability, confirmability and authenticity.

2.3.4.1 Truth value achieved by credibility

Polit and Beck (2008:539) define credibility as the “the confidence in the truth of the data”. Credibility also implies that the researcher should take charge of the entire course of the research process, building trust by honouring confidentiality and not breaking any promises, and understanding the phenomenon from the participants’ point of view (Trochum, 2006:1).

a) Prolonged engagement in the field

Prolonged engagement with the participants is achieved by remaining in the field until data saturation occurs. Prolonged engagement, according to Lincoln and Guba (1985 in Denzin & Lincoln, 2008:18), refers to the investment of sufficient time in collecting data in order to gain an in-depth understanding of the culture, language
and views of the participants. In this study, the researcher will interview seven participants until data saturation is achieved and no new themes emerge.

b) Triangulation

Henning (2005:103) defines triangulation as coming from various points or angles towards a “measured position” where the true position is found. In this study, various methods of data collection will be used such as individual in-depth phenomenological interviews with chosen participants, observations and field notes. These will be compared to existing literature.

c) Reflexivity

During this process, the researcher explores any personal feelings and experiences that may influence the study and he or she will integrate this understanding into the findings of the study. The researcher uses continuous observations by means of field notes and consistent pursuing of interpretations in different ways, in conjunction with a process of constant and tentative analysis (Babbie & Mouton, 2003:77).

d) Structural coherence

In this study, the focus will remain on the experiences of parents living with mental health care users smoking cannabis. Structural coherence entails that there should be consistency between the data and the interpretation of the data, even if data may conflict; credibility is ensured if the apparent contradictions can be explained by the interpretation of the data (Repko, 2008:214).

e) In-depth interviewing

The purpose of in-depth interviewing is to allow the interviewer to enter into the interviewee’s perspective in order to discover what is in and on someone else’s mind (Patton, 2002:341-348). In this study, the participants will have an opportunity to respond in their own words and to express their own personal perspectives. The researcher will be able to discover things that she cannot directly observe such as
the thoughts, feelings, intentions and meanings that people attach to what goes on in the world.

f) Authority of the researcher

The researcher has the authority to conduct this study as she has been successfully trained in research methodology. Again, the researcher is under the supervision of an advanced psychiatric nurse and an educator with experience in this field of study.

g) Peer review

The supervisors will guide the candidate through the entire research process. Furthermore, the services of a colleague with experience in a qualitative research method will be employed to discuss the study process.

2.3.4.2 Applicability achieved by transferability

Polit and Beck (2008:339) contend that transferability is “the extent to which the findings can be transferred to or have applicability in other settings or groups”. In this study, purposive sampling (Babbie & Mouton, 2001:277) will be used and sufficient descriptive data provided in the research report for the evaluation of the applicability of the data to other contexts. Guba and Lincoln (1985:365) discuss the use of dense description as a strategy to ensure transferability. Because transferability in a qualitative study depends on similarities between sending and receiving contexts, the researcher collects sufficiently detailed descriptions of data in context and reports them with sufficient detail and precision in order to allow the reader to make judgements about the transferability aspect.

Some of the strategies that will be used to ensure transferability will now be discussed.
a) Dense description of demographics

A clear and detailed description of the demographics of the participants will be presented.

b) Rich description of the results

A rich in-depth description of the results, with supporting direct quotations from the participants, will be provided.

2.3.4.3 Consistency achieved by dependability

Dependability indicates the consistency of the findings even if the inquiry was to be replicated in another context. According to Polit and Beck (2008:539), dependability refers to the stability of data over time and conditions. The researcher will use a code-recode procedure, which means that, even at a later stage, she will be in a position to recode the same data. She will also use an independent co-coder to confirm the findings. This can be achieved by following the procedures discussed in the paragraphs that follow.

a) Dependability audit

This is when the researcher can clearly follow the audit trail used by the original research in the study. In this study, the researcher will keep reflectivity notes to facilitate the audit trail, in order to put other researchers in a position to trace the methods used to promote a dense description of the experiences of parents living with mental health care users smoking cannabis.

b) Dense description of the research method

The research method was discussed in depth.
c) Code-recode procedure

Coding is whenever one finds a meaningful segment of text in a transcript; one assigns a code to signify that particular segment (Maree, 2007:105). This is the consensus discussion between the researcher and an independent coder. Both the researcher and the independent coder will discuss the data collected in order to reach consensus about the lived experience.

d) Triangulation

In addition, the researcher will triangulate all data collected during the process, including the results of the interviews and field notes, in order to search for common themes to provide reliable findings.

2.3.4.4 Neutrality achieved by confirmability

This is the fourth and last criterion in ensuring trustworthiness. Neutrality is the extent to which the findings of the study are free from bias (Maree, 2007:295). Neutrality promotes others’ acceptability of the study as worthy. The researcher will approach this study and enter the field without subjectivity or a set of ideas. The approaches that follow will be used to facilitate neutrality.

a) Confirmability

External auditors will attempt to follow the research process to understand why and how decisions were made. The three supervisors and the qualitative independent coder will be working closely with the researcher to ensure confirmability.

b) Reflexivity

Field notes will be taken as previously defined in paragraph 2.3.1.2 (b).
c) Description of the methods to be applied in data collection

A detailed description of the methods used for collection, analysis and interpretation of the data will leave a clear trail of evidence, allowing other researchers to follow the process back to the original researcher.

d) Literature control

Literature control was discussed in paragraph 2.3.1.4.

2.5 AUTHENTICITY

Authenticity demonstrates fairness and implies that the researcher must have the participants’ scenarios treated fairly and with respect. Polit and Beck (2008:540) support the notion by defining authenticity as the extent to which researchers fairly and faithfully show a range of different realities. The researcher will present a report that conveys the perceived true feelings of the participants’ lives in relation to the research phenomenon as it was lived during the study. The researcher will not marginalise the participants, but will firmly include them as agreed to. The researcher will use verbatim quotes and consciously include verbatim quotes from all the participants in order to represent their experiences in a fair manner. Brink (2006:118) agrees with the aforementioned author by stating that authenticity can be established by means of context-rich and meaningful or thick descriptions.

2.6 SUMMARY

This chapter presented a dense description of the research design and method. The researcher will apply a qualitative, exploratory, descriptive and contextual design, using individual in-depth phenomenological interview strategies in order to elicit information about the experiences of parents living with mental health care users smoking cannabis. Measures aimed at ensuring trustworthiness were also discussed.
Chapter 3 will focus on the results of the investigation and the discussions of these results.
CHAPTER 3: EXPERIENCES OF PARENTS LIVING WITH
MENTAL HEALTH CARE USERS SMOKING CANNABIS

3.1 INTRODUCTION

In this chapter, the researcher discusses, in detail, the results of the research study of the experiences of parents living with mental health care users smoking cannabis. These experiences are expressed by participants during interviews and the researcher’s observational notes, and identified by means of the data analysis. The results were obtained by using Tesch’s method (Creswell, 2007:158) of open coding. The findings are presented according to the central themes and categories.

3.2 ANALYSIS OF INTERVIEWS

In this research study, seven interviews were conducted in order to reach data saturation (Shank, 2002:30). Observational notes were also made on participants’ reactions to questions asked. The participants comprised seven females aged between 45 and 50 years old. All the participants met the criteria set in chapter 2. They all signed the consent form and gave permission to be interviewed and be audiotaped.

The central question asked to all participants was, “How is it for you living with a mental health care user smoking cannabis?” The seven interviews were tape-recorded after a consent form had been signed by the participants. The interviews were transcribed and analysed. The interviews were conducted, throughout the process, in the hospital and at the participants’ homes, after having obtained permission from the Chief Executive Officer (CEO) of the mental health hospital to conduct the research. The CEO’s permission was granted by means of a written letter (see annexure 3). The times of the interviews were agreed on between the researcher and the participants to be convenient and suitable for the participants as well as the researcher. All the interviews were conducted during the day.
The interviews were transcribed and analysed using Tesch’s method of open coding (Creswell, 2007:158). Consensus was reached between the researcher and the independent coder. The independent coder holds a postgraduate qualification and was previously used by the University of Johannesburg for the coding of other qualitative research studies.

In order to identify the similarities and the uniqueness of the results, a literature control is used (Creswell, 2007:158) in the final section. The analysis of the data is supported by verbatim quotes from the participants’ interviews in order to provide evidence of the themes.

3.3 DESCRIPTION OF THE ENVIRONMENT IN WHICH THE RESEARCH WAS CONDUCTED

The research was conducted in a Gauteng psychiatric institution; in the case of some participants, the research was conducted at their homes. In this psychiatric institution, all the mental health care users are admitted under Act no. 17 of 2002 (Government Gazzette, 2004:4). Mental health care users are admitted as voluntary, assisted, certified and forensic mental health care users. In the wards where the interviews were conducted, rooms suitable for conducting interviews were provided. The same held true for the rooms provided by the participants for interviews that were conducted at their homes.

3.4 DESCRIPTION OF THE SAMPLE

All the participants are parents of mental health care users smoking cannabis. Their children, aged between 18 and 35 years, have been admitted to a psychiatric institution for more than once. All seven the participants were females and working in different fields. It was not the researcher’s intention to interview only female participants, but due to the unwillingness of the male parents, as well as the fact that some parents are single parents (female), the researcher had no other choice as to
interview only the mothers, as they were available and willing to participate in this research study.

These parents were secretly and individually approached with regard to obtaining permission for participation in a study that would enable them to describe their experiences of living with mental health care users smoking cannabis. Participation was regardless of their residential place, race or level of education. The criterion used was the willingness of the participants to engage in the study. Only parents who met the inclusion criteria were approached, as discussed in chapter 2. Purposive sampling was used to select participants. The researcher established a rapport with the participants, which facilitated the data collection process. The rights of the participants were protected as described in chapter 1. Their ages ranged from 45 to 50 and upward. The sample size was determined by data saturation. According to Burns and Grove (2005:359), the quality of information obtained from interviews and observations influences the sample size. The higher the quality and richness of data, the fewer participants are needed to achieve data saturation in a study.

3.5 ANALYSIS OF THE FIELD NOTES

During the data collection process, the researcher kept the notes from her various sources: documenting observation (participant observation), experiential or reflective remarks (Burns & Grove, 2005:549), and theoretical and methodological observation (Burns & Grove, 2005:225), which are detailed in the paragraphs that follow.

3.5.1 The Researcher’s Observation during the Interview Process

During the period of the interviews, the researcher noted that some of the participants seemed to have found someone who could listen to their terrifying life stories. They were freely expressing their challenges; at times they even raised their tone of voice as a form of wanting to be heard more clearly. Others seemed not to be taking their everyday-life challenges well, as was evident by them displaying signs of helplessness and hopelessness when asked to describe their experiences of living
with their children. Some of them needed to be probed further in order for them to express themselves. They appeared sad; the researcher observed that some of them were sobbing during the interviews.

The researcher also noted that some of them seemed to be uneasy with the use of an audiotape recorder, even though they were prepared for and informed beforehand about the use of an audiotape recorders. At some stage they were not audible enough and seemed distracted, as is evident by that fact that they did not answer questions asked correctly. Some of the participants were observed to be a bit agitated; they persistently tapped on the floor with either one or both of their feet, or even tapped on the table with their fingers. The researcher also observed that some experienced fine hand motor tremors, while still others experienced some sort of thought blocking. They seemed cautious in terms of sharing their experiences, as evident by the fact that they became shy when talking about the unacceptable behaviour of their children.

Prior to the interviews, each participant was briefed about the research objectives, the process of interviewing and the entire study, with emphasis on the ethical measures and confidentiality.

### 3.6 DISCUSSION OF THE RESULTS

The central story line reflects that as a parent, living with a child (mental health care user) who uses cannabis, is a “painful” experience linked to unfulfilled parental expectations, strained interpersonal relationships that contribute to an unsupportive environment for both the parents and the user, a sense of loss related to the pervasive changes in the child’s ways of being, living in an unsafe home environment culminating in a sense of betrayal and emotional turmoil expressed as feelings of helplessness, hopelessness and despair, triggering a “death wish” concerning the mental health care user who uses cannabis.

Parents living with mental health care users smoking cannabis are challenged by the type of life their children are living. Instead of these children living their lives
according to their parent’s expectations, they choose to smoke cannabis. Smoking cannabis leads to poor performance at school; they fail grades and eventually drop out of school. They involve themselves in criminal activities such as stealing, car theft, house-breaking, rape and prostitution. They experience that their children’s personalities change. These mental health care users smoking cannabis furthermore do not adhere to the prescribed treatment; hence they relapse and become aggressive and violent as a result. They are admitted to psychiatric institutions time after time. This kind of behaviour of these mental health care users negatively affects the lives of the people around them.

The discussion of the findings of the parents living with mental health care users smoking cannabis is presented in a narrative format based on the outline provided in table 3.1. Tesch’s open descriptive methods of data analysis were employed, as described in chapter 2 (2.3.1.4) (Creswell, 2007:158). The discussion is guided by the central story line, representing the essence of these parents’ perspectives of the research phenomenon, followed by a discussion of the themes and sub-themes. The verbatim quotes of participants, gathered from the different data sources (individual phenomenological interviews and field notes), are used as supporting evidence throughout the discussion. These quotes are reflected in italic writing. Data saturation was reached after the seventh interview, as evidenced by no new themes emerging during the rest of the data collection process. This was also confirmed by the independent coder (see annexure 7).

