THE EXPERIENCE OF PARENTS WITH DRUG-ADDICTED TEENAGERS

by

MOIPONE HILDA MARTHA MABUSELA

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Study leader: Dr. A.C. Gmeiner

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This research study is dedicated to my children Bontle and Katlego.
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SUMMARY

We live in a society where the use of substances such as alcohol and cigarettes are socially accepted. These substances are used both by parents and teenagers. The teenagers use more of the so-called 'street drugs', for example cocaine, heroin and Ecstacy.

It has been proven that the use of such substances affects the individual physically, emotionally, mentally and socially. To explore more on the social aspect of the teenager, I studied the effects of teenage drug abuse on parents. The goal of this study is to:

- explore and describe the experience of parents with drug-addicted teenagers.
- describe guidelines for advanced psychiatric nurses to assist parents in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health.

This study was undertaken within the framework of the Nursing for the Whole Person Theory (Oral Roberts University, Anna Vaughn School of Nursing, 1990:136-142; Rand Afrikaans University, Department of Nursing Science, 1992:7-9), which functions in an integrated biopsychosocial manner (to achieve his quest for wholeness a person interacts with his internal and external environments holistically. The parameters of nursing and beliefs about man, health, illness and nursing are also described.

A functional reasoning approach is followed, based on the model for nursing research developed by Botes (1991:19). A phenomenological approach to nursing research was utilised. In-depth semistructured interviews were conducted with parents of drug addicted teenagers and field notes were taken with the permission of the institution to which teenagers were admitted.

Steps were taken throughout the research to ensure trustworthiness. Data were analysed following methods suggested by Tesch (in Creswell, 1994:155) and the services of an
independent coder were obtained.

After analysis of data, follow-up interviews were conducted with two of the parents included in the sample. A literature control was undertaken to validate data and to compare findings with those of other research studies.

The results of this study indicate that parents suffer emotional disturbances, financial losses, social discrimination and that they use destructive defence mechanisms. Despite this, the parents still display a feeling of hope.

Conclusions were drawn and recommendations were made concerning nursing practice, nursing education and nursing research and guidelines were given for advanced psychiatric nurses to assist parents in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health.
OPSOMMING

Ons leef in 'n gemeenskap waar die gebruik van alkohol en sigarette sosiaal aanvaar word. Dit word deur beide ouers en tieners gebruik. Tieners gebruik meer van die sogenaamde 'straatdwelms', byvoorbeeld kokaïne, heroïne en Ecstasy.

Dit is bewys dat die gebruik van hierdie stowwe die individu fisies, emosioneel, psigies en sosiaal affekteer. Ten einde die sosiale aspek van die tiener dieper te verken, het die navorser die uitwerking van tieners se dwelmmisbruik op ouers bestudeer. Die doel van hierdie studie is om:

- die belewenis van ouers van dwelmverslaafde tieners te verken en beskryf; en
- riglyne te beskryf vir gevorderde psigiatriese verpleegkundiges om ouers te help om hulpbronne te mobiliseer om die bevordering, handhawing en herstel van hulle geestesgesondheid as 'n integrale deel van gesondheid te faciliteer.

Hierdie studie is onderneem op 'n geïntegreerde biopsigososiale wyse (liggaam intellek en psige) in die konteks van die gesin en/of gemeenskap, binne die raamwerk van die Verplegingsteorie vir Mensheelheid (Oral Roberts University, Anna Vaughn School of Nursing, 1990:136-142; Randse Afrikaanse Universiteit, Departement Verpleegkunde, 1992:7-9). Die parameters van verpleging en oortuigings omtrent die mens, gesondheid, siekte en verpleging word ook beskryf.

'N Funksionele denkbenadering word gevolg, gebaseer op Botes (1991) se model vir navorsing in verpleging. 'n Fenomenologiese strategie tot verpleging is benut. In-diepe semi-gestruktureerde onderhoude is gevoer en veldnotas geneem met die toestemming van ouers en die inrigting waar tieners toegelaat is.

Stappe is deurgaans in die studie geneem om vertrouenswaardigheid te verseker. Data is geanaliseer volgens Giorgi en Tesch (in Cresswell, 1994:155) se metodes en die dienste
van 'n onafhanklike kodeerder is bekom.

Na afloop van data-analise is opvolgonderhoude met twee van die ouers wat by die studie betrokke was, gevoer. Literatuurkontrole is gedoen om die data te bevestig en om bevindings met dié van ander studies te vergelyk.

Die resultate van hierdie studie dui daarop dat ouers emosionele afwykings toon, finansiële verliese ervaar, daar sosiaal teen hulle gediskrimineer word en dat hulle vernietigende verdedigingsmeganismes gebruik. Ten spyte hiervan, toon die ouers steeds 'n gevoel van hoop.

Gevolgtrekkings is gemaak, asook aanbevelings betreffende die verpleegkundige praktyk, verpleegkunde-onderwys en -navorsing. Riglyne is ontwikkel vir gevorderde psigiatriese verpleegkundiges om ouers te help om hulpbronne te mobiliseer ten einde die bevordering, handhawing en herstel van hulle geestesgesondheid as 'n integrale deel van gesondheid te fasiliteer.
CHAPTER 1

OVERVIEW OF THE STUDY

1.1 BACKGROUND AND RATIONALE

According to a study conducted by Lee Rocha-Silva (1991:17-20) on alcohol/drug abuse and related matters, entitled "Young South Africans between the ages of 10 - 21 years", teenagers manifest a fair degree of risk proneness with regard to the development of alcohol-/drug-related problems. In line with the assumptions of this study concerning factors contributing to alcohol-/drug-related problems, the research findings indicate that the teenagers found themselves in a social environment in which there is a fair degree of social support for alcohol/drug use and limited discrimination against such use, including exposure thereto. It is also clear that these social factors had a psychological impact on the teenagers concerned. There were indications of tolerance towards alcohol/drug use, limited fear of discrimination against alcohol/drug use and a person's need for, or attraction to alcohol/drug intake. Contact with and, in fact, actual use of alcohol/drugs were also not unusual among the teenagers. More specifically, preventive agents need to take cognizance of the use of licit drugs, such as over-the-counter drugs, alcohol, cigarettes/tobacco and, to some extent, non-prescriptive sedatives, tranquillisers and stimulants, which seems to have been fairly prevalent among the teenagers according to a study among teenagers aged 14 years and older in metropolitan areas and in neighbouring squatter camps and towns in the Republic of South Africa, as well as a related study in the self-governing states in the same year.

Tobacco, particularly among males, and pain relievers which are bought over the counter, such as Grandpa, Syndol and others, are used especially by women. Snuff also seems to be fairly popular among women. In most cases, tobacco is used regularly - at least once a week - whereas the opposite applies to pain relievers. The use of tobacco is prevalent in squatter camps. Moreover, in the self-governing states, the use of tobacco is particularly prevalent among males, the comparatively older age group (50 years and
older), those in the comparatively lower educational category (standard five and lower), the lower income group, those not affiliated to a church, and labourers. The use of tobacco is, in fact, not so common in the less industrialised self-governing states (prevalence rates are lower than 10%) than in metropolitan areas, neighbouring squatter camps and towns in the Republic of South Africa (prevalence rates are higher than 10% but lower than 25%) (Rocha-Silva, 1992:18).

Apart from tobacco and pain relievers, the use of dagga and the sniffing of solvents is worth mentioning. The use of dagga, in particular, is prevalent in squatter camps, generally among males. There are some indications that the use of dagga becomes more prevalent as people get older. The rate at which the sniffing of solvents occurs is more or less in the order of 2%. Cocaine and LSD is fairly popular among males and then particularly among those in the towns neighbouring on metropolitan areas in the Republic of South Africa, although fair proportions of the females in these towns also admit to the use of cocaine and LSD (Rocha-Silva, 1992:18-19).

Regarding the use of drugs other than alcohol among teenagers in standard eight and ten in the suburbs, tobacco, solvents and dagga are most popular, especially among the males. Whereas the percentage using the latter two substances is below 10%, the population using tobacco is in the order of 30% (Rocha-Silva, 1992:19).

There are sporadic instances where Ecstasy is used. Ecstasy is the new drug of the nineties. It turns teenagers into party animals and it is feared that the substance will become the scourge of the decade (Sunday Times Metro, 12 February 1995:3-4). Ecstasy has been available freely in South Africa for some time and it has attained cult status in Britain and Europe where it is used mainly by teenagers and young adults. Young people between the ages of 16 and 25 mostly attend raves and they are extremely susceptible to peer pressure, which makes them an easy target for drug pushers. If one chats to one of them, the subject of drugs is bound to be raised, or at least perhaps a confession that they like raves. Before long one will be offered the drug without having to pay immediately (You, 11 April 1996:20). Ecstasy apparently gives users so much energy that they cannot
stop dancing. Amidst the euphoria fluids build up in the body, resulting in death - the latest victim was an 18 year-old teenager who died in England on her birthday. Despite the risks, however, more and more young South Africans find this drug irresistible (Y/De Waal, 1996:20-24).

According to Fatima Esau, a counsellor at the Cape Town Drug Counselling Clinic, two or three people have visited the Clinic during the last two years after taking Ecstasy. This year ten people were counselled during the first two months and there has been a considerable increase in telephone calls from users and concerned family members (Y/De Waal, 1996:24). Almost all the teenagers who have been admitted to the Alcohol and Drug Rehabilitation Centre in Gauteng, regarded Ecstasy as a 'priority' drug. Despite the risks involved, teenagers refuse to be convinced that they should break the habit. One teenager asked: "How can you possibly write about Ecstasy if you haven't tried it yourself?" Alice, a 20 year-old shop assistant who works in a rave boutique, is fed up with what she calls 'biased stories' about Ecstasy in the media. According to her, people really do not know what they are talking about. "Unless you have taken Ecstasy yourself, you have no idea how wonderful it is" (FL/Hobbs, 1996:78).

Some teenagers defend the drug with a fervour usually reserved for religious experiences. They say it is amazing, incredible, mind-blowing, exquisite, spiritual, that it is five billion times better than any other drug that has ever been invented. They simply cannot understand why society is 'hell-bent' on preventing them from having a good time. Hundreds, possibly thousands of young people in this country are swallowing Ecstasy every weekend, believing it is a 'safe' and even 'natural' drug that has none of the addictive potential, or the dangerous side effects, of alcohol, nicotine and other socially-sanctioned over-the-counter drugs. The recreational use of Ecstasy has spread like a contagion among young affluent whites in South Africa's major cities. Although the majority of users are between 20 and 30 years old, the drug has also become popular among girls and boys as young as 13 years of age. According to Lee Wilcocks, counsellor at Aspen Oak Associates (FL/Hobbs, 1996:78), if you ask children these days about drugs they have experimented with, Ecstasy often appears on the list. The families of 54
of 54 victims cannot be expected to accept this, as one mother said at a press conference on the topic of 'Ecstasy tablets destroy families', long after her 19 year-old son died in hospital following his collapse at a London disco in January this year.

According to Adele Searll, anti-drug campaigner, one drug is not safer than another. People will always find an excuse to take drugs. They only become aware of the dark side after they have been destroyed by the drug. Pharmacist David Bayver of Drug Wise also expresses outrage at the notion that Ecstasy is portrayed as a healthy drug with no side effects. This could not be further from the truth. He comments: "Young people must know that when they take Ecstasy, they are not only risking their health but their lives too. People are still ignorant of the extensive damage and potential complications associated with Ecstasy." Dr Chris van der Burgh agrees when he states: "There is no way that this can be described as a 'safe drug'. This is not a substance to be trifled with." (FL/Hobbs, 1996:80).

Craig Coull, a rehabilitated drug user looks at the decriminalisation of dagga in South Africa. He states that with an estimated 300 million people using it world-wide, cannabis is yet again becoming a fashionable and widely used mind-altering substance. Lawyers for human rights think it is 'ludicrous' to fill our prisons with this number of offenders. They believe that criminalising those who use cannabis will not resolve the problem and maintain that, regardless of whether or not the substance is decriminalised, it will continue to be used and abused. Making the substance legal could well eliminate much of the criminal activities surrounding the dealings in the drug and allow for the regulation of distribution. Dr Sylvian de Miranda, director of Phoenix House, is a well-known authority on the subject of drug and alcohol abuse. He would like to see a change in the law which would allow for the "dope" offender to be dealt with outside the criminal justice system, without a criminal record being imposed. He supports his statement by saying that there are many people whose careers and lives have been ruined as a result of past criminal convictions, which could have been handled in another way. He gives an example of an individual who was convicted for possession at a young age and who was subsequently given a criminal record. From that point onwards, he had stopped smoking dagga and went on to excel at his career and even received a gold medal in
commerce. He was later given a once-in-a-lifetime opportunity in the form of a three year bursary to study at Stanhope University in America, but unfortunately was unable to gain entry into the US because of his criminal record. It is, therefore, necessary that decriminalisation be considered as an alternative to present legislation.

Last year, Dr Sipho Mzimela, Minister of Correctional Services, called for an investigation into the possibilities of decriminalising dagga. In his opinion, many inmates do not belong in our crowded prisons and should be catered for elsewhere to make way for more serious criminals. He said that prisoners serving time for possession of cannabis should be among those given amnesty.

One man who refuses to be deterred is Gheral Jupiter-Jons. He belongs to an organisation known as the Rastafari Unity Movement Alliance who, since 1991, has been campaigning for decriminalisation and the release of what he calls "Ganja prisoners". According to him the law is oppressive, but he would rather "rot in a prison cell" than turn away from Rastafari's culture. "In what's supposed to be a New South Africa, Rastafarians are discriminated against because of old ganja laws and now it is mostly black people who are affected by these laws. Ganja has been used by Africans for many centuries - it is tradition and traditions should be venerated, we Rastas smoke the herb for religious purposes in an ordered and controlled manner, to help us meditate. We are only obeying the laws of John Rastafari, so why should we be imprisoned for this?" (G/Coull, 1996:11)

Greg Jacobs, an environmental activist and member of Earthlife Africa, has done extensive research on the subject. He believes that the paranoia surrounding cannabis has little to do with health or the physical effects of the herb. He says: "It is all about racism, colonialism and capitalism. The use of dagga was a normal yet highly controlled cultural function, until the colonists arrived here in South Africa. They did not have the frame of reference for the use of dagga (but did for alcohol) and imposed their eurocentric values on indigenous people. As the economy developed, capitalists wanted control of the labour forces and one way they achieved this was through commodifying and criminalising dagga. The capitalists could brew alcohol in massive quantities and hold a captive labour
market, regulate the market and make a profit. Dagga is not a crime problem, but an economic and political one that is a legacy of apartheid." Until the beginning of this century, cannabis was the world's largest agricultural crop, providing the raw material for most paper, textiles and fabrics.

According to McCarthey (in Y/Craig, 1996:10-12), cannabis became 'demonised' through pressure from the oil industries, cotton manufacturers, pharmaceutical companies and any other industry which stood to lose profit trying to compete with this wonder plant. However, McCarthey also believes that the ones most strongly opposed to a legitimate cannabis industry are, in fact, the dealers themselves. "Drugs like cocaine and LSD get a free ride on the back of cannabis, which is like a double-decker bus that carries the hard-core chemical drugs to their destination. The underground dagga network is huge in South Africa and the drug merchants are taking full advantage of it. If the real drug pushers are benefiting from the illegality of cannabis, then surely the law needs to be changed." (G/Craig, 1996:10-12.)