The experiences of parents living with mental health care users smoking cannabis are categorised into themes and categories, as are reflected in table 3.1.
Table 3.1 - Experiences of parents living with mental health care users smoking cannabis

<table>
<thead>
<tr>
<th>THEMES</th>
<th>CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Experiences of unfulfilled parental expectations linked to the behaviour of the child, the chronic nature of “dagga” use and a sense of failing the self</td>
<td>1.1 Experiences of unfulfilled parental expectations linked to the behaviour of the child</td>
</tr>
<tr>
<td></td>
<td>1.2 Experiences of unfulfilled parental expectations with regard to recovery from “dagga” use</td>
</tr>
<tr>
<td></td>
<td>1.3 Unfulfilled parental expectations linked to a sense of failure as a parent</td>
</tr>
<tr>
<td>2. Experiences of strained interpersonal relationships contributing to an unsupportive environment for both child and parents</td>
<td>2.1 Experiences of strained interpersonal relationships between the parent and the child</td>
</tr>
<tr>
<td></td>
<td>2.2 Experiences of strained interpersonal relationship between the siblings and the child</td>
</tr>
<tr>
<td></td>
<td>2.3 Experiences of strained interpersonal relationships between other relatives and the child</td>
</tr>
<tr>
<td></td>
<td>2.4 Experiences of strained interpersonal relationships between the wider community, including the police, and the child</td>
</tr>
<tr>
<td>3. Experiences of a sense of loss related to the pervasive changes in the child’s ways of being</td>
<td>3.1 Experiences of perceived personality changes</td>
</tr>
<tr>
<td></td>
<td>3.2 Experiences of aggression and violence</td>
</tr>
<tr>
<td></td>
<td>3.3 Experiences of anti-social and criminal behaviour</td>
</tr>
<tr>
<td>4. Experiences of living in an unsafe home environment, culminating in a sense of betrayal</td>
<td></td>
</tr>
<tr>
<td>5. Experiences of emotional turmoil expressed as feelings of helplessness, hopelessness and despair, triggering a death wish</td>
<td>5.1 Experiences feelings of helplessness, hopelessness and despair</td>
</tr>
<tr>
<td></td>
<td>5.2 experience desiring an extreme resolution to an untenable situation- a coping mechanism</td>
</tr>
</tbody>
</table>

The themes and categories identified in the results will be discussed in this section, in the same order as tabulated above.
3.6.1 Theme 1: Experiences of Unfulfilled Parental Expectations Linked to the Behaviour of the Child, the Chronic Nature of “Dagga” Use and a Sense of Failing the Self

Mental health care users smoking cannabis do not live up to the expectations of their parents. For these parents, their children’s deviant behaviour results in unfulfilled parental expectations.

3.6.1.1 Experiences of unfulfilled parental expectations linked to the behaviour of the child, the chronic nature of “dagga” use and a sense of failing the self

All parents want a better and a brighter future for their children. For these parental expectations to be fulfilled, the parents become part and parcel of their children’s academic life. These parents become involved in their children’s school work; they assist their children with home work and assignments, they attend parents meeting in order to learn what is happening at their children’s school, the children’s progress as well as intervening where needed.

The parents continue to support their children emotionally, physically, financially and otherwise. These parents also mould the behaviour of their kids; they teach their kids good morals and behaviour, which include being truthful, showing respect for others, especially the elders; these parents also teach their children to be loving and caring, and encourage them to express their feelings in order to prevent their children from repressing their feelings, which might cause problems later in life.

As these children grow, the level of expectation from their parents also rises. It is expected of them to be more understanding and responsible for their actions. It is expected of them to perform well at school, pass all grades at the required time, become university graduates and, finally, become the “working class”. But all these parental expectations do not realise as the parents longed for; instead, their children behave in a certain way with which their parents are not acquainted; these kids become truant, they fail grades, they drop out of school and get expelled. And when things start going wrong, or not going according to plan, between the children and
their parents, many divergences occur. Since these children are unable to meet certain obligations due to reasons like not having a basic education, or having been implicated in criminal behaviour that hampers them from getting employed, several conflicts in terms of roles arise. Being unemployed is a challenge in itself. Having to meet the obligations of other family members who require financial aid poses yet another problem when one is unemployed. This can pose a serious threat to the happiness, productivity and existence of the system, as it means that their parents must continue to financially support these kids. This is what the participants said:

“... He failed grade 9 three times ...”

“... At his school they were saying he does not attend school as expected ...”

“... They wrote a letter telling that she is expelled from the school ...”

“... At his school they were saying he does not attend school as expected ...”

“Improving academic performance is an important goal for teachers and parents alike as youth face adulthood and an increasingly competitive job market that requires advanced learning skills. During adolescence, intellectual, physical and emotional development is 'critical' (Regan, Zhang, William, Johnson, & Daniel, 2003:109-111).

Regan et al. (2003:109-115) suggest that cannabis use impairs cognitive ability and may interfere with the learning process or retard motivation to learn. According to Tristan and Barry (2012:371), studies found that college students who use cannabis regularly have impaired skills concerning attention, memory and learning 24 hours after they had last used the drug, suggesting that cannabis smoking impairs the cognitive process. Studies have shown that the use of cannabis may increase the risk of discontinuing high school and of increasing job instability in young adults; these effects on development may cascade throughout young adult life and impact on the user’s quality of life.
3.6.1.2 Experiences unfulfilled parental expectations with regard to recovery from “dagga” use

When these children receive treatment from either the psychiatric institution or a rehabilitation centre, staying away from cannabis becomes their mainstay goal, with the help and the continuous support of their parents and the health care-providers; in the long run, after the assessment and the evaluation of the health care professional, they are discharged and go back to their respective communities to live with their families. The parents have hopes that since their children are “rehabilitated” from cannabis, they will now live their lives without the influence of cannabis.

The following quotes support participants’ experiences in this regard:

“... There were some unlawful things that he did with his friends hence he was fired there ...”

“... My aunt’s son thought that when my son gets out of jail he will be a changed person ...”

“... He is fine and then smokes dagga again, and then he goes back ...”

“... When she reaches home, she starts all over again, It’s like I’m wasting my money ...”

Although scientists do not yet know whether the use of cannabis causes mental illness, high doses can induce an acute psychosis, disturbed perceptions and thoughts, including paranoia and/or panic attacks. In people who already suffer from schizophrenia, cannabis use can worsen psychotic symptoms. Evidence to date suggests a link between early cannabis use and an increased risk of psychosis among those with a pre-existing vulnerability (National Institute on Drug Abuse, 2003:7).
3.6.1.3 Experiences unfulfilled parental expectations linked to a sense of failure as a parent

Parents carry hope and aspirations that taking care of their children, raising them and taking them to school will bear fruit that will benefit the rest of the family members, such as their children becoming responsible grown-ups who work and are financially stable, having their own houses and having children. But when these hopes and aspirations are not fulfilled due to their children’s deviant behaviour, the parents tend to blame themselves for their child’s failure in life. Most parents think that they are responsible for their child’s behaviour, and yet they are not the ones who created or influenced their children’s unacceptable behaviour. They regret at having failed to raise a “good child”. They also feel that other people blame them for their child’s behaviour and, as a result, they feel embarrassed about their child’s behaviour. The participants have this to say:

“… I thought he will attend school as expected of him so that he can be a role model to my younger son …”

“… Eish that he can be a child that I raised; a child that I saw that it will be a good child …”

“… Now my heart is painful because what I longed for will never happen …”

“… Every parent wants a better future for his or her children …”

Many parents feel depressed and are filled with shame because they were not able to produce a happy family. They question their parenting abilities, agonise over where they went wrong and start to feel like failures. Women particularly live under the threat of not meeting societal expectations and being condemned as bad mothers (Cottrell & Monk, 2004: 107).
3.6.2 Theme 2: Experiences Strained Interpersonal Relationships Contributing to an Unsupportive Environment for both Child and Parents

When children behave in a way that is socially unacceptable, their families and the people around those children experience some form of broken relationships between the user and parents, siblings, relatives and the community at large.

3.6.2.1 Experience of strained interpersonal relationships between the parent and the child

When a child’s behaviour suddenly changes, parents are the first ones to notice the sudden change in behaviour since they know their children better than anyone else. A change in behaviour causes many challenges for those affected, especially when the change is negative. As for these parents, they will do everything in their power in trying to correct the behaviour of their children.

Since these children behave the way they do while under the influence of dagga, things can turn out very ugly between the parent/s and their children. These children may become disrespectful towards their parents, becoming both verbally and physically aggressive when reprimanded for their unruly behaviour. They shout, swear at their parents or even fight their parents. The following quotes express the views of the participating parents:

“... He becomes aggressive when I try to reprimand him ...”

“... You as a parent you just tolerate her because she is your child. Other family members can’t, and they just run away from you ...”

“... She shouts and fights with me ...”

“... It's like there is no bond between the two of us ...”
The *stress-strain-coping-support* model (Arcidiano, Vellerman, Procentese, Bereti, Albanesi, Sommantico, & Coppello, 2010:659-680) suggests the following: Firstly, living in a family where someone misuses alcohol or drugs (cannabis) is commonly very *stressful*, both for the person misusing the substance and anyone who is a close family member. Secondly, these family members, who are concerned about and affected by a drinking or a drug problem in the family, are likely to show signs of *strain*, including forms of physical and psychological ill-health. Thirdly, family members in this situation are often faced with a difficult life task involving trying to understand what went wrong and what to do about it (referred to ways of understanding and of responding as *coping*). Lastly, family members can be helped or hindered in how well they respond and by how other people react and interact. This is the *support* component; the other people include other family members, friends, neighbours and professionals.

According to Boehlke (2011:15), the family members of a child smoking cannabis can experience a financial challenge. The amount of money that is spent on the drug can be significant. The money used for someone’s recreational drug or drug habit could be the money that should pay something else in the family such as bills, groceries and household expenses. People who are caught using or carrying cannabis could face serious jail time, probation and court costs and fines. If their employees are aware of their drug use or they fail a drug test at work, they could be fired. This could be a devastating blow to the overall financial income on which a family relies.

### 3.6.2.2 Experience of strained interpersonal relationships between the siblings and the child

Siblings are expected to love, respect and care for each other, but this is not the case when one of the siblings smokes cannabis. Instead, there is a communication break down between the sibling under the influence of cannabis and other siblings, as he or she might respond in a way that angers the other sibling. This scenario also creates resentment between the siblings, since the parents’ energy and time are
seen as largely focused on the one who smokes cannabis. The participating parents expressed their views as follows:

“… It becomes chaotic, because the one (younger son) after my son becomes irritable about his brother’s behaviour. So, in that note, my younger son no longer speaks to his brother …”

“… His sister always argues and fights with him when his sister reprimands him of his behaviour …”

“… My daughter no longer speak to him, she just leaves him like that …”

When an adolescent uses alcohol or drugs, siblings in the family may find that their needs and concerns are ignored or minimised while their parents react to a continuous crisis involving the adolescent who abuses alcohol or drugs (National Institute on Drug Abuse, 2003:11). Adolescents’ abusive behaviour affects other children in the home and parents fear for their safety. Some parents are concerned that observing a sibling’s dangerous activities such as aggression and drug abuse, may affect the other children and put the rest of the family at risk. In addition, focusing on the abusive teen often leaves little time and energy for parents to pay attention to other children (Cottrel & Monk, 2004: 1075).

3.6.2.3 Experience of strained interpersonal relationships between the other relatives and the child

Relatives who are aware of the child’s misconduct are likely to point fingers at the child when their possessions go missing, irrespective of whether that child stole their goods and valuables or not. The child is labelled a “thief”. People who abuse substances are likely to find themselves increasingly isolated from their families. This is evident from the following verbatim quotes:
“… Since they know his behaviour, even if it’s not him, they will say it’s him, knowing that he is a thief …”

“… The other family members are not close, they are not very supportive, and they are not here …”

“… He doesn’t have communication even with my two younger brothers, because wherever he goes or visit, as soon as he left, they are always complaining about him …”

“… The challenges are that now my son makes me fight with my relatives. We are no longer close with my sisters …”

A growing body of literature suggests that substance abuse has distinct effects on different family structures (National Institute on Drug Abuse, 2003:15). The effects of substance abuse frequently extend beyond the nuclear family. Extended family members may experience feelings of abandonment, anxiety, fear, anger, concern, embarrassment or guilt, or they may wish to ignore or cut ties with the person abusing the substance. An older adult with a substance abuse problem can affect everyone in a household. More family resources may need to be mobilised to treat the older adult’s substance use disorder (National Institute on Drug Abuse, 2003:15). The emotional damage and social isolation caused by victimisation may also be compounded by a lack of support, and even stigmatisation, from friends, family and social institutions, which can cause a second wound in the victim. Those closest to the victim may be traumatised by the crime in ways that make them unsupportive of the victim’s needs. Davis, Taylor and Bench (National Institute on Drug Abuse, 2003:18) found that close friends and family members sometimes withdraw from and blame the victim.

3.6.2.4 Experiences of strained interpersonal relationships between the wider community, including the police and the child
Every day in community life events, either negative or positive, like funerals and weddings respectively, takes place. Community members keep talking about these different types of social activities. It does not end there, however; criminal activities also take place, which community members experience by being either the victim or the bystanders.

One will hear people along the streets, taverns and pubs, church and meetings, talking about what happened, how it happened or even what they saw. People or community members share and exchange their views, thoughts and opinions about any type of event such as criminal behaviour and social activities. In their conversations, among other things, you will find community members criticising or disapproving criminal behaviour; some even suggest to others what should be done, like involving police officers and/or hiring security guards to provide the members of the community with security day and night.

Due to the high volume of criminal behaviour that keeps community members, and even strangers talking, people easily forget that while sharing or exchanging their thoughts about criminal behaviour, there is a chance that they might know the child they are talking about, that they might even be related to, or that it might be the child of the parents they share and exchange opinions about.

Should this happen, the parents of the perpetrator might feel anger towards their own community members to whom they talk about their child. This can lead to broken relationships between members of the community, such as neighbours, church members and members of the social group and the parents, as the parents of the child (perpetrator) might confront and tell the child that he or she (the parent) got or heard the information from their neighbours; the child might pick a fight with the particular neighbours and by so doing, the neighbours might call the police for help, which again might lead to the child being taken to prison because of his or her behaviour.

The participants had the following to say:
“... Some you just hear them gossiping around, not recognizing you, and you could hear that it is your child they are talking about ...

“... We no longer communicate with our neighbours because she fights with them ...

“... They will call you all sorts of names, when your child goes out, they say you sent her to go and steal, or do unacceptable things so that you can have an income at home ...

“... Initially we had a good relationship, until he started being involved in criminal activities, house breaking, car-theft, so we are no longer close with my neighbours ...

Criminal activity is a huge societal problem and some of it is related to the use of cannabis (National Certificate of Educational Achievement, 2012:5). According to the recent trends in illegal drug use 2011 report, 33% of frequent users said they encountered problems due to illegal behaviour in the past six months (National Certificate of Educational Achievement, 2012:8). As indicated by the New Zealand arrestee drug use monitoring 2011 report, the number of people who had been using cannabis in the past month prior to being detained increased from 14% in 2010 to 18% in 2011, and the proportion of people who were using cannabis at the time of being detained increased slightly from 3% in 2010 to 5% in 2011 (National Certificate of Educational Achievement, 2012:10). Cannabis abuse leads to criminal activity, whether it be theft, violence or vandalism of property, all of which make it a community and societal problem (National Certificate of Educational Achievement, 2012:14). Many users attempt to steal money from their family members and neighbours to support their drug habits. In the long-term, criminal activity damages the reputation of local communities, leading to major property damage that cannot always be cleaned or repaired (National Certificate of Educational Achievement, 2012:15). Families and communities suffer as a result of violent crime committed due to cannabis use. Families are also torn apart when loved ones go to prison for drug-related crimes (National Certificate of Educational Achievement, 2012:17).
3.6.3 Theme 3: Experiences Sense of Loss of Parents Related to the Pervasive Changes in the Child’s Ways of Being

As stated in theme 2, children who smoke dagga do change their behaviour, which means that their personalities also change. The parents experience a sense of loss in the following ways: experiences of perceived personality changes, experiences of aggression and violence and experiences of anti-social and criminal behaviour.

3.6.3.1 Experiences perceived personality changes by parents

When a child’s behaviour and personality change, his or her parents’ perception of him or her is completely different, especially when the change is from good to bad, as in participants’ experiences. For example, these children, before they started smoking cannabis, were perceived as “good” children by their parents. This can be challenging and frustrating for the parents since the “change” is persistent and has a bad effect on the parents.

The parents said the following:

“… I don’t know my son to be like this …”

“… He smokes and when he had smoked, he becomes another person …”

“… If he can go back to the person that I know …”

“… Suddenly he quit going to church, and that’s when we noticed that he has now changed …”

According to the American Psychiatric Association, 2000 (in Haase, 2009:58), people with anti-social personality disorder demonstrate impulsive and aggressive behaviour, have a low tolerance of boredom and behave irresponsibly. Individuals
with anti-social personality disorder externalise their difficulties; they attribute blame to others and do not want to face the consequences of their actions; they lack empathy.

3.6.3.2 Experiences of aggression and violence by parents

Managing the child who smokes cannabis or trying to control the child’s behaviour since the change in behaviour occurred, can be challenging to the child’s parents, because the child displays aggression and violence towards the parents and other members of the family. The following quotes support participants’ experiences in this regard:

“… He becomes agitated and very physical aggressive when you speak to him …”

“… She uses whatever she can get hold of to injure people …”

“… I’m afraid of him because when you talk to him, he becomes aggressive …”

“… He shouts, and I would say, ‘don’t talk to me like that’. And he will say, ‘It’s my life, this is my time, and it is not that time of yours’ …”

Adolescent violence in the home occurs as part of a continuum of abusive behaviours that frequently starts as verbal abuse and progresses over time to emotional and physical abuse (Eckstein, 2004:365-388). The range of abuses against family members may include the abuses mentioned in the paragraph that follows.

Physical violence – hitting, punching, kicking, using weapons, threatening physical gestures, damage to property – breaking or damaging property and emotional, verbal and psychological abuse – screaming, yelling, making threats against self and
other family members, insults, intimidation, coercion, humiliation, blaming, manipulation, public abuse and verbal abuse against parents, frequently “echo” language used by abusive and violent partners (Howard, 2011:02). Adolescents may denigrate their parents’ appearance, intelligence, parenting, care and ability to nurture and contribute meaningful to society. They are also prone to financial abuse – extortion and demanding money - in- and outside the home contexts.

A report from Mary Brett (2006:28) concludes that the early use of cannabis - the drug most widely used - is a warning sign for later gang involvement. Serious problems such as fighting with weapons, breaking windows and theft among males, and aggressive acts, violent quarrels with teachers, public cursing or being sent to see the school head among females, were all predicators of early cannabis initiation (Pederson, Mastekaasa & Wichstroom, 2001:415-431). Dengenhardt, Hall and Lynskey (2003:37-48) state that those who use dagga (cannabis) at an early age are at a greatest risk of delinquency and violence.

3.6.3.3 Experiences anti-social and criminal behaviour by parents

Well-behaved children are perceived to be the ones who display socially acceptable behaviour. These children are the ones who are responsible for their actions, the ones who, when they have done anything wrong, become remorseful of their actions; they show feelings of guilt as well as empathy towards the victims. These children are those who are able to conform to the law, the ones who do not commit any form of crime. They do not violate other people’s rights; they do not exploit or manipulate other people for their own personal gain. They are able to sustain consistent employment and are able to develop stable relationships.

Contrary to such children’s behaviour, parents living with mental health care users who smoke cannabis, , instead experience that their children exhibit anti-social and criminal behaviour that is characterised by stealing, shoplifting, house-breaking, car-theft, rape, prostitution and spending time in jail. These children steal from their parents, siblings, neighbours and the community at large. They steal money, home appliances, jewellery and furniture. It does, however, not end there; some of these
children, while under the influence of cannabis, engage themselves in sexual activities, putting themselves in danger of contracting sexually transmitted diseases that expose them to HIV and Aids, since some of these children deflect to prostitution, some of them commit rape. Because of these children’s socially unaccepted behaviour, one can only imagine how challenged their parents, siblings, neighbours and members of the community are; hence, when these children are taken to prison because of their deviant behaviour, it often comes as a relief to their parents, who are harmfully affected by their children’s behaviour.

The participants said the following in this regard:

“He steals from his brother. He steals from his sister, and he steals even money at home …”

“… He started being involved in criminal activities, house breaking, and car theft …”

“I … think that she is selling her body for money …”

“… She is in and out of the jail …”

According to the Australian Bureau of Statistics’ (2006:102-05) Crime and Safety Survey, 2005, approximately 70 percent of persons aged 15 years and over perceive that there are problems relating to crime and/or public nuisance in their neighbourhoods. Some of the most commonly perceived problems are dangerous or noisy driving (40% perceived this as a problem), housebreaking, burglaries and theft from homes (33%), vandalism and graffiti (25%), car theft (17%), youth gangs (15%) and drunkenness (13%).

According to McAttamney and Morgan (2009:03), the term anti-social behaviour incorporates a range of behaviours - from minor offensive or harmful acts to more serious criminal activity. Anti-social behaviour is a serious cause of concern to Government, non-governmental organisations, the private sector, communities, families and individuals for several reasons.
Anti-social behaviour can have a negative impact on community perceptions of society and people’s quality of life. Anti-social behaviour threatens the establishment and maintenance of a safe and secure community, which is an important prerequisite for community well-being and cohesion as well as sound economic growth, continuous business activity and investment. Individuals who engage in anti-social behaviour risk becoming excluded from important support mechanisms such as school, their families and service providers. They also risk coming into contact with the criminal justice system. Involvement in anti-social behaviour can persist throughout adolescence into adulthood, becoming more significant social issues with long-term negative consequences for the individual, family and the wider community (McAttamney and Morgan, 2009:6).

3.6.4 Theme 4: Experiences of Living in an Unsafe Home Environment by Parents Culminating in a Sense of Betrayal

As stated in category 3.3 (see table 3.1), these children present with anti-social and criminal behaviour. It is not surprising for the parents to feel unsafe in the presence of their children. Envision installing burglar doors to all the rooms inside the house, making sure that whenever this child is around, everyone in the house can be certain that all their belongings are safe by keeping a watchful eye and closely monitoring this child, which can be time-consuming and very frustrating to the ones who live the experience.

And since these children do not operate in an isolated environment, they have friends whom they share the common anti-social and criminal behaviour with; when these children are visited by their friends, the parents and other members of the family feel threatened by their presence, knowing that they all behave in the same way. This experience that the parents and other people involved go through makes them feeling betrayed by their own children because of their children’s deviant behaviour. According to Cottrell and Monk (2004:1072), young people who associate with peers who engage in unruly behaviour – delinquency, substance abuse, violent
activity, sexual activity or dropping out of school – are much more likely to engage in the same unruly behaviour.

The following quotes indicate how the participants feel about their environment (living environment):

“… He steals from us at home”; “everything is locked up …”

“… I have to lock in my room when I go to work …”

“… Everything is locked up; it is like a jail …”

“… We always make sure that all the rooms are locked because he even steals even a ‘small thing’ …”

Cottrell and Monk (2004:1070) suggests that victimisation can shatter basic assumptions about the self and the world that individuals need to function normally in their daily lives such as that they are safe from harm, that the world is meaningful and just and that they are good, decent people. This happens not only to victims of violent assaults, but also to victims of robbery and burglary and to their friends and families.

3.6.5 Theme 5: Experiences Emotional Turmoil by Parents Expressed as Feelings of Helplessness, Hopeless and Despair Triggering a Death Wish

From the paragraphs stated above, one can confirm that living with mental health care users smoking cannabis is challenging, as is evident in the parents who experience feelings of helplessness, hopelessness and despair, triggering a death wish.

3.6.5.1 Experience feelings of helplessness, hopelessness and despair
The parents of these children are confronted with negative emotions about everyday life with regard to the behaviour of their children. In this research, none of the participants expressed the hope of seeing things change for the better. The challenges with which the parents living with mental health care users who smoke cannabis are faced cannot be over-emphasised, as cannot how they feel. Participants verbalised their feelings of helplessness, hopelessness and despair as follows:

“… I don’t know what to do; I really don’t know what to do …”

“… It makes me feel so frustrated, like I don’t know what to do …”

“… I cannot cope with him …”

“… Now I’m really helpless …”

Parents consistently report the emotional and psychological impacts as more profound and long lasting than incidents of physical abuse. Parents report that the most significant effects relate to shock, incredulity and disbelief when it concerns their own children’s deviant behaviour towards them (Howard, 2011:4). Prevailing effects include significant and enduring mental health problems, particularly anxiety and depression (Cottrell & Monk, 2004:1080). Intense feelings of anger, fear, isolation, low self-esteem, helplessness and depression are common reactions. Like combat veterans, crime victims may suffer from post-traumatic stress disorder, including recurrent memories of the incident, sleep disturbances, feelings of alienation, emotional numbing and other anxiety-related symptoms (Cottrell & Monk, 2004:1070).