It is, however, important to note that the teenagers use drugs for experimental use with regard to substances other than tobacco and alcohol. It is agreed that drug use among urban students is more developed, not only quantitatively but also in that the use of different drugs is systematically strongly inter-correlated. Pattern variations between school-goers may also reflect a stronger external or western influence on urban than rural adolescent drug use behaviour.

By far most drug abusers in South Africa are introduced to drugs at school-going age and exposure to an increasing variety of drugs - from cigarettes to cocaine. This occurs more frequently as access becomes easier and the value of drugs is dropping on a daily basis. In the beginning of the year 1996, messages were forwarded to parents and schools stating that there are people handing pre-school children stickers in the form of a tattoo called "Blue Star" which is the size of a pencil eraser, each soaked with LSD. The drug is absorbed through the skin by handling the paper (Thomas and Montagu, 1996:1).

According to City Vision Newspaper in Gauteng, the police seized 4 kg cocaine and
arrested three people one Monday at Johannesburg International Airport. Police
spokesman Captain Jan Combrincic (in City Vision, 1996:10) said the value of the cocaine
was estimated at R3 million because of its purity. Officers of the South African National
Narcotics Bureau, acting on information received, arrested a 34 year-old Nigerian alleged
to be in possession of the cocaine, a 39 year-old South African alleged to be the courier
and her alleged accomplice, also a South African. The officers arrested the courier after
she arrived at the airport on a flight from Rio de Janeiro (City Vision, 28 May 1996:10).
The South African National Narcotics Bureau provided some of the statistics pertaining
to drug-related offences during the year 1994 and 1995, with reference to some of the
most commonly abused drugs (see Table 1.1).

<table>
<thead>
<tr>
<th>SUBSTANCE</th>
<th>1 JAN - 31 DEC 1994</th>
<th>1 JAN - 31 DEC 1995</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DAGGA</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Arrests: possession</td>
<td>3 159</td>
<td>2 047</td>
</tr>
<tr>
<td>• Mass confiscated</td>
<td>4 451 kg 000</td>
<td>1 470 kg 529</td>
</tr>
<tr>
<td>• or found abandoned</td>
<td>7841 445</td>
<td>237 342 kg 681</td>
</tr>
<tr>
<td>• Arrests: dealing</td>
<td>7 896</td>
<td>4 065</td>
</tr>
<tr>
<td>• Mass destroyed in cultivation</td>
<td>6 914 242 kg 000</td>
<td>Statistics not yet available</td>
</tr>
<tr>
<td><strong>MANDRAX</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Arrests: possession</td>
<td>324</td>
<td>172</td>
</tr>
<tr>
<td>• Tablets confiscated</td>
<td>27 125 kg</td>
<td>883</td>
</tr>
<tr>
<td>• Arrests: dealing</td>
<td>2 458</td>
<td>1 286</td>
</tr>
<tr>
<td>• Tablets abandoned</td>
<td>4 726 157</td>
<td>9 161 715</td>
</tr>
<tr>
<td><strong>COCAINE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Arrests: possession</td>
<td>28</td>
<td>23</td>
</tr>
<tr>
<td>• mass confiscated</td>
<td>0 kg 666</td>
<td>0 kg 110</td>
</tr>
<tr>
<td>• Arrests: dealing</td>
<td>266</td>
<td>269 + 2 for crack</td>
</tr>
<tr>
<td>• Mass abandoned</td>
<td>68 kg 895</td>
<td>187 kg 505+</td>
</tr>
<tr>
<td>• Mass abandoned</td>
<td>0 kg 150 crack</td>
<td></td>
</tr>
<tr>
<td><strong>ECSTASY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Arrests: possession</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>• Units confiscated</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>• Arrests: dealing</td>
<td>7</td>
<td>32</td>
</tr>
<tr>
<td>• Units abandoned</td>
<td>1 262</td>
<td>2 117</td>
</tr>
</tbody>
</table>

Drug abuse is not a problem that affects individuals only, it affects their family members,
acquaintances and immediate associates and the justice system as well, as there is a correlation between drug abuse and the high crime rate. It is an obstacle to implementation of the Reconstruction and Development Programme.

1.2 STATEMENT OF THE PROBLEM

One parent who brought his teenager, aged 19 years, for admission to a specific rehabilitation centre in the Gauteng region in 1995, told me that his son has been involved in drug abuse for two years and had stolen furniture in the home/house and all their valuable assets were sold by the teenager. The family had to sell their house in order to pay their son's debts or else the son would be killed by drug-lords. Another family decided to disown their teenager because they felt that they could not live with someone who was destroying their lives. There are other parents who have even taken their teenagers to be detained. The behaviour of teenagers who abuse drugs causes stress to the parents and these parents find it difficult to cope with their teenage children. Teenagers also feel differently about drugs, as one expressed her feelings as follows: "I haven't done Ecstasy in years because it has a really horrible effect on me. I can't function for three days afterwards. I've never done heroin, so I don't know, but people say Ecstasy is a combination of the warm squishy feeling you have with heroin, and the hyper-kinetic, ballsy energy you have on coke (cocaine) and that it is slightly hallucinogenic, so the green of your jacket is really green. And you just love everybody. When I did it I would see people in clubs that I couldn't stand and I'd find myself being nice to them. It's not a very good drug. I mean, there are no good drugs, but it made me as sick as a dog." (FL/Hobbs, 1996:78-81).

In lieu of the above, the following research questions were asked:

- How do parents experience having a drug-addicted teenager?
- What guidelines can be developed by an advanced psychiatric nursing practitioner to assist parents in mobilising resources to facilitate the promotion,
During clinical contact with parents with drug-addicted teenagers, parents present or express feelings of anger, shame, guilt and depression, which are part of their repertoire of responses to external and internal stimuli. As such they become part of the process of addiction and may serve as triggers of substance use, while also serving to maintain the use of the substance. In other cases, the parents are blaming themselves for the teenager's drug abuse; they tend to take responsibility for the teenager's behaviour. There is, therefore a need for parents to receive support from advanced psychiatric nurses. It is the psychiatric nursing practitioner's duty to facilitate promotion, maintenance and restoration of parents' mental health as an integral part of health (Poggenpoel, 1994:55).

1.3 PURPOSE OF THE STUDY

The purpose of the study is twofold:

- The exploration and description of the experience of parents with drug-addicted teenagers.

- The description of guidelines for the advanced psychiatric nurse to assist these parents to mobilise resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health.

1.4 RESEARCH MODEL

The model of research in nursing developed by Botes (1991:19) will be utilised in this study. According to this model, nursing activities take place at three interrelated orders.

First order activities are concerned with nursing practice. During nursing practice the research problems are discussed and research findings are validated. Thus, in this study I came into contact with the problem of drug-addicted teenagers and parents who are
unable to cope with it because it affects their external environment. It adversely affects their mental health status and their quest for wholeness.

In the second order, nursing activities are concerned with research and theory generation and thus the development of nursing knowledge. By exploring and describing the experiences of parents with drug-addicted teenagers, it is hoped that the findings will contribute further to nursing knowledge.

In the third order, which relates to the paradigmatic perspective, I will state my metatheoretical, theoretical and methodological assumptions. This will be discussed in the following section.

1.5 PARADIGMATIC PERSPECTIVE

This is the establishment of appropriate facts, the matching of facts and theory and the articulation of the theory (Mouton and Marais, 1988:146-147).

In this research study, the paradigmatic perspective will be based on the Nursing for the Whole Person Theory (Oral Roberts University, Anna Vaughn School of Nursing, 1990:136-142; Rand Afrikaans University, Department of Nursing Science, 1992:7-9). This theory is based on the Judeo-Christian world view and a philosophy built on the Bible as the source of truth. This theory reflects the focus on the whole person - body, mind and spirit - as well as on the parameters of nursing service and beliefs about man, health, illness and nursing.

1.5.1 Metatheoretical assumptions

- Person

The person in this study refers to the parents of the drug-addicted teenager, the drug-
addicted teenager and the researcher. They are all spiritual beings who function in an integrated biopsychosocial manner to achieve their quest for wholeness. They interact holistically with their internal and external environments. Their experience of any situation will thus be seen as holistic.

- **Mental health**

Mental health is an integral part of wholeness. Wholeness is a state of spiritual, mental and physical wholeness. The pattern of interaction between internal and external environment determines the individual's health status. Mental health can be qualitatively described on a continuum from maximum health to minimum health. In this study, the patterns of interaction of external and internal environments of the parent will determine his/her mental health.

Maintenance of mental health refers to those nursing activities directed towards continuing and preserving the health status of the parents.

Promotion of mental health refers to nursing activities contributing to a greater degree of wholeness of the parents.

Restoration of mental health refers to those nursing activities which facilitate the return to the previously experienced levels of health of parents (Oral Roberts University, Anna Vaughn School of Nursing, 1990:136-142; Rand Afrikaans University, Department of Nursing, 1992:7-9).

- **The environment of the rehabilitation centre**

This means the internal and external environment. The internal environment comprises body, mind and spirit, while the external environment involves physical, social and spiritual aspects.
1.5.2 Theoretical assumptions

The theoretical assumptions of this study will be based on the Nursing for the Whole Person Theory (Oral Roberts University, Anna Vaughn School of Nursing, 1990:136-142; Rand Afrikaans University, Department of Nursing, 1992:7-9).

1.5.2.1 Theories and models

Nursing for the Whole Person Theory (Oral Roberts University, Anna Vaughn School of Nursing, 1990:136-142; Rand Afrikaans University, Department of Nursing, 1992:7-9) will be used as a theoretical viewpoint of the study.

The use of bracketing during taking of field notes: Bracketing means that the researcher suspends or lays aside what is known about the phenomenon being studied and this, in turn, facilitates "seeing" all the facets of the phenomenon and the formation of new gestalts. In this research study I will deliberately rid myself of my sedimented views developed both from own experience and the literature review, and make myself open to the respondents' views (Burns & Grove, 1993:567).

1.5.2.2 Theoretical assumptions

The researcher will be guided by the theoretical assumptions of the Nursing for the Whole Person Theory (Oral Roberts University, Anna Vaughn School of Nursing, 1990:136-142; Rand Afrikaans University, Department of Nursing, 1992:7-9).

The assumptions are as follows:

- The parents with drug-addicted teenagers are spiritual beings who function in an integrated biopsychosocial manner to achieve their quest for wholeness.

- The whole person nursing approach to parents focuses simultaneously on
spiritual, mental, physical and social aspects of wholeness.

- The psychiatric nurse facilitates the promotion, maintenance and restoration of parents' mental health through the health delivery system.

- Promotion, maintenance and restoration of mental health requires the mobilisation of all resources in the external and internal environment of the parents with drug-addicted teenagers.

1.5.2.3 Central statement

The exploration and description of the experience of parents with drug-addicted teenagers will provide the basis for describing guidelines for advanced psychiatric nurses to assist parents in mobilising resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health.

1.5.2.4 Other definitions

**Parents**

In this study, parents with drug-addicted teenagers refer to a mother, father or guardian who is either biological or adopted a teenager.

**Teenager**

Kaplan, Sadock and Grebb (1994:51) describe the teenager as an adolescent. Adolescent is subdivided into three categories: early (11 to 14 years); middle (14 to 17 years) and late (17 to 20 years). In this study we will look at the late teenager (17 to 20 years) because most teenagers admitted to the specific rehabilitation centre are within this age range. I will refer to "teenager" throughout this study.

**Drugs**

This term refers to over-the-counter medications, prescription drugs, street drugs and
household preparations. In this study the focus will be on street drugs, namely cocaine, dagga, Mandrax, LSD, Ecstasy and others (De Miranda, 1987:1-4).

**Drug addiction**

Drug addiction or dependency is a maladaptive pattern of substance use, leading to clinically significant physical, mental and social impairment in people, occurring at any time in the same twelve-month period, as measured by tolerance, withdrawal and increasing the dosage to the required satisfaction level (Kaplan and Sadock, 1994:387).

### 1.5.3 Methodological assumptions

The methodological assumptions guiding this study are in line with the research model developed by Botes (1991:19). The central thesis of the model is that research should be functional. Nursing research should be undertaken in order to improve nursing practice. In this study, insight into the experience of parents with drug-addicted teenagers will provide the basis for describing guidelines for advanced psychiatric nurses to assist these parents in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health.

### 1.6 RESEARCH DESIGN AND METHOD

In this section, a description will be given of the research design and research method of the study.

#### 1.6.1 Research design

The research design in this study will be qualitative, exploratory, descriptive and contextual. It follows the research model in nursing outlined by Botes (1992:12) which states that the activities of the discipline of nursing take place at three levels which are interrelated and influence one another. The model demands that the researcher pays attention to the determinants of research, which form the basis for making decisions from
interpretation, conceptualisation, formulation, research design through to implementation.
The determinants of research are as follows:

1.6.1.1 Characteristics of the research field

The teenagers were admitted at a rehabilitation centre in the Gauteng region, where their numbers are increasing every month, also as a result of high drug trafficking and abuse in the country, more often at schools. The parents with drug-addicted teenagers will, therefore, be seen at this rehabilitation centre.

1.6.1.2 Assumptions of the researcher

These have already been discussed in paragraph 1.5.1.

1.6.1.3 Research context

The study will be conducted at a specific rehabilitation centre in the Gauteng region. It is a private centre admitting drug abusing teenagers and adults. The study is confined to parents who are members of the rainbow nation of South Africa, who have drug-addicted teenage children.

1.6.1.4 Purpose of the research

The purpose of the research is twofold:

- The exploration and description of the experience of parents with drug-addicted teenagers.

- The description of guidelines for the advanced psychiatric nurse to assist these parents in mobilising their resources to facilitate the promotion, maintenance and restoration of mental health as an integral part of health.
1.6.2 Research method

This study will be conducted in two phases: The first phase is concerned with phenomenological interviews with parents of teenagers addicted to drugs. The results of phase one will serve as a basis for guidelines for the advanced psychiatric nurse. The second phase entails formulation of guidelines for advanced psychiatric nurses. These guidelines will be used in assisting these parents to mobilise resources in order to promote, maintain and restore their mental health as an integral part of health.

In the first phase, phenomenological interviews will be conducted with parents with drug-addicted teenagers.

Results of phase one will serve as a basis for guidelines for the advanced psychiatric nurse. These guidelines will be used to assist parents in mobilising resources in order to promote, maintain and restore their mental health which is an integral part of health.

1.6.2.1 Phase 1: Exploring and describing the experience of parents with drug-addicted teenagers

In this phase, respondents will be identified to participate in the study and then semi-structured phenomenological interviews will be conducted, followed by data analysis and the taking of field notes and observation of the necessary ethical procedures.

- Sampling

The target population for this study are parents with drug-addicted teenagers, whose teenagers were admitted at the specific rehabilitation centre. Purposive sampling will be used and the criteria for selection will be as follows (Burns & Grove, 1993:246-248):

- Parents whose teenagers, aged between seventeen and twenty years, were admitted at the rehabilitation centre between 1 April and 30 June 1996.
- Parents who live in the Gauteng region.
Parents who can understand and speak the English language.

The criteria for selection will be described fully in chapter two.

**Collection of data**

The parents of each teenager (that is, parents of one family) will be interviewed at the rehabilitation centre on the day their teenager is admitted. Data will be collected through phenomenologically, semi-structured interviews. A tape recorder will be used to record interviews which will be transcribed verbatim (Polit and Hungler, 1987:229; Burns and Grove, 1993:578-581). A central question will be asked during the interview:

"Please tell me: How do you experience having a drug-addicted teenager?"