In addition to feeling solely responsible, parents often feel unsupported and isolated. They feel hopeless and helpless because they are unable to control the situation; because of either physical danger or their own emotional turmoil. Despair at not having a harmonious family life and feeling isolated in their situation make change all the more difficult. The psychological abuse that parents experience is as unnerving and soul destroying as physical abuse (Cottrell & Monk, 2004:1071).
3.6.5.2 Experience desiring an extreme resolution to an untenable situation – a coping mechanism

While these parents feel hopeless, helpless and filled with despair about their children’s behaviour, they develop a mechanism that is suitable for them and that will, at the end of the day, make them feel relieved of all these negative emotions caused by their children. Even though no parent wants to wish or hope a child would die, these parents, since they struggle to cope or come to terms with their children’s deviant behaviour, feel that should their children die, they will be relieved of all these overwhelming feelings. Some of the participants expressed it as follows:

“… If he can die, I'm sure I will rest …”

“… It is better for her to die, and it will be end of the story …”

“… I wish one day I will hear a phone call telling me that your son is dead …”

“… Sometimes when I'm in my sleep I ask God that why doesn't he take him …”

People tend to develop habitual modes and methods of managing stress and coping with upsetting emotions. People respond to perceptions of threat, harm and loss in diverse ways, many of which receive the label “coping” (CenterSite.net, 2013). Coping is often defined as efforts to prevent or diminish threat, harm and loss, or to reduce associated distress. Some prefer to limit the concept of coping to voluntary responses (Skinner & Zimmer-Gembeck, 2007:119). By and large, these habitual methods do help people to manage and defuse stressful situations in which they find themselves, though they are not all equally efficient. Some work better than others. While some really do succeed in helping people to manage upsetting emotion, the lower quality methods generally end up causing more problems than they solve (CenterSite.net, 2013).
When people cannot achieve nor do something that they want to, they channel the energy created by the desire into fantastic imaginings. Fantasy also provides temporary relief from the general stresses of everyday living. Fantasy, when used as a defence mechanism, is the channelling of unacceptable or unattainable desires into imagination. This can protect one’s self-esteem, as in the case where educational, vocational or social expectations are not being met, one imagines success in these areas and wards off self-condemnation (Planetpsych.com, 2013).

3.6 CONCLUSION

A comprehensive amount of data was generated from the parents by asking the following question: “How is it for you living with a mental health care user smoking cannabis?” After coding data, five themes, with categories under each theme, were identified; the experiences of parents living with mental health care users smoking cannabis were described and explored. A literature control was conducted to support findings. Field notes that include observational, theoretical and methodological notes were also outlined.

The last chapter, chapter 4, will discuss guidelines, recommendations, limitations and conclusions, and will conclude with a summary.
CHAPTER 4: GUIDELINES AND RECOMMENDATIONS

4.1 INTRODUCTION

After having explored the experiences of parents living with mental health care users smoking cannabis, the following paragraphs will present the guidelines and recommendations with regard to how the parents living with mental health care users smoking cannabis, including siblings, other family members and the community, can be managed or how intervention can be made for them. The last part of this chapter will focus on the evaluation of the strength and the limitations of this research study and, ultimately, ending with a conclusion.

The objective of this research was to explore and describe the experiences of parents living with mental health care users smoking cannabis, and to describe the guidelines for psychiatric nurses in order to assist the mental health care users and their parents in mobilising the resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of their health. The previous chapter discussed in detail what happened: the parents’ painful experiences linked to unfulfilled parental expectations, strained interpersonal relationships, a sense of loss related to the child’s ways of behaving, living in an unsafe home environment and, lastly, to emotional turmoil.

The findings were compared and contrasted with literature control of other research done elsewhere. Based on the findings, guidelines should be issued and recommendations made in order to manage the parents’ experiences. See table 4.1 for the basis of discussion.
Table 4.1 - Challenges and possible corresponding guidelines to address the challenges of parents of mental health care users smoking cannabis

<table>
<thead>
<tr>
<th>THEMES AND CATEGORIES</th>
<th>GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme 1: Experiences of unfulfilled parental expectations linked to the behaviour of the child, unfulfilled expectations with regard to recovery from “dagga” use and unfulfilled parental expectations linked to a sense of failure as a parent</strong></td>
<td><strong>Guideline 1: Evidence-based prevention programme in schools, family and community, as well as the prevention of relapse related to “dagga” use</strong></td>
</tr>
<tr>
<td>1.1 Experiences of unfulfilled parental expectations linked to the behaviour of the child</td>
<td>1.1 Facilitation of school-based programmes</td>
</tr>
<tr>
<td>1.2 Experiences of unfulfilled parental expectations with regard to recovery from “cannabis” use.</td>
<td>1.2 The importance of psycho-education</td>
</tr>
<tr>
<td>1.3 Unfulfilled parental expectations linked to a sense of failure as a parent</td>
<td>1.3 Facilitation of support groups</td>
</tr>
<tr>
<td><strong>Theme 2: Experiences of strained interpersonal relationships</strong></td>
<td><strong>Guideline 2: Use of family-focused approaches</strong></td>
</tr>
<tr>
<td>2.1 Experiences of strained interpersonal relationships between the parent and the child</td>
<td>2.1 Implementation of functional family therapy, brief strategic family therapy and multidimensional family therapy</td>
</tr>
<tr>
<td>2.2 Experiences of strained interpersonal relationships between the siblings and the child</td>
<td>2.2 Implementation of functional family therapy, brief strategic family therapy and multidimensional family therapy</td>
</tr>
<tr>
<td>2.3 Experiences of strained interpersonal relationships between the other relatives and the child</td>
<td>2.3 Implementation of functional family therapy, brief strategic family therapy and multidimensional family therapy</td>
</tr>
<tr>
<td>2.4 Experiences of strained interpersonal relationships between the wider community, including the police, and the child</td>
<td>2.4 Utilisation of environmental approaches</td>
</tr>
<tr>
<td>THEMES AND CATEGORIES</td>
<td>GUIDELINES</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------</td>
</tr>
<tr>
<td><strong>Theme 3: Experiences of a sense of loss related to the pervasive changes in the child’s ways of being:</strong> perceived personality changes, aggression, violence, anti-social and criminal behaviour</td>
<td><strong>Guideline 3: Dealing with personality changes, prevention of aggression and violence and reducing and preventing anti-social and criminal behaviour</strong></td>
</tr>
<tr>
<td>3.1 Experiences of perceived personality changes by parents</td>
<td>3.1. Implementation of functional family therapy, brief strategic family therapy and multidimensional family therapy; implementation of cognitive behavioural therapy, dialectic behaviour therapy and schema-focused therapy for the child</td>
</tr>
<tr>
<td>3.2 Experiences of aggression and violence by parents</td>
<td>3.2. Prevention of aggression and violence</td>
</tr>
<tr>
<td>3.3 Experiences of anti-social and criminal behaviour by parents</td>
<td>3.3 Reducing and preventing anti-social criminal behaviour</td>
</tr>
<tr>
<td><strong>Theme 4: Experiences of living in an unsafe home environment culminating in a sense of betrayal</strong></td>
<td><strong>Guideline 4: Interventions for feeling unsafe in their home environments</strong></td>
</tr>
<tr>
<td>4.1 “… it is like a jail …”</td>
<td>4.1 Community participation, involvement of local government and the police to promote safety</td>
</tr>
<tr>
<td><strong>Theme 5: Experiences of emotional turmoil expressed as feelings of helplessness, hopelessness and despair triggering a death wish</strong></td>
<td><strong>Guideline 5: Management of negative emotions</strong></td>
</tr>
<tr>
<td>5.1 Experiences of feelings of helplessness, hopelessness and despair</td>
<td>5.1 Facilitation of cognitive behaviour therapy</td>
</tr>
</tbody>
</table>

### 4.2 GUIDELINE 1: EVIDENCE-BASED PREVENTION PROGRAMMES IN SCHOOLS, FAMILY AND COMMUNITY AND THE PREVENTION OF RELAPSE

School teachers, as well as parents, other family members and the community at large, of children smoking dagga are faced with many deviant behaviour from these children. These children perform poor academically, they fail grades, drop out of school and are also truant; they relapse because of non-adherence to prescribed treatment. The guidelines discussed in the paragraphs that follow will help parents
living with mental health care users smoking cannabis to find ways in which to cope with their challenges.

4.2.1 Facilitation of School-based Programmes

School-based prevention programmes should be grounded in theory on risk and protective factors for substance use (Komro & Toomey, 2002:5). These programmes should focus on developing the following skills and attributes among young people: self-control, emotional awareness, communication, social problem-solving, academic support and social competence. Emphasis should be placed on addressing social norms relating to alcohol and drug use. Particular emphasis should be placed on normative education that reinforces awareness that not all adolescents engage in substance abuse (Komro & Toomey, 2002:7). In communities, schools should be one of the many settings in which prevention occurs. A number of systematic reviews and meta-analyses has shown parenting programmes to be effective tools for changing children’s behaviour (Komro & Toomey, 2002:8). One such a review found that parenting programmes led to a significant reduction in one or more of the outcome variables measured, including alcohol and drug use among children (Komro & Toomey, 2002:9-11). Family skills training programmes are also an effective prevention strategy. This strategy works to strengthen strong protective factors already located in family structures. Foxcroft, Ireland, Lister-Sharp, Lowe and Breen (2003:397-411) found that the positive effects of this intervention on alcohol and drug use are sustained over time. Encourage media involvement to increase awareness of substance use in communities, to provide accurate information on substance use, to decrease stigma, and to strengthen attitudes and norms supportive of sobriety (NIDA, 2003; Treno & Lee, 2002:35-40). Mobilise the community to make structural and systemic changes by forming coalitions with organisations in the target community that share the goal of preventing and reducing substance abuse (Komro & Toomey, 2002:14; NIDA, 2003:25)

4.2.2 The Importance of Psycho-education

Psycho-education is a specific form of education that aims to help clients that experience a problem related to substance use to access clearly and concisely
presented facts about a broad range of issues. Psycho-education and self-help material, for example books, information pamphlets and computer programmes, have been used as an adjunct to face-to-face treatment and as a stand-alone intervention since the 1970s (Finfgeld, 2003:241-255). Psycho-education should be delivered in a manner consistent with motivational interviewing (MI) principles, which assume that the client can make better choices when equipped with adequate knowledge, self-awareness and decision-making skills. Lincoln, Wilhelm and Nestoriuc (2007:232-245) show that the more people are aware of their condition and how it affects their own lives and that of others, the more control they have over their condition. Education may be delivered with or without personal contact, and in an individual or group setting. One of the key factors is linking the information with the client’s personal experience.

4.2.3 Implementation of Support Groups

Support groups can play a significant role in helping parents to take concrete steps towards ending the abuse, and thereby taking control of their lives. They can provide parents with an opportunity to realise that they are not alone in their struggles, and give them an opportunity to reach out to others in the same situation. This can be crucial for parents who feel helpless in their own abusive situation, as being a source of support for others diminishes the feelings of helplessness (Cottrell & Monk, 2004:1072).

4.3 GUIDELINE 2: THE USE OF FAMILY-FOCUSED APPROACHES FOR STRAINED INTERPERSONAL RELATIONSHIPS

In families where the child smokes cannabis, interpersonal relationships are most likely to be affected because of the behaviour of the child smoking cannabis. Between the parents, siblings, other family members and community members, there are broken relationships, communication breakdown, resentment and anger towards the child smoking dagga. Parents are often blamed by other family members. Since many people are affected by the deviant behaviour of these children, several family-
focused approaches will be effective in mending these strained interpersonal relationships.

4.3.1 Implementation of Functional Family Therapy, Brief Strategic Family Therapy and Multidimensional Family Therapy

Family-based interventions hold that family functioning may cause, maintain or worsen adolescent conduct disorders or risk behaviours such as substance misuse. These include Functional Family Therapy (FFT), which is described as a behavioural model that works in the family system in an attempt to alter maladaptive family interactional patterns that might contribute to adolescent behavioural difficulties such as substance misuse and conduct problems (Waldron & Turner, 2008:238-242). Brief Strategic Family Therapy (BSFT) is based on social learning theory and attachment and the underlying premise is that adolescents’ unruly behaviour is the product of maladaptive family interactions and poor boundaries. Therapy aims to alter these interactions in order to improve the family system as a whole, as well as changing the adolescent’s specific maladaptive behaviours (Santisteban, Suarez-Morales, Robbins & Szapocznik, 2006:259-271). Multidimensional Family Therapy (MDFT) and Multi-systemic Therapy (MST) are based on Bronfenbrenner’s ecological approach and emphasise the importance of working in a young person’s and family’s “systems” (Waldron & Turner, 2008:250). Both approaches recognise that risk factors associated with anti-social behaviour and emotional problems arise from many levels of influence (Schoenwald, Brown & Henggeler, 2000:113-127).

If family relationships are appropriately modified, these approaches can be effective in reducing the unruly behaviour (Woolfenden, Williams & Peat, 2001:CD003015). For example, research into adolescent substance misuse has found that family factors (such as poor communication, parental criticism, ineffective discipline, emotional disengagement) can negatively impact on the adolescent and increase his or her risk of substance abuse (Curry, Wells, Lochman, Craighead & Nagy, 2003:658; Liddle, Rowe, Dakof, Ungaro & Henderson, 2004:49-63). Consequently, family-focused interventions that target negative patterns of interaction have been found to be the most effective approaches to adolescent substance abuse when compared to individual supportive interventions or skills training (Carr, 2009:8).
In summary, each of the family-based interventions discussed here is significantly better at reducing adolescent substance abuse than “treatment as usual.” While components of these forms of family therapy differ, the underlying principles are the same and include enhancing positive family relationships by improving communication and conflict resolution, tackling problems in the family that are maintaining the adolescent’s substance abuse, increasing the level of support provided from parent to adolescent and shifting the focus of the problem from something in the adolescent to something in the family system.