Each interview will last approximately 45 to 60 minutes. The researcher will use facilitating communication techniques such as minimal responding, listening, clarification, and rephrasing to encourage the parents to speak freely about their experiences and this will be described fully in chapter 2. Follow-up interviews will be conducted with some of the participants to validate the informants' frame of reference.

A pilot study will be conducted with two parents from two families, who meet the required criteria, to identify possible research problems.

**Data analysis**

The tape-recorded interviews will be transcribed verbatim and then analysed according to the methods suggested by Tesch (in Creswell, 1994:155). This will be discussed in chapter 2.

**Literature control**

The results of the research will be discussed in the light of the relevant literature and information obtained from similar studies.
1.6.2.2 Phase 2: Description of guidelines for advanced psychiatric nurses to assist parents in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health

During this phase data collected from informants will be used as a basis for describing guidelines for advanced psychiatric nurses to assist parents in mobilising resources in promoting, maintaining and restoring their mental health as an integral part of health. These guidelines will then be discussed with a psychiatric nursing specialist who is also an expert in the field of qualitative research, for the purpose of refining them.

1.6.2.3 Trustworthiness

To ensure reliability and validity of the interviews, Guba's model (in Krefting, 1991:214-222) will be used. Guba identifies four criteria for trustworthiness. They are: truth value, applicability, consistency and neutrality. Truth value is ensured by using strategies of credibility; applicability by applying strategies of transferability; consistency by strategies of dependability and neutrality by strategies of confirmability. These strategies will be discussed in more detail in chapter 2.

1.6.2.4 Ethics

In this research study, ethical conduct will be ensured by following the ethical standards set for nurses by the South African Nursing Association (1991). The following ethical measures will be taken and will be described in chapter 2: Informed consent, privacy, anonymity and confidentiality, and providing participants and the rehabilitation centre with the results.

1.6.3 Conclusions and recommendations

Conclusions and recommendations will be highlighted after the results of the research study have been discussed.
1.7 CHAPTER SEQUENCE

CHAPTER 1: BACKGROUND AND RATIONALE
CHAPTER 2: RESEARCH DESIGN AND METHOD
CHAPTER 3: RESULTS OF PHASE 1: PHENOMENOLOGICAL INTERVIEWS AND LITERATURE CONTROL
CHAPTER 4: PHASE 2: GUIDELINES AND LITERATURE CONTROL, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS.

1.8 CONCLUSION

In order to meet the challenge of the 1990's, South African researchers within the field of alcohol/drugs should take cognizance of the high rate of drug trafficking and abuse and, most importantly, the impact of drug abuse on immediate family members or associates. In this Chapter we have seen that drug abuse is a problem and that it is taking control over the teenagers. The question which follows is what the parents experience having a drug-addicted teenager and how guidelines can be described for advanced psychiatric nurses to assist parents in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health.
In chapter one the orientation and rationale of the research study were described. In chapter two a description of the rationale, research design and research method will be given.

2.1 RATIONALE

It is a well-known fact that a major disadvantage of South Africa’s readmittance to the international community has been the dangerous trend of illicit drug traders targeting this country aggressively as a new untapped market place (Nursing News, March 1996:44).

At least once a week we see and read news on television and in newspapers about drugs that have been confiscated in the country. Recently, detectives of the South African Narcotics Bureau in Johannesburg seized twelve kg cocaine - the second-largest haul in the country so far - at Johannesburg International Airport on 6 June 1996. The cocaine has a street value of nine million rand and has been described as extremely pure (The Star, 7 June 1996). The biggest haul before that was two years when police seized thirteen kg in Hillbrow.

Parents of the nineteenth and twentieth century face various challenges in bringing up or caring for their teenage children, such as the epidemic of HIV/AIDS infection, where teenagers are at high risk of contracting the infection or disease, suicides among teenagers, transformation in the country and drug trafficking and abuse which are all very difficult for teenagers to resist. Metro visited several popular drug haunts in Berea, Yeoville and Bertrams in Gauteng one week to find out how easily narcotics, ranging from dagga to heroin, could be bought. They were shocked to discover that teenagers ranging from age thirteen to twenty had no difficulty buying and consuming drugs like food. The drug pushers are always on the alert for customers. Some of the teenagers are
prostitutes without their families being aware of it- families or parents assume that they are working in decent jobs (Capel David, art. 1995:3). The teenager seems to be comfortable abusing drugs, therefore in this research study I will establish how parents experience having drug-addicted teenagers, as no such research has been done. I will also describe guidelines for advanced psychiatric nurses to assist parents in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health.

2.2 OBJECTIVES OF THE STUDY

This study has the following objectives based on the identified problem:

- To explore and describe the experience of parents with drug-addicted teenagers.
- To describe guidelines for advanced psychiatric nurses to assist parents in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health.

2.3 RESEARCH DESIGN AND METHOD

The research design and method which will be utilised in this study will be discussed as follows:

2.3.1 Research design

The design of this research will be qualitative (Burns and Grove, 1993:28-29), exploratory (Mouton and Marais, 1990:43), descriptive (Mouton and Marais, 1990:43-44) and contextual (Mouton and Marais, 1990:49-121).
2.3.1.1 Qualitative

A qualitative study is one where the procedures are not strictly formalised while the scope is more likely to be undefined and a more philosophical mode of operation is adopted (Mouton and Marais, 1990:205). It seeks to gain insight into the experiences of parents with drug-addicted teenagers. It is concerned with the nature of other experiences which are unique to each individual. Its qualitativeness can also be explained by the fact that it is a systematic, subjective approach used to describe life experiences and giving them meaning (Burns and Grove, 1993:28-29).

2.3.1.2 Exploratory

The goal which is pursued in exploratory studies is the exploration of a relatively unknown research area. The aim being to gain new insight into the phenomenon (Mouton and Marais, 1990:43) by exploring the experience of parents with drug-addicted teenagers.

2.3.1.3 Descriptive

It is the researcher's goal to describe that which exists as accurately as possible by collecting accurate information or data on the domain phenomena which are under investigation (Mouton and Marais, 1990:43-44). The experience of parents with drug-addicted teenagers will be explored and described as well as the guidelines for assisting parents in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health.

2.3.1.4 Contextual

A contextual study is one where the phenomenon of interest is studied in terms of its immediate context (Mouton and Marais, 1990:49). This research study will be contextual in that it will focus on the experience of parents with drug-addicted teenagers, who reside
in Gauteng Province and whose teenagers are admitted to a specific rehabilitation centre.

2.3.2 Research method

This study will be conducted in two phases:
The first phase involves the exploration and description of the experiences of parents with drug-addicted teenagers by means of semi-structured, in-depth phenomenological interviews as a method of data collection.

2.3.2.1 Ethical issues

In this research study, ethical conduct will be ensured by following the ethical standards set by the South African Nursing Association (SANA, 1991:3-4; Addendums 1 and 2) for nurse researchers. The following ethical measures will be adhered to:

- Informed consent

Two types of informed consent will be obtained before commencing with the collection of data. These are obtaining the permission of the rehabilitation centre to conduct the research in the institution, and obtaining informed consent from prospective parents to participate in the research study.

Consent will be obtained in writing and the following information will be conveyed to the receivers/participants: The title of the research; objectives of the research; research methods, including all the procedures that will be followed; the type of participation that will be expected of the respondents; how the results will be used and published; the right of subjects to terminate their participation without being penalised; potential physical, emotional, social and economical risks that might result from the research; potential benefits of being a subject in the research; and means of communicating with the researcher when prospective subjects and rehabilitation centre authorities have further questions or merely want to contact the researcher for other reasons (Burns and Grove,
Privacy

Privacy means that a person can behave and think without interference, or the possibility of private behaviour or thoughts being used to embarrass or demean that person later (SANA, 1991:2-3). In this research study, privacy will be ensured in that I will avoid collecting more information than is absolutely necessary, especially of a private nature, to reach the objectives of this study.

Anonymity and confidentiality

Anonymity means that the subject’s identity cannot be linked - even by the researcher - to individual responses (Burns and Grove, 1993:99). In this research study numbers will be allocated to each respondent so that it will be possible to review the respondents’ analysed interviews with them later.

Confidentiality is the management of private information, which I must refrain from sharing with anyone without the authorization of the respondent (Burns and Grove, 1993:99). In this research study confidentiality will be confirmed to the respondents both in person and in writing.

Providing participants and the rehabilitation centre with the results

The participants in the research study and the rehabilitation centre where data will be collected, will be provided with the results of the study by means of a bound copy of the study once it is completed.

This brings us to phase 1 of the research study.
2.3.3 Phase 1: Exploring and describing the experience of parents with drug-addicted teenagers

The objective of the first phase is to explore and describe the experiences of parents with drug-addicted teenagers. This phase will entail the identification of respondents or participants in the study and then the collection of data by means of phenomenological interviews and the taking of field notes, followed by verbatim transcription of data and data analysis.

- Population and sampling

The target population for this study is parents with drug-addicted teenagers who are admitted at a specific rehabilitation centre in Gauteng Province. Purposive sampling will be used in this study, which involves the conscious selection by the researcher of certain subjects or elements to include in the study (Burns and Grove, 1993:246).

- Sampling criteria

Sampling criteria are the characteristics which are essential for membership of the target population. The sampling criteria are designed to make the population as homogenous as possible, or to control for extraneous variables (Burns and Grove, 1993:236).

The sample is selected from a population which meets the following criteria:

- Parents whose teenage children are between 17 and 20 years old. This age group is more at risk of abusing drugs since drugs are easily available at schools and tertiary institutions. Peer group pressure also plays a role in this age group. More teenagers in this age group are admitted to the rehabilitation centre than any other age group.

- The teenagers should be admitted at a specific rehabilitation centre between 1
April and 30 June 1996, as they are staying at the rehabilitation centre for a period of three months.

- Parents should live in Gauteng Province because the study is contextual and it can be compared with other provinces.

- Parents who can understand and speak English because the researcher, the supervisor and the independent coder speak and understand English.

**Sample size**

The question which arises here is what size sample should be used? The sample will be determined by the number of subjects needed to complete the study. Thus, in this study the sample size will be achieved when data is saturated, demonstrated by repeating themes (Burns and Grove, 1993:247-248).

**Collection of data**

Data will be collected in this study by means of in-depth phenomenological interviews, field notes, use of communication techniques and the role of the researcher.

- **Phenomenological interviews**

Phenomenological studies are studies in which human experiences are examined on the basis of detailed descriptions by the people being studied - understanding of the "lived" experiences. The procedure involves studying a small number of subjects through extensive and prolonged engagement to develop patterns and relationships of meaning. Through this process the researcher "brackets" his or her own experiences in order to understand those of the informants (Cresswell, 1994:12).

In this study parents of each teenager will be interviewed at the rehabilitation centre on
the day of admission of their teenager and during the stay of the teenager in the case of teenagers who have been admitted during the months of 1 April and 30 June 1996. Interviews will be tape-recorded and then transcribed verbatim (Polit and Hungler, 1987:229; Burns and Grove, 1993:578-581). A central question will be asked during the interview:

"Please tell me: How do you experience having a drug-addicted teenager?"

Each interview will last approximately 45 to 60 minutes. Follow-up interviews will be conducted with some of the participants to validate the informants' information. A pilot study will be conducted with parents from two families, who meet the required criteria in order to identify possible research problems.

- The role of the researcher

According to Polit and Hungler (1987:350), data collection in qualitative research requires a minimum of researcher-imposed structure and a maximum of researcher involvement. For the data-collection stage of this study to be successful, the researcher has to do the following:

- Make use of the researcher’s personality: The use of the researcher’s personality is a key factor in qualitative research. Empathy and intuition are deliberately used and skills in these areas are cultivated through research (Geldard, 1993:8). The researcher must be closely involved in the respondent’s experience in order to interpret it. She must remain open to the perceptions of the respondents rather than attach her own meaning to the experience of participants (Burns and Grove, 1993:94).

- Create an open atmosphere: The best possible interpersonal relationship or rapport with the respondent must be established. This relationship acts to neutralise initial distrust. It is clear that it could act as a control for role-selection effects.
Use of communication techniques

Non-directive communication techniques, such as probing, paraphrasing, summarising, minimal responding, reflecting and clarifying to encourage participants or respondents who are interviewed to freely articulate their views and findings.

- **Probing**

Probing refers to the interviewer's ability to help respondents to identify and explore experiences, behaviours and feelings that will help them engage more constructively in any of the steps of communication (Madela, 1991:18).

- **Paraphrasing**

Paraphrasing is a method of restating the interviewer's basic message in similar, but usually fewer, words. This is used by the interviewer to test her understanding of what the interviewee has said (Brammer, 1988:70).

- **Summarising**

Summarising involves tying together into one statement several views and feelings at the end of a discussion or interview. The main purpose is to give the interviewee a feeling of movement in exploring ideas and findings, as well as to create awareness of progress in communicating (Brammer, 1988:79; Madela, 1994:38).

- **Minimal responding**

Minimal responding means that the interviewer develops a less active role and allows the respondent more time to talk (Madela, 1991:19).
Reflecting of content involves expressing in fresh words the views stated or strongly implied by the interviewee (Brammer, 1988:76; Madela, 1994:38).

Clarifying means bringing vague material into sharper focus. The interviewer makes a guess regarding the interviewee’s basic message or she may also ask for clarification when she cannot make sense of the interviewee’s response (Brammer, 1988:71; Madela, 1994:38).

Field notes

A field researcher needs a system for remembering observations and, even more importantly, retrieving and analysing them (Wilson, 1989:434). In this research study field notes will be written after each interview to describe the underlying themes, the dynamics and situation during the interview, to help the researcher remember all aspects of the interview situation (Wilson, 1989:436). A good set of field notes not only relieves the researcher of some of the burdens of remembering events, but also constitutes a written record of the development of observations and ideas to be used in future publications of the research findings and method. In this research study field notes will be utilised in data analysis, together with the information from the semi-structured interviews. Field notes can be recorded in a format which demarcates observational, theoretical, methodological and personal notes.

Observational field notes are descriptions of events experienced through watching and listening. They contain the who, what, where and how in a situation and as little interpretation as possible (Wilson, 1989:434). In this research study, observational notes will contain the number allocated to the particular interview, observations during the interview, the setting of the interview and the way in which the interview is being
conducted, with some form of simple interpretation attached.

Theoretical field notes are purposeful attempts to derive meaning from the observational notes (Wilson, 1989:435). In this research study the researcher will interpret, infer conjecture and hypothesize to structure her analytic scheme.

Methodological notes are instructions to oneself, critique of one's tactics, reminders about methodological approaches that might be fruitful (Wilson, 1989:435). In this research study the researcher will evaluate her conduct during the interview against the proposed research design and method.

Personal notes are notes about one's own reactions, reflections and experiences (Wilson, 1989:435). In this research study, the researcher will try to take the role of the respondent or participant and be introspective. During data analysis the field notes are also analysed to develop relations to the interview and determine categories (Wilson, 1989:38).