4.3.2 Implementation of Functional Family Therapy, Brief Strategic Family Therapy and Multidimensional Family Therapy

In accordance with paragraph 4.3.1, family-based interventions hold that family functioning may cause, maintain or worsen adolescent conduct disorder or risk behaviour such as substance misuse. These include Functional Family Therapy (FFT), which is described as a behavioural model that works in the family system in an attempt to alter maladaptive family interactional patterns that might contribute to adolescent behavioural difficulties, such as substance misuse and conduct problems (Waldron & Turner, 2008:238-242). Brief Strategic Family Therapy (BSFT) is based on social learning theory and attachment and the underlying premise is that adolescents’ unruly behaviour is the product of maladaptive family interactions and poor boundaries. Therapy aims to alter these interactions in order to improve the family system as a whole, as well as changing the adolescent’s specific maladaptive behaviour (Santisteban, Suarez-Morales, Robbins & Szapocznik, 2006:259-271). Multidimensional Family Therapy (MDFT) and Multi-systemic Therapy (MST) are based on Bronfenbrenner’s ecological approach and emphasise the importance of working in a young person’s and family’s “systems” (Waldron & Turner, 2008:250). Both approaches recognise that risk factors associated with anti-social behaviour and emotional problems arise from many levels of influence (Schoenwald, Brown & Henggeler, 2000:113-127).
4.3.3 Implementation of Functional Family Therapy, Brief Strategic Family Therapy and Multidimensional Family Therapy

In harmony with paragraph 4.3.2, family-based interventions hold that family functioning may cause, maintain or worsen adolescent conduct disorder or risk behaviour such as substance misuse. These include Functional Family Therapy (FFT), which is described as a behavioural model that works in the family system in an attempt to alter maladaptive family interactional patterns that might contribute to adolescent behavioural difficulties, such as substance misuse and conduct problems (Waldron & Turner, 2008:238-242). Brief Strategic Family Therapy (BSFT) is based on social learning theory and attachment and the underlying premise is that adolescents’ unruly behaviour is the product of maladaptive family interactions and poor boundaries. Therapy aims to alter these interactions in order to improve the family system as a whole, as well as changing the adolescent’s specific maladaptive behaviour (Santisteban, Suarez-Morales, Robbins & Szapocznik, 2006:259-271). Multidimensional Family Therapy (MDFT) and Multi-systemic Therapy (MST) are based on Bronfenbrenner’s ecological approach and emphasise the importance of working in a young person’s and family’s “systems” (Waldron & Turner, 2008:250). Both approaches recognise that risk factors associated with anti-social behaviour and emotional problems arise from many levels of influence (Schoenwald, Brown & Henggeler, 2000:113-127).

4.3.4 Utilisation of Environmental Approaches

4.3.4.1 Environmental approaches

The environment can increase or decrease the risks for substance use among young people. Promoting safe and supportive environments includes promoting positive social norms. These include alternative activities and youth groups, attachments, resources, the family and the local community (UNODC, 2008:35).
4.3.4.2 Alternative activities and youth groups

Providing interesting recreational activities can divert the attention of young people away from substance use toward more positive physical and social outlets. The participation of youth groups in community service projects and awareness campaigns should also be encouraged. Involving them strengthens protective factors and social bonding (UNODC, 2008:35).

4.3.4.3 Attachments

Positive attachments can help to reinforce protective factors. Encouraging the presence of caring family members, friends and other adults interested in their well-being provides young people with support and role models. Child-parent relationships were shown to improve when the entire family is involved. Positive peer relationships should also be encouraged. Other positive attachments that could be encouraged are those formed through schools or religion (UNODC, 2008:35).

4.3.4.4 Resources

Young people in need should be directed to appropriate available resources such as social services, educational and health facilities (UNODC, 2008:35).

4.3.4.5 The family

Strengthening parent-child communication can lead to the reinforcement of prevention efforts in the home, with parents serving as role models. Parental skills can be strengthened by means of family skills training, parent support groups, parent peer groups and family counselling (UNODC, 2008:35).
4.3.4.6 Local community

Participation of key persons in various sectors such as schools, families, workplaces, churches, government and the mass media is essential. Local communities can undertake activities that emphasise the prevention of substance use problems, health promotion and community development. Local community action includes setting priorities, making decisions, as well as planning and implementing activities and projects, in order to achieve better health (UNODC, 2008:35).

4.4 GUIDELINE 3: DEALING WITH CHANGE IN PERSONALITY, PREVENTION OF AGGRESSION AND VIOLENCE, AND REDUCING ANTI-SOCIAL AND PREVENTING CRIMINAL BEHAVIOUR

When someone in the family suddenly changes in regard to his or her personality, the result is a loss to the family members; the siblings lose a brother or a sister and the parents a child, as did the other family members and the community members. Crime is a priority concern in South African cities. Of particular concern is the fact that young people make up the largest group of victims of violent crime and that they are also the major perpetrators of crime in our cities. Indeed, some young people are both victims and perpetrators of crime. Youth crime prevention programmes need to find innovative ways of addressing this duality (Palmary & Moat, 2002:34).

From the above guideline (3), one can imagine how frustrating it is for the family members of a child smoking dagga whose personality changed. Change in personality is analogous to change in behaviour. As a consequence, these children’s behaviour is characterised by aggression and violence, as well as anti-social and criminal behaviour respectively.
4.4.1 Implementation of Functional Family Therapy, Brief Strategic Family Therapy and Multidimensional Family Therapy; and Implementation of Cognitive Behaviour Therapy, Dialectic Behaviour Therapy and Schema-focused Therapy for the Child

For functional family therapy, brief strategic family therapy and multidimensional therapy refer to paragraph 4.3.1.1 above.

4.4.1.1 Cognitive behavioural therapy (CBT)

CBT can help people who suffer from borderline personality disorder to identify and change core beliefs and/or behaviours that underlie inaccurate perceptions of themselves and others, as well as problems interacting with others. CBT may help to reduce a range of mood and anxiety symptoms, as well as the occurrence of self-harming behaviour (Davidson, Norrie, Tyrer, Gumley, Tata, Murray, & Palmer, 2006:450–65).

4.4.1.2 Dialectical behaviour therapy (DBT)

This type of therapy focuses on the concept of mindfulness, or being aware of and attentive to the current situation. DBT teaches skills to control intense emotions, reduce self-destructive behaviours and improve relationships. This therapy differs from CBT in that it seeks a balance between changing and accepting beliefs and behaviour (McMain & Pos, 2007:56-52).

4.4.1.3 Schema-focused therapy

This type of therapy combines elements of CBT with other forms of psychotherapy that focus on reframing schemas, or the ways people view themselves. This approach is based on the idea that borderline personality disorder stems from a dysfunctional self-image - possibly brought on by negative childhood experiences -
that affects how people react to their environment, interact with others and cope with problems or stress (Kellogg & Young, 2006:445-58).

4.4.2 Prevention of Aggression and Violence

Rigorous studies on the effectiveness of prevention initiatives, specifically addressing drug-related violence, are scarce. However, available evidence suggests that programmes that aim to prevent violence in drug users, or seek to reduce violence and illicit drug use simultaneously, can have positive effects (WHO, 2006). Drug use and violence can also be addressed concurrently by screening victims presenting with violent injuries for drug use and, similarly, drug users for involvement in violence. In general, strategies to reduce drug-related violence should incorporate a range of approaches that seek to address the individual, relationship, societal and environmental factors that contribute to both violence and illicit drug use. Multi-component programmes that tackle violence and illicit drug use simultaneously by means of a variety of measures can prevent both drug use and related violence. For example, Multi-systemic Therapy (MST) is an intensive family and community treatment that aims to strengthen protective factors proven to reduce the risk of future offending and anti-social behaviour among juveniles during intervention. Strategies include strategic and structural family therapy, behavioural parent training and cognitive behavioural therapies. Working alongside health, criminal justice and other agencies, public health professionals have a central role to play in preventing drug-related violence. Promoting an evidence-based public health approach to violence, public health professionals should encourage and facilitate the use of data and research from a wide range of sources in order to provide comprehensive understanding of the extent, causes and risk factors relating to drug-related violence (UNODC, 2008:40).

4.4.3 Reducing and Preventing Anti-social Criminal Behaviour

Access to education, supportive and consistent parenting and meaningful community and social involvement will increase a young person's resilience to crime. One of the
primary challenges facing local governments and the criminal justice system is to provide adequate alternatives - beyond law enforcement and prison-based options - for young people who are likely to commit crime. Local government can play a vital role in creating an environment that increases a young person's resilience to choosing the criminal option.

Both the social and environmental situation and the local context in which crimes are committed need to be considered when planning crime reduction strategies. For local governments, a reduction in crime should form part of assessing whether overall community development was successful. Targeting young people and building their specific needs into programmes is a key route to achieving this. Local government can play an increasingly significant role in boosting the quality of life of all citizens by investing time, effort and resources in improving the life chances of young people (Palmer & Moat, 2002: 38). Local government could provide resources for additional training for social workers in order to ensure that they are able to use therapeutic approaches to alter the interpersonal conditions that encourage criminality Palmary & Moat, 2002: 40).

4.5 GUIDELINE 4: INTERVENTIONS FOR FEELING UNSAFE IN THEIR HOME ENVIRONMENT

It is not surprising that parents of children smoking cannabis have any other options but to stay in an environment in which everything is locked up, like installing burglar doors in each an every room in their houses since their children steal everything they come across in the house. The next guideline will help parents living with mental health care users to cope and deal with their fear.

4.5.1 Community Participation, Involvement of Local Government and the Police to Promote Safety

Safety is a core human right (National Planning Commission, 2013:20). It is a necessary condition for human development, improving quality of life and enhancing
productivity. When communities do not feel safe and live in fear, the country’s economic development and the people’s well-being is affected, hindering their ability to achieve their potential.

Civil society organisations and civic participation are critical elements of a safe and secure society (National Planning Commission, 2013:23). Community problem-solving during the xenophobic violence of 2008 (National Planning Commission, 2013:25) is an example of non-state interventions and mobilisation resolving conflict and potential criminality. The Municipal System Act, Act no. 2000 (National Planning Commission, 2013:25) provides for local government to promote a safe and healthy municipal environment. Community safety centres, promoted by the Secretariat for Police and provincial departments of community safety, should be revised to give effect to this provision. Local municipalities need to work closely with all state and non-state bodies to establish their safety needs and, within their mandates, develop strategies to increase safety.

Safety audits or safety barometers should be developed with communities, especially the vulnerable, by which to inform local government to respond to safety. This could include better street lighting and the removal of hazardous waste. This initiative should involve the youth and could be ran by sectors, such as educators, sports, arts and culture and social welfare, coordinated by community safety centres. Local government should use its mandate more creatively and innovatively to achieve community safety (National Planning Commission, 2013:26). It is at local level that communities feel empowered to take part actively in making their environment safer and more secure. Spatial planning of the physical environment should be done by consulting communities; designing for safety and crime prevention should be regulated at local level. Specialised skills for safety design could be sourced when capacity is lacking.

The community safety volunteer programme has been implemented in Gauteng, the Western Cape and KwaZulu-Natal with some success (National Planning Commission, 2013:26). The Police Service and Metropolitan police should further develop the Community Safety Programme as part of a community empowerment programme for safety. The programme should be included in the budgets of local
governments, the metropolitan police and provincial departments of community safety. The capacity to implement this programme needs to be developed in all nine provinces (National Planning Commission, 2013:26).

4.6 GUIDELINE 5: MANAGEMENT OF NEGATIVE EMOTIONS, CHARACTERISED BY HELPNESSNESS, HOPELESSNESS, DESPAIR, AS WELL AS SEEKING AN EXTREME RESOLUTION TO AN UNTENABLE SITUATION

Feelings of hopelessness, helplessness and despair are very detrimental to the mental well-being of these parents; as a result, helping these parents to maintain their mental well-being is a priority.

4.6.1 Implementation of Cognitive Behaviour Therapy (CBT)

Cognitive behaviour therapy is a psychotherapeutic approach that addresses dysfunctional emotions, maladaptive behaviours and cognitive processes, and contents by means of a number of goal-oriented, explicit systematic procedures. The name refers to behaviour therapy and cognitive therapy, as well as to therapy based on a combination of basic behavioural and cognitive principles and research. Most therapists working with patients who deal with anxiety and depression use a blend of cognitive and behavioural therapy. Cognitive behaviour therapy is thought to be effective for the treatment of a variety of conditions, including mood disorder among many others (Schacter, Gilbert & Wegner, 2010:600).