- Data analysis

The tape-recorded interviews will be transcribed verbatim and then analysed according to methods suggested by Tesch (in Creswell, 1994:155). Data analysis requires that the researcher must be comfortable with developing categories and making comparisons and contrasts. It also requires that the researcher must be open to possibilities and to see contrary or alternative explanations for the findings. Tesch (in Cresswell, 1994:155) provides eight steps to consider:

1. Get a sense of the whole. Read through all the transcriptions carefully, perhaps jotting down some ideas as they come to mind.
2. Pick one interview - the most interesting, the shortest and go through it, asking what is this about? Think about the underlying meaning. Write thoughts in the margin.
3. When this task has been completed for several informants, make a list of all the
topics. Cluster together similar topics. Form these topics into columns that might be arranged as major topics, unique topics and leftovers.

4. Take the list and go back to the data. Abbreviate the topics as codes and write the codes next to the appropriate segments of the text. Try out this preliminary organising scheme to see whether new categories and codes emerge.

5. Find the most descriptive wording for topics and turn them into categories. Try to reduce the total list of topics by grouping together topics that are related. Perhaps draw lines between categories to show inter-relationships.

6. Make a final decision on the abbreviation for each category and alphabetise these codes.

7. Assemble the data material belonging to each category in one place and perform a preliminary analysis.

8. Record the existing data.

Researchers may want to develop their lists of categories that reflect major and minor themes in the data. Raw data will be sent to an independent coder for open coding. The coder is a specialist in psychiatric nursing and an expert in the field of qualitative research. Consensus discussions will then be held between the researcher and the independent coder when themes will be reflected within the Nursing for the Whole Person Theory.

- Literature control

The results of the research will be discussed in the light of relevant literature and information obtained from similar studies, to verify the research results.
2.3.4 Phase 2: Description of guidelines for advanced psychiatric nurses to assist parents in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health

The objective of phase two is to describe guidelines for advanced psychiatric nurses to assist parents in mobilising their resources to support them in caring for their drug-addicted teenagers. During this phase, data collected from informants will be used as a basis for describing guidelines for advanced psychiatric nurses to be used when assisting parents to mobilise resources in promoting, maintaining and restoring their mental health as an integral part of health. These guidelines will then be discussed with parents for the purpose of validating them.

2.3.5 Trustworthiness

Agar, 1986; as summarised (in Krefting, 1991:214) suggests that a different language is needed to fit the qualitative view - one that will replace reliability and validity with terms such as credibility, accuracy of representation and authority of the writer. Similarly, Leininger, 1985, also summarised (in Krefting, 1991:214) claims that the issue is not whether the data are reliable or valid, but how the terms reliability and validity are defined. Guba’s, 1982, summarised (in Krefting, 1991:215-222) model is based on the identification of four aspects of trustworthiness, namely truth value, applicability, consistency and neutrality. These terms are explained as follows:

**Truth value** is usually obtained from the discovery of human experiences as they are lived and perceived by informants.

**Applicability** refers to the extent to which findings can be applied to other contexts and settings or with other groups. It is the ability to generalise from the findings to larger populations.
Consistency of data refers to whether the findings would be consistent if the inquiry were replicated with the same subjects or in a similar context.

Neutrality refers to the extent to which the findings are a function solely of the informants and conditions of the research, and not of other biases, motivations and perspectives, Guba’s model (in Krefting, 1991:214-222).

Table 2.1 summarises the strategies which are utilised to ensure trustworthiness.
<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>CRITERIA</th>
<th>APPLICABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credibility</td>
<td>Prolonged engagement</td>
<td>Contact in rehabilitation centre on admission of teenagers. Initially spend time with respondent before interview to build rapport. Again allow time for respondent to verbalise experiences.</td>
</tr>
<tr>
<td></td>
<td>Reflexibility</td>
<td>Taking field notes.</td>
</tr>
<tr>
<td></td>
<td>Member checking</td>
<td>Follow-up interviews with participants. Literature control on parenting, its impact on guidelines.</td>
</tr>
<tr>
<td></td>
<td>Peer examination</td>
<td>The services of a colleague will be acquired.</td>
</tr>
<tr>
<td></td>
<td>Authority of research</td>
<td>The researcher has undergone previous training in research methods. This study is supervised by a doctor in psychiatric nursing, who has experience in research.</td>
</tr>
<tr>
<td></td>
<td>Structural coherence</td>
<td>The focus will be on parents' experiences. Results will be reflected within the Nursing for the Whole Person Theory.</td>
</tr>
<tr>
<td>Transferability</td>
<td>Nominated sample</td>
<td>The sampling method will be purposive, no prior selection</td>
</tr>
<tr>
<td></td>
<td>Dense description</td>
<td>Complete design of methodology and literature control to maintain 'transparency'.</td>
</tr>
<tr>
<td>Dependability</td>
<td>Audit trail</td>
<td>Keeping personal logs and reflexivity note.</td>
</tr>
<tr>
<td></td>
<td>Dense description</td>
<td>Research methodology fully described.</td>
</tr>
<tr>
<td></td>
<td>Peer examination</td>
<td>Independent checking by colleague (devil's advocate) and supervision by experts.</td>
</tr>
<tr>
<td></td>
<td>Code-recode procedure</td>
<td>Consensus discussion between researcher and independent experts.</td>
</tr>
<tr>
<td>Confirmability</td>
<td>Audit trail</td>
<td>As discussed.</td>
</tr>
<tr>
<td></td>
<td>Reflexibility</td>
<td>As discussed.</td>
</tr>
</tbody>
</table>

* Adapted with permission from a table in Poggenpoel, Nolte, Dorling et al., 1994:132.*
2.4 RECOMMENDATIONS

Recommendations for application in nursing education, practice and research will be made after the results of the research study have been discussed.

2.5 CONCLUSIONS

In chapter two a description was given of the research design, research methods and measures to ensure trustworthiness. In chapter three, the results of the phenomenological interviews and the literature control will be described.
CHAPTER 3

RESULTS AND DISCUSSION OF RESULTS

3.1 INTRODUCTION

Chapter two dealt with the research methodology and design and in this chapter the results will be presented and discussed according to stages, themes and categories. Patterns of interaction within the Nursing for the Whole Person Theory (Oral Roberts University, Anna Vaughn School of Nursing, 1990:136-142; Rand Afrikaans University, Department of Nursing, 1992:7-9) will be discussed.

3.2 DESCRIPTION OF THE SAMPLE

The sample for this study comprises a total of five parents who have teenagers who abuse drugs. They have the following characteristics:

- The parents are living and have lived with the teenager.
- Four of the parents are biological parents, while one is the adoptive parent.
- They all live in the Gauteng region.
- Their teenagers were admitted to a specific rehabilitation centre in Gauteng between 1 April and 30 June 1996.
- Their teenagers' ages range between sixteen and twenty years.
- They all speak and understand the English language.
DESCRIPTION OF THE SAMPLE

- Four of the mothers were interviewed, 3 fathers were not available and one was a single parent.

- One couple, both father and mother, were interviewed.

3.3 RESULTS

Table 3.1 shows an overview of the major stages, themes and categories from the parents' descriptions of their experiences living with drug-addicted teenagers.

The first stage is when the parents initially discovered that their teenager was abusing drugs.

The second stage is when the parents take action, such as sending the teenager to an institution for rehabilitation.

The third stage is when the teenager is back at home from the rehabilitation centre.

Although a considerable amount of research has been conducted on teenagers and drug abuse, research studies which specifically focuses on the experience of parents with drug-addicted teenagers has not been broadly conducted. Few literature sources discuss the effects of drug abuse on the family.

The results are tabulated as follows (see table 3.1):
Table 3.1. An overview of stages, themes and categories of experience of parents with drug-addicted teenagers

<table>
<thead>
<tr>
<th>STAGES</th>
<th>THEMES</th>
<th>CATEGORIES</th>
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<tr>
<td><strong>FIRST STAGE</strong></td>
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| Discovering that the teenager is abusing drugs. | 1.1 Emotions | * Shock
* Fright
* Anger |
|                   | 1.2 Social                  | * Isolation from family, friends and others     |
|                   | 1.3 Defence mechanisms      | * Denial
* Avoidance
* Intellectualising |
|                   | 1.4 Financial loss and loss of valuables | * Teenager stealing money and valuables from parents |
| **SECOND STAGE**  |                             |                                                 |
| Seeking help for teenager or taking action (sending teenager to an institution). | 2.1 Emotions | * Anger
* Feelings of persecution
* Shame
* Guilt feelings
* Worry
* Hope
* Failure
* Distrust/uncertainty/insecurity |
|                   | 2.2 Social                  | * Social discrimination                         |
|                   | 2.3 Defence mechanisms      | * Intellectualising                             |
|                   | 2.4 Financial loss          | * Money spent on treatment                      |
| **THIRD STAGE**   |                             |                                                 |
| Post-treatment and teenager back at home with parents. | 3.1 Emotions | * Fear
* Helplessness
* Despair |
|                   | 3.2 Defence mechanisms      | * Intellectualising                             |
|                   | 3.3 Social                  |                                                 |
|                   | 3.3.1 Relationships         | * Changed relationship between parent and teenager |

3.4 DISCUSSION OF FINDINGS

The discussion of findings will be based on stages, themes and categories as set out in
In discussing the results, relevant data from the literature will be incorporated, although in the literature no studies were found that focus specifically on parents' experience with drug-addicted teenagers besides teenagers and drugs.

The findings will be discussed below.

3.4.1 First stage

3.4.1.1 Emotions

Shock

All respondents experienced feelings of shock when they initially discovered that their teenager was abusing drugs. Some of the respondents described their shock as follows:

"I think it is a great shock."

"Big shock, big shock."

Another respondent described it as follows:

"I think it was an extremely traumatic experience because one you know just doesn't think it can happen to oneself and I think the process of finding out and also not knowing what to do."

This shock is supported by Searll (1995:28) who states that there are many young people suffering from this illness and their sometimes shocking behaviour is no more than a symptom of their affliction.
Fright

All respondents were frightened by the teenager's behaviour, as some described it as follows:

"It is frightening, I think to any parent if they realise that their kids are drugging."

"It doesn't make it less traumatic on people that work, it is exactly the same, it affects every person in that way, the shock, the fright..."

"They often say that the drug addicts go into the alcohol, it is a substitute one for the other and that is always the thing that you are frightened of."

Searll (1995:131) describes this by saying that many parents have the frightening experience of realising that they are actually capable of feeling hatred towards their teenager.

Anger

All respondents experienced anger towards their teenager as evidenced by the following:

"If you really love your child you will do that for him, it doesn't matter all the pain that you have to go through with him, all the anger that you have to go through with him."

"I can't do more for you, I'm afraid I had really no interest and this is the...I mean you just become quite helpless because they cannot listen to reason because they just doesn't sink in anymore and just nothing sinks in, you know, if you shout it doesn't sink in, if you threaten it means nothing."

"I used to call him and sit with him for hours and ask him why he was lying because I know that he was lying and then we use to spend hours speaking to him and he would say that he was lying because...uhm...he really didn't have an excuse or I would get upset or his father would get upset about that and he was working and he said to me so what?"

In literature, Searll (1995:131) puts it that the anger and frustration experienced by parents are also normal feelings. It is very common for parents of addicts to feel intensely
angry, not only with their children, but also with each other, with the drug merchants, their children's friends, their schools, the police, the government and anyone else they can think of to blame.

Edmonds and Wilcocks (1995:64-65) acknowledge the feelings of being hysterical, ranting and raving, punishing and threatening the child physically or emotionally as ways of expressing anger.

3.4.1.2 Social

- Isolation from family, friends and others

All respondents experienced social isolation from extended families, friends and colleagues and this is indicated by the following:

"I find that friends and family at distance, they are actually becoming distant, they are not coming around to visit as often as they were."

"I am becoming to feel more isolated..."

"Look I had comments from various of my colleagues sort of blaming also the first thing is that they do blame the family you know, that the first thing that he was too spoilt."

"Yes, it is not acceptable socially yet that a druggy, it's not like an alcoholic they say, well it's a disease, drugs unfortunately still has a stigma."

Some parents experienced social judgement as indicated by the following:

"It is quite easy for people to criticise others and say ag, you know, how come they can't get over it."

According to Searll (1995:124), families also suffer agonies of embarrassments, cutting themselves off from their friends and attempting to hide their shameful predicament.
3.4.1.3 Defence mechanisms

- Denial

All respondents denied that their teenagers were addicted to drugs:

"Well I think at first it was very hard to believe in what was happening but once that process had taken place...uhm...you just look at it at a different light and you try to cope with it."

"Well, he was very clever, he hide it away from us and because of his lies, you know, you believe your child, you trust it can't be true, it can't happen to you as such."

"I heard that he was on cocaine, I thought that it was impossible."

"There is lots of people that deny that their kids are doing it then it take even longer than sorting out the problem."

"They shouldn't, first go and sit down and say why did it happen to me, I think we all attempt to do that."

This is supported by Searll (1995:128), who states that parents should not pretend that nothing is wrong with their child or that, given time, everything will come right, because denial can only prolong the agony.

Beschner and Friedman (1986:185) state that, to begin with, few parents are ready to believe that their own child is using drugs. They have a tendency to disbelieve or deny the symptoms of drug use in their children and to interpret even obvious indicators in other ways. According to the Treatment and Recovery Handbook of Riverfield Lodge (unpublished), denial is the most commonly used unconscious defence. The need to protect the inner self from psychological pain is so strong that even something that is done every day is denied.
Avoidance

Three respondents avoided the issue that their teenagers were using drugs and this is supported by the following:

"It was very hard to like be able to talk to other people about it, you know, when they ask what is your son doing, has he done his matric? Has he done this? Has he done that? In the beginning it was very bad just to talk, I didn't just want to lie and sometimes I just said look, I don't want to talk about it."

"I cannot possibly be worried and responsible for my son for the rest of his life, he is not an invalid, he is not disabled, he is a goodlooking boy, very popular with the girls, no problem there, he's got to do something with his own life really."

As far as avoidance is concerned, Hjelle and Ziegler (1987:83) state that people with this predisposition have neither sufficient social interest nor activity to participate in any way in life. Fearing failure more than desiring success, their lives are marked by the socially useless behaviour of running away from the tasks of life.

Intellectualisation

Four of the respondents said it was an eye opener for them. They described what they learned as follows:

"...same with young kids you don't give them money if they are drug addicts because they are going to spend it on drugs., you buy them what they need, I've learned that and it took me a long time to learn that."

"I think she (referring to mother of teenager) has learned and she has learned very well to know basically how to handle the situation."

"I have learned to cope with this now, I mean I can tell people now that my son had a drug problem and thank God he is much better now."

"You learn all the time, I often say what I have learned in the last three years I would of never thought possible and I think in the end I have also
grown as a person by becoming less judgemental of other people's problems."

According to the *Treatment and Recovery Handbook* (Riverfield Lodge - unpublished, p. 79), the dependent finds it difficult to handle the negative emotions associated with his drinking/drugging. The understanding of dependency in purely intellectual terms is used to prevent, rather than to promote, insight, and keeps dependency on a cognitive level blocking emotional awareness and involvement. For example, 'I don't know why I had a relapse, but according to the literature, relapse can be therapeutic'.

3.4.1.4 Financial loss and loss of valuables

- Teenager stealing money and valuables from parents

All respondents experience the stealing of money and/or valuables from them by the teenager. This is described by the following:

"I lost my husband in a car accident and that's when I really think I lost it because all the jewellery he was wearing, his watch, and his wedding ring and his 21st birthday ring I had in a box at home and that was stolen and that was from the home someone in the home."

"He would get into the car and steal cigarettes and started stealing food...he slipped into the house, he went to the downstairs and he knew what time I was making lunch, he came into the bedroom and my handbag and he stole money out."

"There was a problem with money all the time, I mean you know, things kept on disappearing...he stole from me he took jewellery from me...because more drugs he needed, more money so therefore he had to steal."

"I was lucky because he sold his clothes and everything and his bike and his roller blades but he only started pinching from my purse and it hadn't gone as far as other people that I've heard that they have lost jewellery and that they have organised a house break and R40 000 worth of furniture has disappeared."

"I think he then reached the stage where he actually really took rings
"from me, that were my late mother-in-law's rings."

This is supported by Searll (1995:124) when she states that she had spoken to the mothers, fathers, grandparents, aunts, uncles, sisters, brothers, husbands and wives of addicts, all of whom told the same story of car accidents, disappearances, violence, stealing, dealing, debts, overdoses, suicides and destitution.

3.4.2 Second stage

3.4.2.1 Emotions

- Anger

All respondents experienced anger and it originated from the first stage when they discovered that their son was abusing drugs and they are still angry with teenagers and also the professionals and others. This is expressed as follows:

"I'm beginning to get buried, I'm angry about my son..."

"I think I had a tremendous problem with the school, I mean we had told the headmaster that there was a drugging problem and particularly when he stayed with me last year, we said please he must not be given time off at school without us knowing, they must not accept excuses from him, they must keep in touch with us and nothing of that sort happened and we only find out how bad it actually had gone when we went to one of those parent/teacher evenings and essentially most of the teachers screamed at us, they startled us."

"You are under such strain and stress all the time that other children do a little thing and you really jump at them, you shout because you just cannot cope anymore. You want to run away and you can't, they don't do their homework properly, you shout and scream."

"The psychiatrist really, I think dropped us in the deep end, he just said look he can cope by himself and all of that and I have never heard such nonsense."

Moses and Burger (1975:212) state that the worst reaction is anger and direct threats.
According to them, the parent must weigh these warning signs carefully before rushing into action.

**Feelings of persecution**

Two of the respondents had feelings that they were being persecuted by the people who sell drugs to their teenagers. They described these feelings as follows:

"I get threatening calls because of this court case, I get anonymous calls, threatening calls, these people want to actually get hold of him, uhm...this is, I am entering a world that I never knew when I just find out that he was on drugs, I'm seeing a whole different world, the Nigerians, the Suns Hotel."

"I have to be very aware of what I'm doing if I go out of my house if one of these people are waiting to do something to me."

This is supported by literature. According to Searll (1995:130) parents may even fear for their own safety.

**Shame**

All respondents experienced feelings of shame. This was described as follows:

"I was highjacked last year badly and I couldn't lift this arm properly, but if I was not divorced, I would have my husband here, my son wouldn't have gone away without it."

"I am losing everything, I'm losing money, megabucks and I'm losing friends and I'm losing family and so is he."

"I am ashamed of it in a way I feel a failure."

Yes you do and the most horrible thing is that you think that you've got friends and you can talk to them and then what did they do, they find pleasure in telling other people about your problem not that any parent must be ashamed of what your children are doing."
Searll (1995:128-129) advises parents not to let feelings of embarrassment and shame prevent them from inviting friends to their home or from seeking help.

- Guilt feelings

All respondents blamed themselves for their teenagers' behaviour. The following described their feelings:

"But I should have been more aware when I notice the stealing...uhm...and the stealing got progressively worse."

"I am divorced and I feel the divorce has caused this."

"Well, I mean that is the first thing you think, what did I do wrong and I mean I knew (name) she had gone through tremendous guilt."

"But I also feel that actually parents are to blame because youngsters get too much money when they go out and I think if one could just find out where the money is going as such, I think in a way, in a certain way I think I gave too much to my kids pocket money, I gave quite a lot, I spoil my kids."

According to literature, parents searching for the reasons why their child is on drugs tend instantly to blame themselves or - even worse - each other. Searll (1995:128) states that a teenager who is abusing drugs can be a great manipulator and an expert at making his parents feel guilty, furious, afraid, nervous, apprehensive and miserable. Beschner and Friedman (1986:191) add to this by saying that drug-abusing adolescent and their parents sometimes both feel guilty about the problem, but guilt feelings and self-blame do not necessarily result in improvement.

- Worry

All respondents were concerned about their teenagers' welfare, as the following indicates:

"Scared for him because I thought he could have been killed, he could have been murdered, he could have been raped, sexually
molested...uhm...could have been shot, could have overdosed, I was scared for him, I thought like seeing your child in hospital on an oxygen tent, you're helpless, you feel totally helpless and you feel scared for him and you worry about him constantly. I have to take sleeping pills, I can't sleep at night because I see all these things in my mind."

"I don't know what he is done when he is on his way there, you know, you sit and you worry and you worry."

"I mean you have these feelings, I mean I had, I don't know how many sleepless nights, you know, when we didn't know where he was...uhm...you know, you always picture a child with a needle in his arm somewhere in the streets of Hillbrow."

"We were in a dilemma. I would say we were really very worried, we realise that he's basically like an opportunist."

"It worries me that we have got a roof over his head and if his stomach is full that worries me."

According to Searll (1995:129-130) the feelings of fear and worry, although completely understandable, are very draining and can be extremely difficult to overcome. Many parents become very anxious and they worry that something bad will happen to their child, they also feel a frightening sense of powerlessness because they believe that they have no control over the situation.

- **Hope**

All respondents experienced a sense of hope despite their negative feelings. They describe it as follows:

"I'll hit upon a light, my son will hit upon a light that will maybe help him in this dark area, so there is always a real hope, I don't think you can give up, I don't think you can give up hope, there has to be hope somewhere."

"I believe that he is not taking drugs at the moment."

"If I take teenagers from the age 17 and 18, especially boys they're going through a bit of rebellious stage and then suddenly they start waking up, you know, I will start doing something with my life, I mean positive for
themselves and hopefully this will happen to our son."

"If you are a caring person and you love your children, you will go to any extent to help them ever knowing that you have that fear that he can go back any day, but you must trust that he will not, that he has learned and that he really doesn't want to go back."

Beschner and Friedman (1986:193) maintain that parents in parent-organized communities no longer feel quite so powerless in regard to the drug use of their adolescent children.

- **Failure**

Three respondents said that they feel they are being a failure:

"A failure, a failure, you do feel like that because you think at this age he should be at standard 8, maybe 9."

"And if your own mother thinks that you are lousy as a mother, well it must be true then you know, it is very hard, it is a terrible, terrible thing..."

"Well, look I think it is very hard for a mother to say my child is taking drugs because immediately it is like an indication of a failure, some kind of a failure."

According to Beschner and Friedman (1986:191) a mother once said she felt that she had failed as a parent to her daughter.

- **Distrust/uncertainty and insecurity**

All respondents experienced mistrust, uncertainty and insecurity. They described it as follows:

"I've changed my pin numbers, I hide my bags, I hide everything, I watched him like a hawk, I search him when he comes in, I kept that for about 10 days."
"I don't trust him to do anything even not going down the stairs to the car, I know he can buy drugs from the sellers in the street, I know he can, I just don't trust him."

"You wait for him to come in, sometimes search him, search his pockets. You have to be there when he comes home to make sure that there is nothing on him to look to see, it's not very nice to wait for him, it's not very nice."

"I think the main problem really was how to deal with it, but when you are dealing with a six foot, when 18 year old, it is very difficult."

"We are not sure if he is over it, you know, and I think to re-establish some sort of a trust is very very difficult."

"I mean when he was with me I instructed my domestic worker every morning when he left for school to search his room for drugs you know, you look at everything, you look suspiciously at everything. You know even now I just came back from leave now and I saw him and I looked at him and I made sure I had a close look at his eyes you know, I looked at his general behaviour."

"...you've got to watch him 24 hours."

"...when you can start trusting them again little by little because that is very hard to regain that trust."

"They never talked to you, they are always lying and you don't know how many people he is owing money to or how many things he is still going to pinch so that he can go and buy his drugs."

"The fright, the mistrust because you will never trust them again until they have proven to you that they can be trusted."

"I think it is going to take a very long time but when they come out of the rehabilitation centres, you'll have to give them a chance to prove to you and that is very difficult because the very first time that he goes out your thought is, oh...is he going to come back and is he going to be drugged again, or is he going to come back and he is going to replace the drugs with alcohol."

Johnson (1993:71) states that just one betrayal may create distrust and, once established, distrust is extremely resistive to change.
3.4.2.2 Social discrimination

All respondents experienced isolation/distancing by friends, extended family and significant others. They described their feelings as follows:

"I find that friends and family at distance, they are actually becoming distant, they are not coming around to visit as often as they were."

"And then it got worse you know, you get phone calls from parents saying they don't want your son in the house, it just become a terrible thing, a drug addict affects my family, my friends is affected and my sister, my niece, my other daughter, her fiancé."

"I am beginning to feel more isolated, I'm losing friends and I'm losing family and so is he."

"Various of my colleagues sort of blaming also the first thing is that they do, they blame the family you know, that's the first thing that he was too spoilt."

"I think public awareness and certainly there is still a stigma attached to it."

"Yes, it is not acceptable socially yet that a druggy it's not like an alcoholic, they say well it's a disease, drugs unfortunately still has a stigma."

"Yes you do and the most horrible thing are that you think that you've got friends and you can talk to them and then what did they do they find pleasure in telling other people about your problems."

"Again so it is quite easy for people to criticise others and say ag, you know how come they can't get over it?"

Beschner and Friedman (1986:192) acknowledge the social isolation that parents experience because they say parent peer groups also help to dispel the sense of isolation of parents who must cope with the drug abuse of their adolescent offspring.
3.4.2.3 Defence mechanisms

- **Intellectualising**

All respondents learned about drugs in terms of what drugs are, how they affect their teenagers and how they as parents experience living with drug-addicted teenagers.

"I can tell you all the places where to buy and what these young lads will do to get drugs, they will sell themselves, I'm not that stupid, I never ever knew Hillbrow, I never even know this side of society but now I do... I have been to all the group sessions, it is now six months since he first asked for help and it's just gone mind blowing, the things I've learned and the things I've known and the things that he has been doing, I was totally unaware of it..."

"I am a lot more aware of drugs...I am now in a position where I can in fact give advice to newcomer parents...I am able to also assist."

"They wake up in the morning and they crave, they really do, my son was telling me in that rehabilitation place he was, the first couple of days are really bad...it is Mandrax and cocaine that's expensive stuff, they say it is such a different state that maybe in some ways I can relate to...it is so fantastic and you suddenly come down to reality."

"You learn all the time I often say how, what I have learned in the last three years I would of never thought possible."

3.4.2.4 Financial losses

- **Money spent on treatment**

All the respondents experienced financial losses; they paid for all kinds of treatment to help their teenagers. This is supported by the following:

"What more can you do, you spend thousands of rands, that's what I have done, I've done everything."

"I am losing everything, I'm losing money, megabucks."
"I don't draw five hundred rands out but there was the withdrawals, there was the withdrawals."

"Look as far as the financial side it costs us R13 000 for three months, that's without the units, the medical aid only paid R1 000,00, they are not prepared to pay more for relapse."

"Well it is a nightmare financially certainly, okay, obviously it also depends on the financial situation you find yourself in. With some people it might end quite quicker because they just haven't got you know R2 500,00 to give to their son."

What Wodarski and Feit (1995:159) regard as most important, is that the increased use of drugs leads to abuse which can lead to addiction and/or result in problems involving school, crime and delinquency, relationships and money.

3.4.3 Third stage

3.4.3.1 Emotions

Fear

The respondents all experienced fear that their teenagers could take an overdose and die, fear of being unable to control the teenager's behaviour. These experiences are indicated by the following:

"Scared for him because...he could have been overdosed, and it is a bit scary, a bit scary because I don't know what is going to happen."

"My fear is that he got an OD (overdose) on drugs, that's my biggest fear because he nearly has that happened three or four weeks ago, my biggest fear is that he is not going to see 21."

"I think the worst was really thinking that he might OD (overdose), that he might kill himself."

"That he would OD (overdose) or take his own life...or break in somewhere and steal to sell and then get caught and get locked away, that's all my fears"
"So you are always in that fear when are you going to loose him? Will he be safe or will it be his time to die."

This is verified by Searll (1995:129-130) who mentions fear of the following:

- He could have an accident.
- He could overdose or die.
- He could become embroiled in a fight or a gang war.
- He could be accosted and unable to defend himself.
- He could assault someone.
- He could be arrested and jailed.
- He could disappear.

**Helplessness**

All the respondents experienced feelings of helplessness:

"They (referring to teenagers) want to take them (drugs) not because anybody is forcing them to do it, because they want to do it and you are totally helpless."

"I feel as parents, we have done our best that we've can done to him we can't it's up to him now, everybody has got a life to make. If he feels that he want to make a hash of it he is going to hurt us as parents but there is nothing more that we can do about it."

"I mean he is got to basically wake up from his deep sleep and I can't do it, I don't know what the answers are now."

"Definitely, yes, we have come to the end of the road and we don't know what to do anymore."

According to Wodarski and Feit (1995:147), data indicate that parents whose adolescent are at risk, fall into multiple social and psychological difficulties. The clearest empirical finding with regard to adolescents at risk seems to be the lack of knowledge on the part of the parent or parents and the consequent lack of effective management of the child's
behaviour in a manner that facilitates his/her psychological and social development.

**Despair**

All the respondents experienced feelings of despair. They described them as follows:

"It is very hard, it is just sometimes you feel like burying your head and think hell, you know am I going to get up tomorrow morning and how am I going to go through another day?"

Searll (1995:129) acknowledges feelings of hopelessness, helplessness, loneliness and despair and she suggests guidelines for parents on how to deal with such feelings. This will be discussed in chapter 4.

Beschner and Friedman (1986:189) maintain that, in addition to painful self-reflection, love and concern can lead to overwhelming grief, disappointment and despair, as well as concerns about the child's physical and mental state and his or her ability to function in the future.

### 3.4.3.2 Defence mechanisms

**Intellectualising**

All the respondents learned to set limits for their teenagers. Respondents who attended the Toughlove support group stated that Toughlove was powerful and helpful to them. They learned a lot from attending Toughlove and described their feelings in this respect as follows:

"I think Toughlove in my case helped an enormous amount just to go there and talk and realise that you are not the only person."

"I mean I have heard and I have read about Toughlove and that was essentially then where we went, you know, and these were the people who for the first time were in fact able to give us very concrete steps to take to
cope with the situation. Also was the situation regarding ourselves, I continue to go to Toughlove because I am now in a position where I can in fact give advice to newcomer parents."

"I think through Toughlove I also learned to say, you know, what the money that I'm giving you might perhaps be your last trip and I don't want this, I cannot take that responsibility."

"I must say Toughlove has helped me an enormous amount and really recommend parents, who think their children are taking drugs."

According to Beschner and Friedman (1986:202), in order to learn how to be a good listener, a parent must be able to adopt a non-judgmental attitude and a non-defensive stand. This does not mean that the parent has to agree with everything the adolescent is saying, or even to take it all as being factual or accurate. These authors (1986:189) believe that it is particularly difficult to make the initial decision to address the problem, because it forces parents into a myriad of painful feelings and self-realizations.

3.4.3.3 Social

All the respondents experienced social discrimination throughout all three stages. Social discrimination means unequal treatment of groups of basically equal status. Whether differentiations are regarded as discriminatory or not, depends on the denial or recognition of such gradations in a given society (Fairchild, 1970: Dictionary of Sociology).