The premise of mainstream cognitive behavioural therapy is that changing maladaptive thinking leads to a change in affect and behaviour, but recent variants emphasise changes in one's relationship to maladaptive thinking rather than changes in thinking itself (Hassett & Gevirtz, 2009:393). Therapists or computer-based programmes use CBT techniques to help individuals to challenge their patterns and beliefs and to replace errors in thinking, such as over-generalising, magnifying negatives, minimising positives and catastrophising with more realistic and effective thoughts, thus decreasing emotional distress and self-defeating
behaviour or leading to a more open, mindful and aware posture toward them in order to diminish their impact (Hassett & Gevirtz, 2009:393). Mainstream CBT helps individuals to replace maladaptive coping skills, cognitions, emotions and behaviours with more adaptive ones (Gatchel & Rollings, 2008:40), challenging an individual's way of thinking and the way that he or she reacts to certain habits or behaviours. However, there is still controversy about the degree to which these traditional cognitive elements account for the effects seen with CBT over and above the earlier behavioural elements such as exposure and skills training (Longmore & Worrell, 2007:173).


4.7 EVALUATION OF THE STUDY

A sample of seven parents whose children, smoking cannabis, have been admitted to a psychiatric institution in Tshwane more than once cannot precisely represent the whole view of the experiences of parents living with mental health care users smoking cannabis. For this reason, the researcher recommends that more studies be conducted into different areas and institutions with bigger samples.

4.7.1 Strengths

The study explored the experiences of parents living with mental health care users smoking cannabis. A phenomenological approach revealed the different experiences that these parents go through. The standard means of conducting a research study were used, and findings were contextualised and supported by literature control. Guidelines were developed from the experiences of parents living with mental health care users smoking cannabis.
4.7.2 Limitations

The research was conducted among the parents of mental health care users smoking cannabis. A few of the previous studies related to cannabis that were conducted, but on different topics, made it difficult for the researcher to analyse and compare the findings with such studies, since there were not enough theories or literature. The researcher and the participants communicated mostly in English, which is not their first language, though Setswana and IsiZulu were at times used.

4.8 RECOMMENDATIONS

The recommendations discussed in the paragraphs to follow are made with regard to the mental health nursing practice, mental health nursing research and mental health education.

4.8.1 Mental Health Nursing Practice

According to the South African Nursing Council, in terms of Government Regulation 425, psychiatric nursing practice provides a scientific basis for cognitive and effective skills that are required for comprehensive nursing in institutional or community settings, of mental health care users, in various age groups, whose capacity to meet their own needs is compromised completely or partially by psychiatric disorders (SANC R425:5 of 25 February 1985). Polit and Hungler (2002:3) state that the ultimate goal of any profession is to improve the practice of its members in order that the service provided to its clients will be maximally effective. Proper decentralisation of mental health services in the country and adequate staffing of mental health trained personnel will have a positive impact on communities. Mental health nurses should work with the influential agencies in the community in order to influence the policy makers at national level to positively address the experiences of parents living with mental health care users smoking cannabis.
4.8.2 Mental Health Nursing Research

Advanced mental health nurse practitioners, as well as managers of the mental health care facility, should encourage parents in the context of this study to participate and be involved in research. Advanced mental health nurses must take a lead in incorporating the findings, which will promote the health of parents living with mental health care users smoking cannabis, in clinical practice and protocols and in community partnerships and programmes in order to benefit the effort to meet the holistic needs of the parents. A task team should be formed with the responsibility for the research in the mental health care facility, with an appointed leader being the coordinator and being able to liaise with other departments. More qualitative research should be done to determine whether recommendations proposed in this research had an impact on the parents living with mental health care users smoking cannabis. Further studies must be recommended in this field in order to cover the impact of cannabis abuse in all psychiatric hospitals in South Africa with regard to the patients diagnosed with cannabis-induced psychotic disorder.

4.8.3 Mental Health Nursing Education

The more aware health professionals become of their clinical judgment and decision-making strategies, the more able they are to develop themselves. The advanced mental health nurse practitioner should mobilise resources by means of training and learning. All mental health nurses should be involved in nursing education of nursing students coming to the mental health facility for training; especially training that involves cannabis and other substance abuse, in order that it can benefit the students as well as the psychiatric institution at the same time in terms of developing staff members professionally and academically. The need for continuous psycho-education for in-patients as well as out-patients must be emphasised by psychiatric nurses in order to assist mental health care users smoking cannabis in gaining knowledge about cannabis smoking so that they can make an informed decision.
4.9 CONCLUSION

The purpose of this study was to explore and describe the experiences of parents living with mental health care users smoking cannabis, whose children were admitted to a psychiatric institution in Tshwane more than once, the impact of the experiences and how these parents cope with their challenges, in order to issue guidelines for psychiatric nurses to help those parents who are already struggling with the behaviour of their children and to prepare those who are at a risk of parenting children with the same behaviour.
LIST OF REFERENCES


ANNEXURE 1: ETHICAL CLEARANCE FROM THE UNIVERSITY OF JOHANNESBURG AND PRETORIA
Faculty of Health Sciences Research Ethics Committee

30/08/2011

Number: S118/2011
Title: Experiences of parents living with mental health care users smoking dagga
Investigator: Granny Mondiana, Department of Nursing; University of Johannesburg.
Supervisor: Prof Marie Poggenpoel
Sponsor: None
Study Degree: MCur (Psychiatric Mental Health Nursing)

This Student Protocol was reviewed by the Faculty of Health Sciences, Student Research Ethics Committee, University of Pretoria on 30/08/2011 and found to be acceptable. The approval is valid for a period of 3 years.

Prof M J Bestor
BSc (Chemistry and Biochemistry); BSc (Hons)(Biochemistry); MSc (Biochemistry); PhD (Medical Biochemistry)

Prof R Delport
(female) BA et Scien, B Curationis (Hons) (Intensive care Nursing), M Sc (Physiology), PhD (Medicine), M Ed

Computer Assisted Education

Prof J A Ker
MBChB; MMed(Int); MD – Vice-Dean (ex officio)

Dr NK Likibi
MBB HM – (Representing Gauteng Department of Health) MPH

Dr MP Mathabula
Deputy CEO; Steve Biko Academic Hospital

Prof A Nienaber
(Female) BA (Hons) (Wits); LLB (Pretoria); LLM (Pretoria); LLD (Pretoria); PhD; Diploma in Dataometrics (UNISA)

Prof L M Nithi
MBChB(Natal); FC(SA)

Mrs M C Nzeku
(Female) BSc(NUL); MSc Biochem(UCL,UK)

Snr Dr J. Phalatse
(Female) BSc (ED); B Tech Oncology

Dr R Reynolds
MBChB (Pret); FCPath (CAMSA) MRCPCH (Lon) Cert Med. Onc (CMSA)

Dr T Rossouw
(Female) MBChB (cum laude); MPhil (Applied Ethics) (cum laude), MPH (Biostatistics and Epidemiology (cum laude), DPhil

Mr Y Silwewuya
MPH (Univesity Of Umea, Sweden); Master Level Fellowship (Research Ethics) (Pretoria and UKZN); Post Grad. Diploma in Health Promotion (Unitech), BSc in Health Promotion (Unitech)

Dr L Schoeman
(Female) BPharm (NWU); ABHons (Psychology)(UP); PhD (UKZN); International Diploma in Research Ethics (UCT)

Dr R Sommers
Vice-Chair (Female) - MBChB; MMed (Int); MPharMed

Prof T J F Swart
BCHD, MSc (Otorhinolaryngology); MRCPCH

Prof C W van Staden
Chairperson - MBChB; MMed (Psych); MD; FC Psych; FTCL; UPLM; Dept of Psychiatry

Student Ethics Sub-Committee

Prof R S K Apelu
MBChB (Legon,UG); PhD (Cantab); FGDP International Research Ethics (UCT)

Mrs N Briers
(female) BSc (Stell), BSc Hons (Pretoria); MSc (Pretoria); DHETP (Pretoria)

Prof M M Ehlers
(female) BSc (Agri) Microbiology (Pret); BSc (Agri) Hons (Wits); MSc (Agri) Microbiology (Pret); PhD Microbiology (Pret); Post Doctoral Fellow (Pret)

Dr R Leech
(female) B Art et Solen; BA Cur; BA (Hons); M (.Ed); PhD Nursing Science

Dr S A S Okonju
BSc(Hons). Stats ( Ahmadu Bello University –Nigeria); MSc (Applied Statistics (UKC United Kingdom); PhD (Ahmadu Belo University – Nigeria)

Dr L Schoeman
CHAIRPERSON; (female) BPharm (North West); BAHons (Psychology)(Pretoria); PhD (KwaZulu-Natal); International Diploma in Research Ethics (UCT)

Dr R Sommers
Vice-Chair (Female) MBChB; MMed (Int); MPharMed

Prof L Sykes
(female) BSc, BDS, MDent (Prcs)

DR L SCHOEAN; BPharm, BA Hons (Psy), PhD;
Dip. International Research Ethics
CHAIRPERSON of the Faculty of Health Sciences
Research Ethics Committee, University of Pretoria

+27 012 354 1677 & 08999916047
email: lschoeman@up.ac.za
http://www.heatlhethics.up.ac.za
Private Bag X332, Arcadia, 0007 - 31 Bophelo Road, HW Snyman South Building, Level 2, Room 2.33, Gezina, Pretoria

93

DR R SOMMERS; MBChB; M Med (Int); MPhar Med;
VICE-CHAIR of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

93
FACULTY OF HEALTH SCIENCES
HIGHER DEGREES COMMITTEE

HDC23/02-2011
26 May 2011

TITLE OF RESEARCH PROPOSAL: Guidelines for advanced psychiatric nursing practitioners to assist parents living with mental health care users who smoke cannabis

DEPARTMENT OR PROGRAMME: M.CUR: Nursing

RESEARCHER: MONDLANA, G
STUDENT NO. 200940265

SUPERVISOR: Ms V van Niekerk

CO-SUPERVISOR: Prof M Poggenpoel
Prof CPH Myburgh

The Faculty Higher Degree Committee has scrutinised your research proposal and confirm that it complies with the approved research standards of University of Johannesburg.

The attached recommendations were made by the committee which will improve the quality of your proposal.

Please make these changes and corrections to the satisfaction of the supervisor/s and submit a corrected copy of the proposal to the Faculty Research Administrator.

The HDC would like to extend their good wishes to you in your endeavour of your research project.

Yours sincerely,

Prof. Heidi Abrahamsse
Chair: Faculty of Health Sciences HDC
ANNEXURE 2: REQUEST FOR PARTICIPANTS’ CONSENT
May 2011

Dear prospective participant

INVITATION TO PARTICIPATE IN THE RESEARCH

I, Mondlana G, an M.Cur (Psychiatric Mental Health Nursing) student at the University of Johannesburg, am currently conducting a research programme and would like to invite you to participate. If you give consent to participate, I will conduct an interview with you which will last for about 30 to 45 minutes. I also request your permission to audiotape the interviews.

The objectives of the study are as follows:
to explore and describe the experiences of parents living with mental health care users smoking cannabis; and
to describe guidelines that can be utilised by the psychiatric nurse to assist these parents to mobilise resources to facilitate their mental health.

Participating in this study will benefit you to have the opportunity to share your experiences of children smoking cannabis.

As the participant, your participation is voluntary and you have the right to withdraw from the study at any time you feel uncomfortable. Your names and addresses will not be used. The audiotapes will be kept under lock and key. Only the researcher and the supervisor will have access to them. The audiotapes will be destroyed two years after the publication of this report.

A summary of the results will be made available to participants on request through the nursing offices.

For clarification and additional information, contact the researcher at:
927 Block Ww
Soshanguve
0152
TELEPHONE: +27 (0) 76 782 3614
E-MAIL: grannymondlana@yahoo.com

Your cooperation will be wholly treasured.

Yours sincerely
Miss G. Mondlana
RESEARCHER

VvNiekerk, R.N.
SENIOR LECTURER: NURSING SCIENCE
Supervisor

M. Poggenpoel, R.N, PHD
PROFESSOR: NURSING SCIENCE
(Co-Supervisor)

C.P.H. Myburgh, M.Com; B. Ed; M. Ed; D.Ed
PROFESSOR: EDUCATION SCIENCE
(Co-supervisor)
ANNEXURE 3: REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT THE MENTAL HEALTH CARE FACILITY
The Chief Executive Officer
Private Bag X263
Pretoria
0001

Dear Madam

REQUEST TO CONDUCT RESEARCH

Good day,

I, Mondlana G, request to conduct a study at your institution. I intend conducting a research project entitled “Experiences of parents living with mental health care users smoking cannabis” in order to comply with the requirements for M.Cur degree in Psychiatric Nursing Science at the University of Johannesburg. This study will be done under the supervision and guidance of Professor C.P.H. Myburgh of Education and Psychology, Professor Marie Poggenpoel and Dr Vasti van Niekerk of Nursing Science.

The foremost motivation of this research project is to develop and describe guidelines for and advanced psychiatric nurse practitioner to assist parents of mental health care users smoking cannabis, which facilitate mobilisation of resources for these parents, therefore promoting, restoring and maintaining mental health as part of health. In order to achieve this overall purpose, the following objectives are proposed:

to explore and describe the experiences of parents living with mental health care users smoking cannabis; and
to describe guidelines for psychiatric nurses in order to assist mental health care users and their parents in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health.