- Relationships

Changed relationship between parents and teenager

This refers to hatred, stress and the lack of communication between parent and teenager. Parents described this as follows:

"Drugging is not easy for any family, it does destroy a lot of friendships."
"They are not cool, they are definitely not cool because they are destroying their lives plus the family plus close friends and relatives."

"Our relationship at that stage when he was drugging was very traumatic because we used to fight."

"The entire family and even when my very aged mother came to visit from Germany it was a nightmare, our lady that helps us Jane, she has been with us for many years, even they suffered because he would be rude to them."

"My husband and I may have a closer bond now because it was very very hard for us to work through."

"A drug addict affects my family, my friends are affected, and my sister, and niece, my other daughter, her fiancé..."

"Because we are rescuing him all the time that he is going back to this because there has been his sister, there's been us, there's been his brother and everybody's now pushed him aside."

"Oh no, it really does damage us terribly, it is very very stressful for the whole family, for the brothers, sisters."

Literature verifies this (Searll, 1995:124) where it is stated that drug addiction can wreak havoc in a family. The destructive behaviour of a youngster who is dependent on drugs can cause trauma, tension, guilt, envy and bitterness, it can tear marital relationships to shreds and cause resentment and even hatred between siblings.

Searll (1995:124) also states that brothers and sisters are often embarrassed by the addict in that they may be teased at school and shunned by friends who automatically link them with the addict's behaviour. They may also resent the fact that their parents' attention and energy are always focused on the drug-addicted child. Sometimes they feel rejected and begin to hate the brother or sister they previously adored. Occasionally, they might feel obliged to protect the addict in some way, especially if they are aware of the problem and their parents are not.

Literature also refer to family factors which contribute to drug abuse among adolescents include negative communication patterns, inconsistent discipline regarding behavioural
limits, an absence of closeness to parents, unconventionality of parents, lack of parents' involvement in their child's activities, poor weak parental control, greater influence by peers than parents, and incompatibility between parents and the child's peers (Aziz and Shah, 1990:278).

Findings of another research study, Glickman and Utada, 1983 (as summarised by Beschner and Friedman, 1986:181) show a dramatic degree of misunderstanding, disagreement and conflict between parents and their adolescent children who are seriously involved in drug abuse. This is supported by Beschner and Friedman (1986:187). The relationship between the parents is seriously harmed until they reach the point where they can no longer communicate (Grobler, 1970:25).

**Interpretation of results**

It is clear from Table 3.1 that parents suffer more or less in the same way as a teenager who is abusing drugs. The themes in all three stages re the same indicating that the process of suffering is continuous and intense. To elaborate on the emotional pain - during the first stage the parents focus on themselves and they feel they have not achieved what they wanted, hence they are shocked, angry and frightened, tend to be in a state of disbelief; they experience a sense of conflict within. Further to the second stage they start thinking about what went wrong, especially during parenting and tend to blame themselves for the behaviour of their teenagers. They take responsibility for their teenagers' faults. During the third stage they feel helplessness, they do not know what to do, who to contact and accept the situation as it is. On the social aspect the society or close family tend to isolate or discriminate against them in all three stages.

They use different defence mechanisms in all three stages, firstly denying, avoiding the issue but eventually they seek information and become drug literate.

Finally it is a nightmare from the beginning and continues to be. Teenagers start stealing at home - from money to assets. During the second stage parents spend money on
treatment and seeking help. The parents adopt different ways of interacting with the teenager. Despite all these experiences parents always hope for the best - especially after they have come to terms with their feelings.

In a nutshell, parents of drug addicted teenagers are emotionally, socially and financially abused.

3.5 PATTERNS OF INTERACTION WITHIN NURSING FOR THE WHOLE PERSON THEORY

There are certain patterns of interaction between internal and external environments that are implied in the Nursing for the Whole Person Theory (Oral Roberts University, Anna Vaughn School of Nursing, 1990:136-142; Rand Afrikaans University, Department of Nursing, 1992:7-9). These patterns of interaction reflect the mental health status of the parents, as indicated by the following.

- Disturbance in sleeping patterns as evidenced by taking of sleeping tablets.

- Inability to maintain harmonious relationships with the teenager as evidenced by feelings of anger, shame, distrust, fear and thus leading to adopt different ways of interacting with the teenager.

- Feelings of distrust as evidenced by locking up their possessions and keeping a watchful eye on the teenager.

- Feelings of loneliness as evidenced by isolation from others and feeling shame or embarrassment to talk about their teenagers.

- Emotional disturbance as evidenced by feelings of shock, fright and anger. ("It is frightening...I think it is a great shock.")
Fear for their own life ("I have to be very aware of what I'm doing, if I go out of my house if one of these people are waiting to do something to me.")

Broken relationships as evidenced by distrust of teenager by parent. ("I've changed my pin numbers, I hide my bags, I hide everything, I watched him like a hawk.") Another parents changed ways of communicating with the teenager - she communicated by writing letters to the teenager and suspending verbal cues/communication.

Change in their financial state as evidenced by paying for teenager's treatment and teenager stealing money from them.

3.6 UNIQUE CONTRIBUTIONS OF THE STUDY

Firstly, nowhere in the literature could evidence be found of a similar study of the experience of parents with drug-addicted teenagers.

Secondly, most of the literature discusses the effects of teenage drug abuse on family, touching only on a few topics such as relationship and communication.

Thirdly, a considerable amount of literature suggests guidelines for the parents. Thus, this research study described and explored the experiences of parents as told by the parents themselves. Many negative feelings were explored. There were also positive feelings, although they were marred by negative feelings.

3.7 CONCLUSION

In South Africa today there is a Muslim Vigilante Movement called People against Gangsterism and Drugs (PAGAD). One of the most notorious figures in the Western Cape underworld, Rashaad Staggie, was shot and set alight on the night of 24 August 1996. Since then, PAGAD has been on the forefront with marches and consultation with
the Ministers of Justice, Correctional Services and Safety and Security. PAGAD's message is: Enough is enough in respect of drugs, drug abuse, drug trafficking and crime rate. I wonder, however, how many of the community out there feels the same way as PAGAD.

This leads us to the next chapter in which the guidelines for parents will be discussed.
4.1 INTRODUCTION

In chapter three, the research results were discussed and relevant literature was incorporated. In this chapter guidelines will be described for advanced psychiatric nurses to assist parents in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health.

4.2 GUIDELINES FOR PARENTS WITH DRUG ADDICTED TEENAGERS

The results of the study show that parents experience emotional pain, use destructive defence mechanisms, lost huge sums of money and valuables and are socially discriminated against by significant others (see Table 3.1). The family experiences the repercussions of each turn of the addictive process. Families can be torn apart, intimidated, and suffer untold emotional anguish because of an addicted child.

Thus, the guidelines will be formulated and described in order for the advanced psychiatric nurse will be able to assist parents with drug-addicted teenagers in the promotion, maintenance and restoration of their mental health as an integral part of health.

In the implementation of the nursing process, the nurse can use a theory that considers a client in totality, that is body mind and spirit, as well as the external environment and patterns of interaction between the internal and external environment. An example of such a theory is the Nursing for the Whole Person Theory (Oral Roberts University, Anna Vaughn School of Nursing, 1990:136-142; Rand Afrikaans University, Department of Nursing, 1992:7-9).
Such an approach will sensitise the nurse and the client to factors that play a role in health or illness and together they can plan and implement the necessary actions.

In Table 4.1 below, guidelines are set according to category of experiences, aims and strategies.

<table>
<thead>
<tr>
<th>AIM</th>
<th>STRATEGY</th>
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<tbody>
<tr>
<td>SHOCK</td>
<td>To accept what is happening and to work through it.</td>
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<td></td>
<td>&quot;Every attempt should be made to keep other members of the family emotionally healthy so that they are not all drawn into the whirlpool of horror&quot; (Searll, 1995:124).</td>
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<td>FRIGHT</td>
<td>To be relaxed and to be able to take constructive action.</td>
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<td></td>
<td>Edmonds and Wilcocks (1995:64-65) suggest that parents should remain calm, seek profession help from a doctor, a counsellor or the school. Talk to someone about how you feel and join a support group for parents in the same situation.</td>
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<td></td>
<td>&quot;Try to take one day at a time. You must allow the addict to take responsibility for his own life. He has to learn from his mistakes eventually and he has to experience the consequences of his behaviour: (Searll, 1995:130).</td>
</tr>
<tr>
<td>ISOLATION FROM FAMILY, FRIENDS AND OTHERS</td>
<td>To have lasting relationships and to rebuild lost ones.</td>
</tr>
<tr>
<td></td>
<td>• Parents should build a relationship with themselves.</td>
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<td></td>
<td>• During counselling they should be able to learn how to handle negative or destructive relationships and to verbalise and express their feelings.</td>
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<td></td>
<td>• Parents are encouraged to attend the support group for parents (e.g. Toughlove).</td>
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<tr>
<td>AIM</td>
<td>STRATEGY</td>
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<td></td>
<td>Parents are encouraged to give talks to media or community members, or</td>
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<td>to join in campaigns against drug abuse. Johnson (1993:16) suggests the</td>
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<td>following ways of finding positive relationships:</td>
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<td></td>
<td>- Simply wait until someone finds you and wants to be your friend.</td>
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<td></td>
<td>- Simply ask other people to be your friends.</td>
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<td></td>
<td>- Give your friendship to others.</td>
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<td></td>
<td>Johnson (1993:16) further suggests the following interpersonal skills:</td>
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<td>- Knowing and trusting each other.</td>
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<td></td>
<td>- Communicating with each other accurately and unambiguously.</td>
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<td></td>
<td>- Accepting and supporting each other.</td>
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<td></td>
<td>- Resolving conflicts and relationship problems constructively.</td>
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<tr>
<th>DENIAL</th>
<th>Acceptance</th>
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<tr>
<td></td>
<td>The time to act is now. Do not waste time by saying it cannot be your</td>
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<td>child. Go to the drug counsellor, or minister, or teacher, or institution</td>
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<td>for drug treatment - find more information on drugs, then seek</td>
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<td>professional help.</td>
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<td>- Join support group immediately.</td>
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<td></td>
<td>- Individual supportive counselling (Okun, 1992:149-220; Corsini and</td>
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<td></td>
<td>&quot;To be able to start acting constructively and with strength and conviction, you will have to stop fooling yourself (Searll, 1995:128).&quot;</td>
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<tr>
<th>AVOIDANCE</th>
<th>Confronting the situation.</th>
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<tr>
<td></td>
<td>Confronting your teenager in a firm but supportive manner in terms of</td>
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<td>personally observed signs, symptoms and behaviour which have given rise</td>
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<td>to your concern and worry about your child having developed a problem</td>
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<td>which could possibly, from your own knowledge, be related to drug abuse.</td>
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<tr>
<td>AIM</td>
<td>STRATEGY</td>
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<tr>
<td>&quot;I am your father (or mother). I love you and care for you; I am concerned and worried because I have personally observed that for the last weeks you... (signs, symptoms and behaviour) (De Miranda, 1987:54).</td>
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<tr>
<td>ANGER</td>
<td>To be able to dissipate his anger.</td>
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<tr>
<td></td>
<td>• Encourage the client to release his/her anger verbally in the safety of the individual counselling environment.</td>
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<td></td>
<td>• Teach the client to relax.</td>
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<td></td>
<td>• Teach the client constructive ways in which to control his anger in the future (Geldard, 1993:150-151).</td>
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<td></td>
<td>The method is borrowed from Gestalt therapy:</td>
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<td>• Start by asking the client who he is most angry with.</td>
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<td>• Place an empty chair facing the client a metre or more away from him.</td>
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<td></td>
<td>• Tell the client to imagine that sitting in the empty chair is the person who is the target of his anger.</td>
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<td></td>
<td>• Say to the client something like “I don’t want to be the recipient of your anger, and so I don’t want you to tell me how angry you are, rather I’d like you to talk to the imaginary person who is sitting in that empty chair, about your angry feelings towards him”.</td>
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<td></td>
<td>• You should preferably now stand beside your client and join him in facing the empty chair.</td>
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<td></td>
<td>• You can “coach” the client in his expression of anger towards the imagined person (Geldard, 1993:151). “By all means express your anger, but try to do so in a controlled manner. It is totally unproductive to behave in a hysterical manner, or to nag, scream, cry, plead, bully or make threats. Go into an empty field and scream or cover your head with a pillow and shriek as loudly as you can” (Searll, 1995:131).</td>
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<tr>
<td>FEELINGS OF PERSECUTION</td>
<td>AIM</td>
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<tr>
<td>-------------------------</td>
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</tr>
<tr>
<td></td>
<td>To feel safe and free.</td>
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</table>

| SHAME                  | To accept the situation as it is and not to be ashamed. | • The implementation of the client-centered therapy to create an empathic relationship between client and therapist that will allow the client to experience spontaneity, genuineness and "here and now" feelings. The goals of this therapy are self-actualization and complete self-realisation (Okun, 1992:113). • Encourage parents to join support group to verbalise his/her feelings and to gain a sense of not being alone. |

<p>| GUILT FEELINGS         | To be able to cast off blame and act positively or constructively. | • Searll (1995:128) described this as follows: &quot;When your child is very young you have complete control over him/her. But as he/she grows up, your influence diminishes and many other factors come into play, not least of which are his friends. So the fact that your child is abusing drugs is not necessarily your fault. So don't feel guilty. Guilt feelings are totally negative and of no use to anyone. Try not to wallow in feelings of guilt, don't dwell on your perceived shortcomings. Don't waste time blaming yourself, your spouse, the school, your child's friends, or government.&quot; |</p>
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<th>AIM</th>
<th>STRATEGY</th>
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| GUILT FEELINGS      | • The use of multiple family therapy, which is an adaptation of group therapy techniques to treatment of the whole family. The multiple family therapy is now used with a wide variety of dysfunctional families and in a great number of clinical settings (Goldenberg and Goldenberg, 1991:253).  
  • Continuation of individual supportive therapy and support group.                                                          |
| WORRY AND FEAR      | • At the support group, parents will be able to express these feelings and share them with other parents.  
  • Conducting family therapy, it is indicated that an individual who manifests dysfunctional behaviour (for example, substance abuse) is seen as representative of a system that is faulty. The nature of that person's problems can often be better understood when viewed in the context of an ongoing family relationship system that is in disequilibrium (Goldenberg and Goldenberg, 1991:6).  
  • "Many parents become very anxious and they worry that something bad will happen to their child; they also feel a frightening sense of powerlessness because they believe that they have no control over the situation. I strongly believe that taking positive action helps to allay fear. For this reason, it is vital to try and re-establish control over them by a situation over your own life" (Searll, 1995:130).  
  • "Try not to dwell on what might happen in the future. I do understand, of course, that it is not easy to stand by and watch helplessly as your child deliberately destroys his/her happiness, and that of everyone and him. But remember that the things that you are worrying about may never happen" (Searll, 1995:130). |
<p>| Expressing these feelings and learning to cope with them constructively |                                                                                                                                              |</p>
<table>
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<tr>
<th>HELPLESSNESS AND DESPAIR</th>
<th>AIM</th>
<th>STRATEGY</th>
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| Acknowledging these feelings and seeking professional help. | • Parents who take the position that it must be their fault because of their parenting, generally feel helpless to do anything about the situation. It is best for parents to keep an open mind and approach the problem objectively and non-defensively, trying to understand how they may have contributed to the problems that led to the youngster becoming seriously involved with drugs. | • The advice that the National Institute on Drug Abuse (NIDA) has for parents is:  
  - **Be firm** ("As your parent, I cannot allow you to engage in harmful activities").  
  - **Self-examination** ("Are my own alcohol and drug consumption habits exerting a bad influence on my child?").  

What you should not be is:  
• **Sarcastic** ("Don’t think I don’t know what you’re doing").  
• **Accusatory** ("You’re lying to me").  
• **Stigmatising** ("You’re a terrible person").  
• **Sympathy seeking** ("Don’t you see how much you’re hurting me?").  
Such statements tend to make the child defensive and likely to tire you out (NIDA, 1984a:455; Beschner and Friedman, 1986:188).  
Parents who confront the situation in an honest, open manner, talking about their own helplessness, guilt, fears and anger, are more likely to gain the youngster’s trust and have some influence on his/her drug taking (Beschner and Friedman, 1986:188).  
• **The more important factors for parents to consider is the quality of their relationship with their children/teenagers and whether or not open communication is possible.** Edmonds and Wilcocks (1995:64) advise that channels of communications be kept wide open. |
### AIM

<table>
<thead>
<tr>
<th>Topic</th>
<th>AIM</th>
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<tbody>
<tr>
<td>Financial Losses and More Money Spent on Treatment</td>
<td>Budgeting and spending money</td>
</tr>
<tr>
<td>Changed Relationship Between Parent and Teenager</td>
<td>To establish and maintain a harmonious and understanding relationship.</td>
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</table>

### STRATEGY

- It has been theorised that affectionate and non-conflictual parent-child relations increase the effectiveness of the parents' role in the development of their child's conventional and adaptive behaviour. Parents' reinforcement of children's conventional behaviour insulates the children against a drug environment the abuse of drugs (Coombs, Paulson and Richardson, 1991; Frankel, Behling and Dixs, 1975; Penning and Barnes, 1982, as summarised by Beschner and Friedman, 1986:197).
- Parents attending a support group will be able to set limits on teenagers by not giving money (which was going to be used to buy more drugs).
- Edmonds and Wilcocks (1995:64) suggest the following guidelines for parents:
  - Set appropriate limits in terms of rules regarding curfews and outings.
  - Allow your child to deal with negative consequences of negative behaviour.
  - Never promise or threaten anything that you are not able or prepared to carry out.
  - Don't throw them out of the home.
  - Don't believe that promises won't happen again.
  - Don't try to find out from them where they are getting drugs from.
- In his family therapy work, Reilly (1978 in Beschner and Friedman, 1986:197) found nine dysfunctional patterns of family interaction to be characteristic of substance abusing members which he postulated could maintain and exacerbate drug abuse. They are as follows:
<table>
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<tr>
<th>AIM</th>
<th>STRATEGY</th>
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<tbody>
<tr>
<td>CHANGED RELATIONSHIPS</td>
<td>- A cry for help by substance abuser to get particular attention from parents.</td>
</tr>
<tr>
<td>BETWEEN PARENT AND</td>
<td>- Global or massive parental denial.</td>
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<tr>
<td>TEENAGER</td>
<td>- The use of drugs by offspring provides various types of gratification which parents need either consciously or unconsciously.</td>
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<td></td>
<td>- Use of drugs and alcohol as self-medication by the substance-abusing member who needs this to express or act out reactions or feelings such as destructiveness or violence.</td>
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<td>- Difficulty in expressing anger between parents and children.</td>
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<td>- Irrational parental expectations of the substance-abusing child.</td>
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<td>- 'Incredible language' - unrealistic promises that cannot be believed.</td>
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<tr>
<td>Parent education</td>
<td>• Parent education consists of two approaches designed by Pinsker and Geoffre, 1981, as summarised by Grady, Gersick and Boratynski, 1985:541-542: behaviour modification techniques (Eimers and Aitchison, 1977, as summarised by Grady, Gersick and Boratynski, 1985:541-542) and communication-centered approach (Gordon, 1970). Both models seem useful, but attempt to attain somewhat different goals. Parent education efforts which rely on behaviour modification techniques as their primary focus are designed to help parents modify and change their children's behaviour. Communication-centered approaches focus on helping parents learn how to express their feelings directly and respond empathically to their children.</td>
</tr>
<tr>
<td>Parent education</td>
<td>• Parents of teenagers must shift from being influential authority figures to parental consultants who must help their children make their own decisions (Grady, Gersick and Boratynski, 1985:541-542).</td>
</tr>
</tbody>
</table>
4.3 CONCLUSIONS

This study arose from three observations.

Firstly that more and more teenagers are abusing drugs and that it will have an effect on parents and families.

The second observation is the need for moral support programmes for parents in the stressful role of living with drug-addicted teenagers.

The third observation is the apparent lack of research studies on parents as a target group, while a considerable amount of research has been done on teenagers and drug abuse.

The purpose of this study was two-fold: firstly, the exploration and description of the experience of parents with drug-addicted teenagers and, secondly, the description of guidelines for advanced psychiatric nurses to assist parents in mobilising resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health.

The central questions posed for the study were:

- How do parents experience having a drug-addicted teenager?

- What guidelines can be developed for an advanced psychiatric nursing practitioner to assist parents in mobilising resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health?

A qualitative, explorative, descriptive and contextual study was carried out to answer these questions. Phenomenological in-depth interviews were conducted with parents who have drug-addicted teenagers. The results of the phenomenological interview and field notes written during the interviews, suggest both positive and negative experiences of the respondents. On the positive side, respondents experience a sense of hope (see Table 3.1 and page 46). This positive experience is, however, marred by negative stressful
experiences (see Table 3.1).

Based on these results, guidelines were developed for the advanced psychiatric nurse to assist the parents to mobilise resources for the promotion, maintenance and restoration of their mental health as an integral part of health. It can, therefore, be concluded that the research questions have been answered and thus the objectives of this research study have been achieved. The central statement of the study has also been supported.

4.4 PRACTICAL PROBLEMS ENCOUNTERED

The following practical problems which could have led to limitations were encountered:

- The use of a small population sample, hence larger samples may be utilised to validate these findings. The period specified may have led to this, because those who were interviewed were parents of teenagers who were admitted to an institution between 1 April and 30 June 1996.

- The parents were seen at different places, that is at an institution, some at their homes and others at work. There were some interruptions during interviews at work, home and in the particular institution. At home, the dogs came into the house and barked. At work parents' colleagues knocked on the office door. At the institution the occupants of the office came into the room.

- Some of the parents who were selected refused to participate in the research study as they were very upset and frustrated about their teenager having disappeared.

4.5 RECOMMENDATIONS

The recommendations from the study will be made with specific reference to nursing practice, nursing education and further nursing research.
4.5.1 Nursing practice

It is clear from the research results that parents of drug-addicted teenagers need professional help and support. Advanced psychiatric nurses play a major role because they often come into contact with parents of drug addicted teenagers. Thus they will be able to assess the needs of parents and to support them.

4.5.2 Nursing education

Nursing curricula should include the topics on drugs, drug abuse, the effects on family members and the role of nursing in helping those affected. Nurses should take responsibility for educating the community about drugs.

4.5.3 Nursing research

The research study is a unique contribution to nursing and other social sciences. More research is necessary to understand the problem of drug abuse and to prevent it from occurring. Special emphasis is crucial especially in research that will evaluate the effects of support by the advanced psychiatric nurse, the effects on the entire family (including siblings, extended family members (in-laws, grandparents, aunts and uncles) and the effect it has on society.

4.6 CONCLUSION

The role of drug abuse by teenagers in South Africa is alarming. This is competing with the rate of HIV and AIDS infection. The youth of today seems to be thinking about here and now and is not concerned with the future. They perceive drugs as "normal" substances that can be consumed freely.

At least once a week the media report on drug confiscation in the country. On 3 December 1996, the media reported that Mandrax tablets to the value of sixty thousand rand had been stolen from a police station in Pretoria. The question that arises is whose teenager will be the next victim of drug abuse? The answer is that it could be anyone's
teenager: your neighbour's, your friend's, your colleague's, your relative - the list is endless. The next question is how many parents out there will experience emotional pain, financial loss and social isolation? Everyone in the society should accept the challenge to unite against drugs.
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**LITERATURE CONSULTED**


**MAGAZINES AND NEWSPAPERS**


COULL, G 1996: *Get the funk out*: April.


DEPARTMENT OF NURSING SCIENCE

Telephone : (011) 489-2722
Fax : (011) 489-2257

Dear Sir/Madam

REQUEST FOR CONSENT TO CONDUCT RESEARCH

I am a M.Cur. (Psychiatric Nursing Science) student at the Rand Afrikaans University, presently engaged in a research project entitled "The experience of parents with drug-addicted teenagers", under the supervision of Dr. A. Gmeiner of the Department of Nursing Science at RAU.

The objective of this study is to explore and describe the experiences of parents who have drug-addicted teenagers and to describe guidelines for psychiatric nurses to assist these parents in mobilising their resources to support them in caring for their drug-addicted teenagers. To complete this study, the researcher needs to set up interviews with parents of drug-addicted teenagers. Parents who meet the following criteria will be interviewed:

- They must be parents whose teenagers are admitted to a specific rehabilitation centre between April and June 1996.
- The parents must be from Gauteng Province.
- They must be able to communicate in English.

The researcher will conduct interviews of approximately 45 to 60 minutes with a minimum of five parents and a maximum of ten parents. The parents' experience with drug-addicted teenagers will be explored. These interviews need to be audiotaped for verbatim transcription and verification of findings by an independent psychiatric nursing specialist.

The researcher intends to keep the respondents and the rehabilitation centre anonymous by omitting the use of names and places. The erasure of the taped material on completion of the transcriptions by the researcher, will ensure confidentiality.

The immediate benefit of the study to parents will be that they will be given the opportunity and attention to verbalise their experiences of caring for their drug-addicted teenagers. Long-term benefits are that the research findings will be used to formulate guidelines for supportive action that would help parents care for their teenagers.

A summary of the research findings will be made available to you.

Thank you.
Dear Sir/Madam

REQUEST FOR CONSENT TO PARTICIPATE IN RESEARCH

I am a M.Cur. (Psychiatric Nursing Science) student at the Rand Afrikaans University, presently engaged in a research project entitled "The experience of parents with drug-addicted teenagers", under the supervision of Dr. A. Gmeiner of the Department of Nursing Science at RAU.

The objective of this study is to explore and describe the experiences of parents who have drug-addicted teenagers and to describe guidelines for psychiatric nurses to assist these parents in mobilising their resources to support them in caring for their drug-addicted teenagers.

To complete this study, I need to conduct interviews of approximately 45 to 60 minutes duration which will be audiotaped for verification of findings by an independent psychiatric nursing specialist. In this matter, I undertake to safeguard your anonymity by omitting the use of names and places. Confidentiality will be assured by erasure of taped material on completion of transcribing the tapes. The transcribed tape material will only be shared by myself and another independent psychiatric nursing specialist. You will give your informed consent of these proceedings and reserve the right to cancel same at any stage of the proceedings. It is understood that you are under no obligation to participate in this study.

The direct benefit to you for participating in this study is that you will have the opportunity to verbalise your experience of caring for a drug-addicted teenager. Long-term benefits are that the research findings will be used to formulate guidelines for supportive action that would promote mental health of parents.

A summary of the research findings will be made available to you.

Thank you.
SIGNED AT ___________________________ this ___________________________

day of ___________________________ 1996.

PARTICIPANT ___________________________ DATE ___________________________

M.H.M. MABUSELA, B.Cur., B.Sc. (Hons) Psychology
M.Cur. (Psychiatric Nursing Science) student
RESEARCHER ___________________________ DATE ___________________________

A.C. GMEINER (DR.)
STUDY LEADER
LECTURER: PSYCHIATRIC NURSING SCIENCE ___________________________ DATE ___________________________
N: Good morning.

R: Good Morning Hilda.

N: As we have arranged this interview I would like to ask you please to tell me how is it like to live with a child who is drug addicted.

R: Hila, it is not easy it is actually - Isa have gone for help the various organizations Sanca and Phoenix...uhm..and has been detoxed twice, he relapse twice...ugh...his got into trouble I find that friends and family at distance, they are actually becoming distant they are not coming round to visit as often as they were because drug addicts steal to get the money and there has been a lot of stealing which I should have picked up a long time ago when the stealing started. There is three of them and one lends the other and so on and so forth and it was difficult to pinpoint sometimes who is still with me, but I should have been more aware when I notice the stealing...uhm...and the stealing got progressively worse...uh...I lost my husband in a car accident and that’s when I really I think lost it because all the jewellery he was wearing, his watch, and his wedding ring and his 21st birthday ring I had in a box at home and that as stolen and that was fro the home someone in the home.

N: So what you are saying is that you are in a way partly taking responsibility, partly blaming yourself that you didn’t recognise it when it started.

R: I didn’t recognised he was stealing of drugs because I was totally drug unaware. I knew nothing about drugs...uhm...I didn’t realise that that was a sight. I also
didn’t knew the sleeping till 10-11 o’clock in the morning was a sight. I didn’t know these things...uhm...it was someone else that point it out to me that it could be drugs, it was one of his friends’ fathers who point it out to me. And then it go worse you know, you got phone calls from parents saying they don’t want your son in the house, it just become a terrible thing, a drug addict affects my family, my friends is affected and my sister, my niece, my other daughter and her fiancé, uhm...everybody, the school he was called to school for bunking, the homework doesn’t get done, he is constipating, sometimes regression...uhm...is hard is very hard and it is just simply not acceptable by society which I can understand, especially the stealing, the shadow side of life where does a young boy of 15 go to get drugs what what is he doing when he can’t get the money. These questions cross your head, they do cross your head.

N: So what you are basically saying is that it affects you as a parent in such a way that you even loose friends...

R: O yes, definitely.

N: They stigmatise you, they isolate you and how do you feel when all this is happening?

R: I just feel that their themselves are ignorant to the fact that it is a addiction, they don’t know enough about it and I am not actually cross with them and I can understand, I can understand where they coming from but as this is a continuing problem and its getting worse and I am becoming to feel more isolated and I’m beginning to get buried I’m angry about my son but lets say on a good day I could see him far enough. I feel like that, sometimes I feel you are pushing me until I am in my grave and you are selfish. I do think that sometimes because its...what more can you do you spend thousands of rands that’s what I have done, I’ve done everything, what happens, my son is still busy to run from me, I’ve got through all this, for what a silver chin this is pure greed.
N: So you also kind of feel a despair that a how can you help you and your son.

R: Ja, I don’t know who else can help him because he is got a court case coming up for theft he was involved with theft with four boys and this is for twelve thousand rand. It is not play play money and God knows what is going to happen to him. He appears again in court on Monday. I have to get layers, social workers and psychology reports and yet last night he go and takes R20-00. I think it is bladdy unfair, I really do, I just think he is kicking me in the teeth and then I look at him when he sleeping and I think you know basically I had a good boy he doesn’t swear at me, he doesn’t loose his temper, he has a problem, his not a problem child, he is a child with a problem which is a drug addiction. If he didn’t have done that he would be wonderful...

N: And how does that make you feel, you know, having this kind of child with a drug addiction.