For these objectives to be achieved, a qualitative design, which is exploratory, descriptive and contextual in nature, will be utilised. In estimation, about 10 participants will be required to participate in the study, depending on the saturation of data. A purposive sample will be drawn from the setting of this research.

Provided that the researcher is granted permission as requested, interviews will be conducted with individual participants in their area of location, and at the time appropriate to them. The participants’ identity will be protected by requesting them not to indicate their names in the interviews. Follow-up interviews will be conducted with some of the participants to confirm if the results obtained by the researcher are indeed what participants described. Participants in this research project will be required to give informed consent and participation is voluntary. Consequently, they have the right to terminate the interview at any stage during the research process if they wish to do so.

This study will help to develop better services that can be helpful to reach the parents living with mental health care users smoking cannabis, therefore benefiting their mental health. Mental health nursing practice and mental health nursing education in the country also stand to benefit directly or indirectly from the outcome of the research. The result of the research will be made available to you institution, as well as to the participants on request.

I will be delighted to answer any further questions about this project. Professor M. Poggenpoel is the person to contact if you further need to know about the research. You may contact Prof Poggenpoel at +27(0) 11 559 2860, Cell: +27(0) 82 8870260

Thank you
G. Mondiana, R.N

M.Cur (Psychiatric Nursing Science), student researcher
V van Niekerk, R.N.
SENIOR LECTURER: NURSING SCIENCE DATE
Supervisor

M. Poggenpoel, R.N, PHD
PROFESSOR: NURSING SCIENCE DATE
(Co-supervisor)

C.P.H. Myburgh, M.Com; B. Ed; M. Ed; D.Ed
PROFESSOR: EDUCATION SCIENCE DATE
(Co-supervisor).
ANNEXURE 4: INFORMATION LEAFLET AND PARTICIPANT INFORMED CONSENT
Title of the study: experiences of parents living with mental health care users smoking cannabis

Dear participant

1. Introduction

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

2. The nature and purpose of this study

The aim of this study is to obtain clear understanding of the experiences of parents living with mental health care users smoking cannabis. The following methods will be described: research setting, population and selection of participants, purposive sampling, method of data collection, which will be done by means of semi-structured interview, and the last method being the data analysis.

3. Explanation of procedures to be followed

This study involves the interviewing of participants by the researcher, which will last about 30 to 45 minutes. The central question that the researcher will ask is: “how is it for you living with a mental health care user smoking cannabis?” An audiotape recorder will be used to record information and the interviewer will also write down some notes.
4. Risk and discomfort involved

There might be minimal risks involved in the study. Some of the questions that are going to be asked may make you feel uncomfortable, but you need not answer them if you do not want to. In case of emotional discomfort, participants will be referred to a relevant professional for counseling to ensure full support.

5. Possible benefits of the study

Participants are going to benefit directly from the study; participants will have an opportunity to share their experiences of living with children smoking cannabis. The results of the study will enable people to gain understanding of the experiences of parents living with mental health care users smoking cannabis.

6. What are your rights as a participant?

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

7. Has the study received ethical approval?

This study has received written approval from the Research Ethics Committee of the faculty of Health Sciences at the University of Johannesburg, the University of Pretoria and the Chief Executive Officer of Weskoppies Hospital. Copies of the approval letters are available if you wish to have one.
8. Information and contact person

The contact person of the study is Granny Mondlana. If you have any questions about the study, please contact her on 076 782 3614. Alternatively, you may contact my supervisor, Professor Poggenpoel on 082 887 0260.

9. Compensation

Your participation is voluntary. There is no compensation for participating in this study.

10. Confidentiality

All the information that you give will be kept strictly confidential; only the researcher, my supervisor, the coder and ethics committee will have access to data. Once we analysed the information, no one will be able to identify you. Research reports will not include any information that might identify you.

Participant’s consent to participate in the study

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

I received a signed copy of this consent agreement.

Participant’s name ……………………………………………………….. (Please print)
Participant’s signature…………………………………  Date………………………………
Researcher’s name ............................................................... (Please print)
Researcher’s signature…………………………………  Date………………………………
Witness’s name........................................................................ (Please print)
Witness’s signature ..............................................................  Date…………………………..
ANNEXURE 5: PERMISSION TO PARTICIPATE IN THE RESEARCH STUDY AND PERMISSION TO INTERVIEW AND AUDIOTAPE
ANNEXURE 6: CONFIDENTIALITY CLAUSE
CONFIDENTIALITY CLAUSE
BETWEEN
GENERATIVE CONVERSATIONS
AND
Granny Mondlana
Research Title:

EXPERIENCES OF PARENTS LIVING WITH MENTAL HEALTH CARE
USERS SMOKING CANNABIS

The research code of ethics mandate that confidentiality should be maintained throughout data collection, data analysis and report writing.

I, Dr R.G. Visagie commit myself to keep all information confidential during and after analysis of the qualitative data for the above stated research study.

Reihla Visagie
22 April 2012
ANNEXURE 7: CODING CERTIFICATE
Qualitative data analysis
Coding certificate

MCur: Psychiatric Nursing Science
Granny Mondlana
THIS IS TO CERTIFY THAT:
Dr. Retha Visagie has coded the following qualitative data:

Seven (7) individual interviews

For the study:
EXPERIENCES OF PARENTS LIVING WITH MENTAL HEALTH CARE USERS SMOKING CANNABIS

I declare that the candidate and I have reached consensus on the major themes reflected by the data during a consensus discussion. I further declare that adequate data saturation was achieved as evidenced by repeating themes.

Retha Visagie
ANNEXURE 8: EXAMPLE OF A SEMI-STRUCTURED INTERVIEW WITH A PARTICIPANT
Interviewer: Good day, Ma'm
Participant: Uhh, good day, Granny

Interviewer: How are you?
Participant: Fine and you?

Interviewer: I’m good.

Interviewer: Ohm, I just want to you to tell me, uhhm, how is it for you living with a mental health care user smoking cannabis (dagga)?
Participant: Mmhh, Granny you know if you are a parent and you are living with a child who is smoking dagga is very difficult.

Interviewer: Mhh …
Participant: Because you don’t know what are you dealing with, until you know what’s going on.

Interviewer: Mmmh
Participant: So from the start when I found out that my child was smoking dagga is when I lost money.

Interviewer: Mmmh
Participant: So I just ask my child, she is a teenager like, but she is older because she is much responsible, when money gets lost and there is no one who knows who took it as well as the utensils, and duvets, without getting information, and you don’t know what is going on, you just hear rumours outside that your child is smoking dagga, you as a parent you must be responsible and listen to people about your child is doing, you must ask her, but refused that she was smoking it until I did the laundry(washing), and I found seeds of the weed.

Interviewer: When she has smoked what do you see on her?
Participant: Like I said that if you have a child who is smoking dagga, you are dealing with something that you don’t know.

Interviewer: Mmmh
Participant: You just see a child being aggressive and when you look into her eyes, her eyes look like a snake, she will harass you, undresses in public.

Interviewer: When she is aggressive what does she do?
Participant: She shouts and fight with me, and even at school she shouts with her school teachers, and here at home she beats up children, and when you are trying to address her, you must hold her with her hands.
Interviewer: How old is she?
Participant: She is now 28 years.
Interviewer: And school, which standard has she passed?
Participant: She only has standard nine (grade 11). She cannot continue with schooling now because she fights with school teachers because she is in a group of friends, and when you belong to a certain group, there is nothing you can do to stop from being part of that group. So even at school they sat down and talked to her, but it didn't work, until they wrote a letter telling that she is expelled from the school.

Interviewer: You as a parent, how do you feel about what your child is doing?
Participant: Eish, Granny what I can tell you is that I wish for a better future for my child, I even have saved money for her so that she can go further with her studies, but now my heart is painful because what I longed for will never happen, for now I wish she could die ... that's how I feel about it. If somebody is dead, you forget about her, you no longer care, I think it's better that way.

Interviewer: So at home there is nothing you talk about.
Participant: We only talk when she is sober, but as soon as she has smoked this dagga, it's like there is nothing you have talked about, there is nothing you have discussed. And she is so brilliant, if only she was not smoking her drug.

Interviewer: May I please take you back to when your child has smoked, I want you to tell me exactly what is she doing, all of them.
Participant: When she has just smoked, she undresses, walks naked in front of young boys, and just imagine walking naked in front of 17 years old. She also breaks the windows, she can even walk in the streets naked, fights with neighbours, and we no longer communicate with our neighbours because she fights with them. She can also get out leave the house, and the next thing it will be policemen telling me that she injured people, she can also bring lot of people in the house.

Interviewer: What are those people which she brings in your house?
Participant: They are her friends, the ones she grew up with, it's like a gang-star, they smoke, they steal even the grocery and sell it.

Interviewer: The stealing of grocery in your home, how many times has this happened?
Participant: It has happened many times, so when you ask for help from the police, they will come and sometimes punishes her, talk to her, but there is nothing they can do because even
if they arrest her, they will bring her back the following day, it’s like when she is admitted in the hospital, when the process is complete, I must take her back. And that’s when she will go back to the “drugs” again.

Interviewer: Mmh, so when she is sober how is she?
Participant: When she is sober, she cleans the house, cook breakfast and lunch, but as soon as she is done with what she was doing, she will then leave the house, there is no way she can just sit, while she is busy cleaning, already there is something that she has targeted, maybe a mug or something so that she can sell it for her drugs, or if you did not put safe your wallet or cell phone, she will take them and sell them, but when she hasn’t smoke she is alright, only when she has smoked then she becomes a ghost.

Interviewer: Does she have children?
Participant: Yes, she has four children, from different, one child has got his own, and the other three have theirs. The father of the fourth child took his kid to raise by himself since the mother is smoking, and the father of the other three is a gang-star as well, there nothing he is doing for these kids, and the father of the other three kids also smoke dagga, and you can imagine when both the mother and the father of these kids have already smoked, though they think that they are good parents.

Interviewer: Who is taking care of her children?
Participant: I am the one who is taking care of them, except one child who is taken care of by his father because the father is doing everything for the child, for the other three children, they are receiving social grant, but they mother misuse it by drinking alcohol and drugs, and with the little salary that I am earning, I must make sure that they are clothed, and they have food. I also take care of my other children, the siblings of my daughter, they as well must eat, and the pay of a domestic worker it is too small.

Interviewer: Mmh, Ma’m, what do you think might have been the cause of your daughter to behave like this, to smoke drug; I mean cannabis, what caused her to ..?
Participant: Really I don’t know, I just found out later that she is using cannabis, but I can tell you that she was a good kid, who was attending school, yes, we were struggling, but not in such a way that can make her use cannabis, may be it because of the peer pressure, or maybe it is something that she doesn’t want to share with me, I even asked her aunts and uncles if maybe she shared with them if maybe I was doing something that might have contributed in her doing like this, but no one told me so, even herself, when I ask her she doesn’t respond, she will only tell you the words that she is thinking about at that time.
Interviewer: So your daughter’s relationship with your other family members how is it?
Participant: It is very bad, because even when she visited them, they also lose their belongings, you as a parent you just tolerate her because she is your parent, other family members can’t, they just run away from you to deal with your problems and your child.

Interviewer: When she has visited your relatives, did they ever come to you and complain that Ma’m you know what, your child has done one, two, three?
Participant: Yes, they do, immediately if they find out that something is missing, they just come to you and they use this terrible words.
Interviewer: Mmhh
Participant: Even though their children do mess up, just because they know that your child is smoking, they will come to you.

Interviewer: And then, like you are saying that they will come and say those terrible words to you, how do you feel as soon as they have told you those words that they are telling you?
Participant: Granny it is too painful as a mother or as a parent, because they don’t know how you did feel because every parent wants a better future. It’s like when you tell her that I don’t want you to go there (to their family members), but because she knows they are their family members, she will go because there is something she is looking for.
Interviewer: Mmhh

Interviewer: Since you are working Ma’m, and she is not attending school, how are your things secured?
Participant: (Laughing). If you can see Granny, my wardrobe, my room is like an office, a kitchen, everything is locked up, it is like a jail, everything is locked up there, but should she get hold of a knife, you will find her having broke in, so really what can I do?

Interviewer: Let me take you back to her children, before you became much more involved in your daughter, what is it that made you took that whole responsible in taking care of her children?
Participant: It’s like one day there was a phone call, she always baby sit her children since I sometimes come back from work in weekends, I received a call from my neighbours and policemen telling me that she has beaten up one of her kids, who is about 10 years, and when I reach there and asked what happened, the child couldn’t tell me that her mother hit her with something, and the child had “something” (an injury/an opening), and I could see that this child was assaulted by a sharp thing (object). And when the police men tried to ask the
child about the injury, you could see that this child has been threatened that if you say that you have been assaulted by a metal, “you will be beaten”. So I have my granny, who visit us sometimes, so I then went to the social workers to ask for assistance, that’s when I realised that I have to take the responsibility. Things that these children were saying, you could cry, I don’t have that knowledge (information) about the things that these kids were saying to the social worker, even though they were talking in privacy, you could still hear their voices, you could cry, yes.

Interviewer: Mmhh, from your neighbours, did they ever come and tell you about the behaviour of your child?

Participant: Some they can tell, some you just hear them gossiping around, not recognising you, and you could hear that it is your child (they are talking about).

Interviewer: Mmhh

Participant: They don’t know you, you are the mother, they are just talking so much, you couldn’t even stand for, it is very painful.

Interviewer: (Moment of silence, observing the participant as she was sobbing)

Interviewer: Uhm, like what terrible words were these relatives were they telling you, what exactly were they saying to you, even the neighbours or anybody?

Participant: Okay, they could tell you like this: they will tell you that you never taught your child how to behave, again, how you can teach your child how to behave whereas you were never married, so your child’s behaviour results from you because even you yourself were not taught how to behave and that’s why you are not married. Black people say that if you are not married, then you are not a woman. So they will tell you that you don’t have good manners, and so is your child. They will call you all sorts of names, you are a “bitch”, you taught your child to be a “bitch”, when your child goes out, they say you sent her to go and steal, or do unacceptable things so that you can have an income at home, so that we can have food, they even say I sent my child to go and steal from them because I am jealous, whereas you give them the permission to come and search in your house (for their missing items). Even when I tell them that my things also get lost/stolen, they don’t believe me, they say she is my daughter, “how could your child steal your things”? As a mother, they won’t believe, I’m telling you.

Interviewer: When they come to report about your child’s behaviour, have they ever find her at home?

Participant: It happened twice that they found her at home while reporting about her
behaviour. They called in policemen, and that’s when my daughter started swearing at the elderly; just imagine a 28 year old swearing at a 65 year old woman, calling her names and that she is a witch. Imagine when your child swears at their aunts who raised her, and when I am no more what is going to happen to her? isn’t it that when you have a problem you reach out to the neighbours for help, but now if my child swears at them in front of me, I keep on asking myself about this child, the question keep on coming back to me, I ask myself: “what kind of a child is she”? I gave birth to her, now what got into her head?, I ask myself. Even if I can call the pastor, she talks the way she likes, and there is nothing you can do.

Interviewer: And then what happens the following day, let’s say may be today she came having smoked dagga, when she comes, and then the following day how is she? Participant: The following day when she wakes up, she is alright, and then apologises, but as she gets it (the cannabis), it will be a fight again, and then she will come back the following day saying Ma’m I apologise, but this comes again, and again, and again.

Interviewer: Mmhh, this cannabis, does she smoke it like only if you are at work, or even if you are around?
Participant: You know, Granny, I think if she has got money, she doesn’t care whether I’m around or I’m gone. And I think they not only smoke dagga, they mix it with something, because when she has smoked, those days are not the same, sometimes she smokes it and becomes violent, but sometimes she smokes and becomes wild.

Interviewer: How is she when she is wild?
Participant: When she is wild, have you ever seen cobra’s eyes? Her eyes roll from side to side, as if there lights on, like there is fire inside her eyes, she doesn’t blink, she looks straight into your eyes.

Interviewer: Except for her eyes, how is her behaviour? Like you are saying that she is wild, how is her behaviour?
Participant: When you try to cool her down, her tone of voice is so scary, her harshness is so scary, and you will feel as well that you have pressed a wrong button, she shivers, and then you will see that now you have crossed the line, she can eat the whole pot of food alone (a Casserole pot).

Interviewer: Alone?
Participant: Alone
Interviewer: Okay, concerning food, how she eats?
Participant: Most of the time she eats meat and pap only. And tea is not always that she
drinks it, when she wakes up, if she finds pap, she eats it, she doesn’t care if her children have eaten already or what, and then there she goes out.

Interviewer: So she doesn’t care if other people have eaten or not?
Participant: She doesn’t care who ate or who hasn’t.

Interviewer: Even her children?
Participant: Even her children; she doesn’t care if they have eaten or not.

Interviewer: Apart from stealing money from you and from your relatives, where else is she getting money from?
Participant: Sometimes I think that she is selling her body for money, because if say maybe she left without having money, different cars bring her home on different days, and when you ask her she won’t answer you, you will never know where she gets money from, but in my mind I tell myself that if she doesn’t have money, then she sells her body if she doesn’t get property so that she can get “drugs”.

Interviewer: She is 28 years now?
Participant: Yes

Interviewer: At what age might she have started smoking?
Participant: I think that she might have started early, when she was 19 years and still at school, that’s when I started seeing so many changes, she was not sleeping at home, and by then she was still afraid of her uncles, she would not come home in the early hours of the morning, she would come home late in the afternoon when she was sober.

Interviewer: How do you cope with her?
Participant: It’s like (taking a sigh), I don’t know what to say, I built her own room outside since she has got kids, we don’t talk to each other, it’s like there is no bond between the two of us, I even hired a helper to help me with cooking an laundry for the kids, and sometimes my daughter is bully at my helper.

Interviewer: What does she do to your helper?
Participant: She shouts at her, swears at her, and she will tell my helper that the helper does not belong there, my daughter also said that she is able to take care of her kids, there is no stranger who will come and take care of her children, but she is unable to take care of her children.

Interviewer: What could be the problem for your daughter to bully your helper?
Participant: The problem starts when my daughter brings her friends at home, and they make the house dirty, and immediately when my helper tries to tell them not mess up the place, and
that’s when my daughter start telling the helper that it’s her mother’s place, the helper cannot
tell her what to do in her mother’s house, it’s like my daughter is very fond of her friends, she
fancy her friends more than anybody else.

Interviewer: Have you ever sat down with her and tried to make some sense into her head?
Participant: It’s long that I have been trying to talk to her, but it’s like it is an endless talk, right
now I don’t talk anymore, I just keep quiet, like I said to you that it is better for her to die, and
lit will be end of the story.

Interviewer: It sounds like you have lost hope that your daughter will ever change, like she will
listen to you, the way you are saying it, it’s like you so wish that may God take her?
Participant: You see, if it was like I never even bothered to be on that look out for help from
the institution that deals with cannabis, I would say that I would take her to those institutions,
so once you have taken her there once, and she goes back for the second time in that
institution, and was given treatment, and when she reaches home, she starts all over again,
it’s like I’m wasting my money.

Interviewer: It seems to be a challenge on you to live with her?
Participant: Eish, Granny, living with a child who smoking dagga, it’s unlike staying with
a small child whom you can smack or do something with her, it’s a very big challenge.
Interviewer: Mmhh, so has she ever tried to fight with you?
Participant: Eish, its more than once; nowadays when she starts with me I just call the police
because I no longer have the strength to fight with her, she can injure me, I trust in the
policemen, sometimes the police men come and take her for that time, and then the following
day they bring her home, no case can be opened for her, they will rather refer to a certain
institution, and the institution will refer you to the social workers. And when she is back from
Weskoppies, she is still the same, she is not willing to change, because in Weskoppies they
teach her a lot of things, like how to live their lives, so if she is not prepared to change, it
becomes difficult to me, even if you can try popping out money, you are back to zero.

Interviewer: What are the other challenges about her except fighting, since you said she
becomes aggressive, what else, especially since you said you are the one taking care of her
children?
Participant: So now, Granny, it is difficult, for instance, you (referring to the interviewer) are
now old, if God remembers you what is going to happen to your kids? What will happen to my
house, my money that I have save, I shall have saved for her so that she comes and misuse
it, and nowadays it is very risky, I don't even know if she is “sick” at this moment, because you don’t know where did she go with her cars, and what is happening. It comes back to me, when she starts feeling sick, I am the one who must take care of her. and with the little salary that I am earning, I cannot afford to raise her three children( since the fourth one is being taken care of by his father), but I have to do something, school fee is now expensive, she should be doing something, like going to work for her children.

Interviewer: Does she only fight at home, or even wherever she is she is she fights?
Participant: Eish, Granny, *at night you can hear her crying, and screaming while I’m sleeping, when people talk especially at the taverns, she fights just like a man*, she uses whatever she can get hold of to injure people, the risky part of it is that if she injures people, they may form a group (against her), *and attack and kill her*, then who is going to tell me who killed her?; and again she can walk a very distance at night from home alone, like passing by the river, the only thing I do at night is to pray that may she comes back un-hurt, and if she dies, it is another cost, because everything is upon me, and again when she is dead, who is going to take care of her kids?

Interviewer: When she comes back being injured, like you said you are not on talking terms, when she arrives what does she say to you?
Participant: She informs me that she is injured and that I must help her, she will say to me: “Help me, put some ice-packs, use the first aid box, bandage me, *I want to go back where I was and fight back*”. What she wants, she must get, it doesn’t matter, and she must always be the winner. And when you are done with first aid, she will knock in your room until you open up for her so that she can leave, and then she will go back and fight again.

Interviewer: So people from outside have not open up a case for her, or what?
Participant: She has been arrested for many times, but the policemen just keep her for a short while, most of the time she is in and out of the jail, almost each and every month, she is attending a court case, but policemen thereafter find out that such cases are based from the taverns/pub. She always fights when she is at the drinking sport/shebeen/tavern.

Interviewer: Err, Ma’m, let me take you back, you said you have installed burglar at your place for you safety, ever since you have installed them, how is the condition there?
Participant: Granny, it doesn’t help that much, you see, burglars have got their own different designs, but the one design I have installed, my daughter can ask someone who is a bit slender to pass through, as soon as the head can pass through, though I wonder what do they use to manage getting in through the burglar door; once they are inside, then they can
do all what they want. And when I ask my daughter that it seems as if you got inside my room, and stole my things she replies by saying that: “What you are saying doesn't make sense, the whole of your house has got burglar doors on, what do you mean when you say I broke in”? She even told me to go and open up a case for her, saying that there is no evidence. Even the key, should I leave it unattended, she makes plan of copying it by using a wet block/brick of soap, then she will take that “copied key” to go and cut another key. My kids are the ones who inform me that their sister was in my room the time I was not at home.

Interviewer: When you ask her that some of your things are missing, how does she respond on that?

Participant: She **yells at me**, saying how can she access my room whereas the burglar door was locked as if it is in jail, she continues saying that or does she look like a fly? And when I inform her that my kids told me so, still she denies breaking in my room, saying that they are lying, and when she comes back having smoked, “you will know her better”, **she swears at me**. Most of the time she doesn’t have the powers to swear at me when she is sober, but when she has smoked, we fight and then she swears even more.

Interviewer: When she has smoked, does she still swears at you even if she has only smoked and hasn’t consumed alcohol?

Participant: It is like when she has smoked, she has got the guts to do anything that she wants to do, but if she hasn’t smoke, or consumed alcohol, she says nothing to me, she just keeps quiet.

Interviewer: Even when she hasn’t smoked, don’t you talk to each other?

Participant: We only talk about simple things, like talking about that we are watching TV. Watching movies, but still I make sure that my purse (wallet) is safe. She can do all the good things, but just imagine when she has smoked. But to steal things, she still does, so that she can sell them, **buy cannabis so that she can bridge the gap of time “lost” while she was sitting with me, so that she can satisfy her “cravings”**.

Interviewer: Do you know her friends, or do you sometimes see them?

Participant: She has got many different friends, I see different faces on different days, **but she cannot keep the friendship with the same friends for more than four months, she can’t. if maybe there is a clash (quarrel), she changes again and find new friends.**

Interviewer: Are you able to talk to her friends, I want to know about the relationship with them, how is she to them?, except that eventually she will fight with them.
Participant: Those that I once met, I asked them how do they befriend with such a person, some will tell you that you cannot advice her, you cannot guide her and tell that don’t do this, she will tell you she is a grown up, and that she has got an ID, and the way I see it, there is no-one who can tell her what to do, if she has planned that this is how things must be done, and thou shall be, and if it is not like that, then the friendship comes to an end.

Interviewer: In other words, she doesn’t want to be directed, she doesn’t want to be given advice, like saying: “don’t do this, don’t do that, rather do it like this” …

Participant: Yes, indeed she wants to dominate, and she influences others to do what she wants them to do, she is not the type of person who wants to be controlled, but she wants to be a leader always.
25 October 2013

To whom it may concern

I, Marina van der Merwe, ID no. 680426 0110 087, state hereby that I am the editor of Granny Mondlane’s dissertation.

I completed a certificate in editing form the University of Pretoria and have more than 18 years’ experience in the industry. I currently work as an editor (in a permanent position) at SITA (State Information Technology Agency), where I have been responsible for editing documentation for the last 13 years.

Best regards

Marina van der Merwe

(083 376 7367)
Dressed respect

Sweating at us. doesn't obey Rule.  Grew us with gun

Assassin failed. Short temper. Monkeys.

Shoplift.

Cupboard broken. Furniture in the house. Money doesn't buy clothes.

Stole family visit he stole. Feel guilty apologize. After

Frustrates me. An
ger. Me.

Betrayal

Hur

Sad.

Set blame something that I didn't satisfy him wish that led him to turn to substance abuse.

Problem experience:

O 3: yes (1976), how long = since.

That won't realize there's something wrong psychiatric institution. He has been in and out of the hospital.