R: A failure, a failure, you do feel like that because you think at this age he should be at standard 8, maybe 9, he should have more, he has a lot of friends be he has lost a lot of friends then he have made new friends then he loose them because of the trouble, the drugs, the stealing. It’s all different sets of friends so everything is erotic there is no constant friend, there is n constant little girl friend and good friend there is always some problem comes up, there is always a problem comes up and some of them are really nice kids and I feel what has he achieved at this age now 16 - nothing, all he has achieved is an addiction. He is not good in school anymore, he is no heading anywhere, he has dropped all his sports. I can’t get him to do any sports. I feel...a mother know how important it is to look at a 16 year old son and seen he participate in that soccer game, that cricket game, he doesn’t have to win the major goal, but he participated, he was part of the team effort that would make me proud. That use to happen before this drug story but it doesn’t anymore, it doesn’t and I feel like a failure because I don’t know what else I must do because although I lost my husband last year that was not my son’s
father, I am divorced and I feel the divorce has caused this.

N: So you’re taking the blame whatever happened between you and your ex-husband the divorce could be the result.

R: Definitely, it has a lot to do with it because although I am quite strict in some ways I am very lax in others. I was highjacked last year badly and I couldn’t lift this arm properly but if I was not divorced I would have my husband there. My son wouldn’t have gone away without it because last year he got on to crack cocaine because I had to give him a cash card to go and draw the money to go and buy the food for the house. He had to help me and that’s when he started the big stealing from my cards. Now if I had not been divorced his father would have been there, would have been a male dominant figure there and I don’t think this would have happened, so I really think divorce has a lot to do with it.

N: And also when you get that does that mean the contact between the parent and the child might lead to the drug addiction. I mean like you are not there you were in hospital, your husband was not there, so there was no supervisor...

R: There was no supervision for about 9 months, it happen on the 1st of June last year and for about 9 months he virtually done everything because I was unable to do anything. I was in the hospital, I couldn’t drive, he was going to open the door, coming back later I would be sleeping, he took advantage of the situation. He hasn’t really seen his father for six or seven years, his father sees him maybe twice a year and I do think it has a lot to do with it too. I think he may have a deep anger towards his father who was so close to him before the divorce and his father’s re-marriage I do feel it has a lot to do with it psychologically but I can’t make his father see him, I can’t make him do that.

N: And now how do you feel about all this?

R: I feel if I am alone on a island with a board to go off because there is nobody, the
father is not interested, he is being to detox twice, he relapse twice, he stole from me again last night, he has a court case coming up on Monday, I mean who is there for me - my sister, my sister and I are very close. Last Sunday and I loan the car to my niece’s friend who is 25 to take my son over to Bruma for a couple of hours because he just have a detox week before he asked them to go to Yeoville to buy dagga, my sister phoned earlier, she found out last night. She swore at my son, she is causing trouble and my sister is the closest thing I’ve got in this country, now I can see we’re distant because of the drug problem because I have to stay with my son, he has got nobody else.

N: You still have to have the parental responsibility, the care and love for your son.

R: Absolutely. If I have to loose my sister, I have to loose my sister if I happen to go there, I’m not allowed to go there because her silver lighter went missing then I can’t go there, there is a lot of places now that I can’t go because I’ve got to stick with my son, I’ve got to accept that, I feel it is unfair but what do you do as a mother, you can’t throw away your kid and just say I am gonna have him committed and his gonna go back I want him back home with me twice, its not work...uhm...I don’t know what to do maybe talking to the psychologist, going to the group sessions somewhere I’ll hit upon a light, my son will hit upon a light that will maybe help him in this dark area, I don’t know what’s life going to be, it could be something traumatic, like seeing a friend die from overdosing or something like that maybe that could give him a shock, or maybe he could meet somebody who is a religious youngster like himself and he sees that there is also young pretty girls that also go to youth clubs, not raves. Somewhere there could be a little bit of light. I met a woman two weeks ago who was actually very religious and she was telling me about youth clubs and my son was listening in the background and I thought maybe this could be a way he must tell me to go. I don’t want to force him to go, he must want to go and I feel something will crack to help with this its got to, its got to, but is gonna take time. In the meantime I am losing everything, I losing money megabucks and I’m losing
friends and I'm losing family and so is he.

N: But, despite that what you are losing materialistic things, and friends and family, I still sense a sense of hoping maybe a miracle will come and help your son.

R: Yes, it is a bit like thinking he has cancer that's how I start to think he's got like a cancer in his body, now some cancer are not treatable, we all knew that, but some are, I mean cervical cancer is curable, so there is always a real hope, I don't think you can give up, I don't think you can give up hope there has to be hope somewhere, it can't go on forever, something good or something bad has got to happen eventually.

N: And the way you feel now is it still the same as you were felt when you discovered that you son were on some drugs?

R: No, no I didn't realise the problem is as bad as it was when he first ask me for help, he ask me for help through the stealing. I said to him are you're a little thief or are you stealing for drugs so eventually he came and he ask me for help and I honestly thought when I took him into Phoenix House that he will be okay in three months he would be fine he didn't he smoked in Phoenix house, he run away, he ended up in streets for thee nights. I didn't know he was that bad but he was I didn't know - a young child a whole future ahead of him, a whole lifetime ahead of him is you can't you got to hope but I just don't know what else to do, I thought overseas I have family and they said send him to me but you're still sending the person with the problem, the problem is not going to go away because you are in a different country. It's like going with a broken leg, when you go off the plane it's still going to be broken so that doesn't help nothing. I just think the treatment, the medication...uhm...and also hi m s elf maybe he will realise that he is losing friends, he is losing good friends, he's got adults who are really against him, I mean I get threatening calls because of this court case, I get anonymous calls, threatening calls this people want to actually get hold of
him...uhm...this is I'm entering a world that I never knew when I first find out that he was on drugs. I'm seeing a whole different world, the Nigerians the Suns hotel, and I can tell you all the places where to buy and what these young kids will do to get drugs. They will sell themselves, I'm not that stupid. I never ever knew Hillbrow, I never even know this side of society but now I do and I'm not sort, you can tell me anything and I won't be sort I have been to all the group sessions.

I heard some Little Water stories and Silwerstrand so I didn't think it would ever become as big a bubble as it become, I never ever envisage this. Now there is parents I know that had been cracked whose children are just as bad as Grant who has been on the drug cocaine, the pinks, the acids, and at the group sessions I ask the counsellor should you tell the parents and he said yes, because you could save a life, but don't expect a handshake or a thank you, parents are deny it. There is so many parents out there, deny it so many parents, but I'm not that is why I'm not afraid to talked about it if people said to me where are you going. I have some people coming round to my place this morning. I said I'm taking my son to group therapy or therapy he is a recovering drug addict. I don't have any fear about saying it because that's how it is. People must be, you can't hide, you can't hide, it is a sickness, it is a sickness I'm not ashamed of it, I am ashamed of it in a way I feel a failure but I've learned to accept it and I can't go lying and hiding and send to the school a sick note because he is off sick today or this or that or the next thing, you've got to tell the truth he is a recovering drug addict, now some people are recovering alcoholics, you don't offer a recovering alcoholic a drink and the same with young kids, you don't give them money if they are drug addicts because they are going to spend on drugs, you buy them what they need, I've learned that and it took me a long time to learn that. It is difficult, it's very difficult. I never knew this would ever happen and it is now six months since he first asked for help and it's just gone mind blowing the things I've learned and the things I've known and the things that he has been doing. I was totally unaware of it, totally, sneaking I didn't think he had the brains to do some of the things he done sneaking out at night going to Hillbrow to get some drugs.
N: So when you discovered that he was doing all these things, how did it make you feel?

R: Scared for him because I thought he could have been killed, he could have been murdered, he could have been raped, sexually molested...uhm...could have been shot, could have been overdose. I was scared for him, I thought like seeing your child in hospital on an oxygen tent, you're helpless, you feel totally helpless and you feel scared for him and you worry about him constantly I have to take sleeping pills, I can't sleep at night because I see all these things in my mind.

N: It has changed your life and you are kind of experiencing what he is also experiencing because all the threats that you are getting they are mainly created by him and it is all comes back to you...

R: Yes, its coming back to me.

N: And you live with fear...

R: Ja, I had one of those tonight he is not able to answer the telephone, I had one on Thursday night, I had one last night because of the court case. He was sleeping, he was sleeping on both occasions when the phone rang, but it scares me that there is people out there they wants to make sure that he doesn't talk when he goes to court. I know that it is all about but he is gonna have to he is gonna have to talk he is going to have to tell the truth when he goes whether it is threatened or not, he is got to tell the truth, there is no use lying so I just tell the people to go away.

N: Is it easy for you to tell them to go away?

R: Well its on the phone I don't know who I'm talking to, they are anonymous callers so I you know I just tell them to get lost. I use stronger language than that, but
what can I do, I really don't know who they are, I've got an idea you can't go around and pinpoint to people and said I'm get involved in this drug scene which is a bit scary because I am completely on my own, completely on my own, there is only a granny in homeland. My daughter has left, she is got engaged, and it is a bit scary, a bit scary because I don't know what is going to happen. They has a institute at ........but he is not too worried about this I don't believe that because when he sleeping he start to talking in his sleep and I can hear the mind is working this is a front, this is a front, and it is all through drugs, it is inhale dagga, staffing dagga, then they try cocaine and they can buy anywhere, anywhere but the schools, everywhere, everywhere there are so many children on it. I know all his friends because he seems to pick up friends very easily all over all these places, they say they want to go read, they say they want to go raves, you can't dance for 6 or 7 hours. Your body can't take that, it is impossible, you have to got something in your body to make you do that but what did I know when he went to I thought was like a young teenage club was under eighteen, I even dropped him, I even dropped him. My sister and I were in town and I dropped him, we didn't know, we never thought, drugs we never thought about it but now I do now I do and it is difficult you know.

N: It sound that you have learned the hard way about drugs.

R: Very hard ja. It was all over in the house and I didn't know it came to me like a shot out of the blue it actually came to me through my stepdaughter, she has came to stay with me for a while and she said to me Phillis he is definitely on something and it is not just dagga. She is only 27 so she is quite wide awake and she started talking to me, she says I'm telling you I can see the way he is talking, the way he is hyper and the way he is drinking coke and she knew all the signs. That was a few months ago and that's when it really started then I noticed, but you see with me been highjacked the money empty my bank, the medical aid, I would pay then there is doctors and its money coming in and out and then he would come home and said there was no receipt he couldn't get any receipt, it was
taken like hundreds of rands at a time.

N: And you by that time you were not aware.

R: Then when I went to do a banks dealing. Eventually when I got up I was able to buy myself an automatic car and have a little handle on the wheel that I can drive and I went to do all my banking because I was just, my sister was helped but not a hundred percent so that was my first call was to go to the bank...impossible I don't draw five hundred rand out but there was the withdrawals, there was the withdrawals and then I said to him I approach him you have to tell me you still stealing for drugs. So a few days later one evening he came to me and he said to me because now he couldn't get any money I've changed my pin numbers I hide my bags, I hide everything I watched him like a hawk, I search him when he come in, I kept that up for about 10 days and one night he just come through to the bedroom, he said mom I've got a problem and even then I thought it was dagga even then and I said to him what is it. He said mom I want crack cocaine, I said you want cocaine, I only see that in movies, I don't even know what cocaine looks like. I nearly fainted.

N: So it was kind of a shock for you.

R: Big shock. Big shock. The next day I phone Phoenix House and asked if he could be assessed and I put him into Phoenix House. The next day I took him there and he run away, then he came home, then I took him to the psychologist, then I could see he was back on it. That is another long story and there was big drama over that and then with the money he again buy crack cocaine in Hillbrow and he nearly overdose and that was only a month ago. I took him to Sanca Roodepoort. I had to put him in there, he took a fit here at Roodepoort, he took a seizure here so he had to get help right away, so it is not really going any better.

N: So what you are saying that shock is still there with you?
R: Ja, ja.

N: All this incidence that happening now and then and the fear is still with you.

R: Uhm, my fear is that not to have him committed for three months, that is no fear anymore, my fear is that he got a OD on drugs, that's my biggest fear because he nearly has that, has nearly happened three or four weeks ago. My biggest fear is that he is not going to see 21 if he keeps this up and he doesn't seem to getting this through his head some blockage there that we not getting through to him and I'm just hoping with the medication and the counselling and the psychology and even things like my sister phoning him up telling him what she thinks of him for taking the girls into Yeoville where they could have been...and things like that maybe maybe something will get through to him that he'll think hey, wait a minute I'm getting into bad situations, I really got to commit myself to becoming clean because at the moment he is not gonna committed he is a three or ten at the moment, I can see that, I can see that.

N: When you say that how does it make you feel?

R: I don't think the word is depressed, I think the word is fedup, you're spend your life running from one side of the city to the other, running to the school to pick him up, running to the clinics waiting for the counselling, double parking getting parking tickets your whole life. I haven't got a life, I mean this is now Saturday, I have been asked to go to the Vaal, I can't go there, I can't take him to the people who have asked me, I'm too afraid he will steal something there, I've got to be alone with him all the time. I'm 50 years of age, do me a favour, do I need this, do I need it but it is my son, what must I do, what must I do and he really doesn't want to be with me all the time but he has to be, he has to be. I don't trust him to do anything even not going down the stairs to the car, I know he can buy drugs from the sellers in the street, I know he can, I just don't trust him.
N: So you kind of feel if you are in a circle.

R: I feel like as if I am in a jail.

N: And you'll have to keep a 24 hour eye watch you feel, you know like a baby.

R: Uhm, just like a baby, but he doesn't obey by watch you know he will go and said I'm going to visit this and I'm, going to visit that one, then I phoned to make sure he is there but I don't know what he is done when he is on his way there you know, you sit and you worry and you worry and you wait for him to come in sometimes search him, search his pockets. You have to be there when he comes home to make sure that there is nothing on him to look to see, it's not very nice to wait for him, it's not very nice.

N: So what you also said is that the trust is totally broken, it's not there anymore.

R: Yes, oh yes. I don't trust him at all because he keeps on doing things I just cannot accept.
FIELD NOTES

OBSERVATIONAL FIELD NOTES

It was Saturday 10:15 in the morning and I had to meet the respondent at an institution where her son (teenager) was attending a group therapy. Our appointment with the respondent was 10h00 and I was 15 minutes late. Immediately I arrived at the institution, I introduced myself to the receptionist and told her why I was there. She said to me the respondent had told her about me and she quickly went to Truworths shop, she won't be long.

After 30 minutes the respondents arrived and apologised for taking a long time. Then she suggested we go to one of the offices for interview. She was very open woman.

THEORETICAL FIELD NOTES

The receptionist was very helpful and she reassured me that the respondent will be coming soon. The respondent herself was very cooperative and she talked freely about her experiences. During the interview the owner of the office, who is the respondent's son's therapist, came into the room and I stopped the tape and the respondent introduced me to the therapist. Then the therapist left the room.

I stopped the tape, the respondent gave him the keys. During this time we were about to finish because we had even gone 5 minutes beyond the stipulated time.

METHODOLOGICAL FIELD NOTES

I did a lot of reflection because the respondent expressed herself freely, where I could not understand I asked for clarification.
PERSONAL FIELD NOTES

I felt a lot of empathy of this respondent and I felt like she does not deserve what she is experiencing at the moment because she had had trauma in the past (divorce, husband death and herself being hijacked). I felt like making friends with her or counselling her.

Although I disagreed with her on one point but I did not raise it loud (in my heart I just said no you may not be correct there) because I placed myself in her situation (when she blamed the divorce for his son's behaviour).