

**CAREGIVERS' AND ADOLESCENTS' PERCEPTIONS OF A CULTURALLY ADAPTED,
EVIDENCE—BASED PROGRAMME FOR SUBSTANCE-MISUSING TEENS**

Vimbayinashe Sithembile Chibambo

CHBVIM002

Supervisors

Dr Catherine L. Ward

Dr Tara Carney

A minor dissertation submitted in *partial fulfilment* of the requirements for the award
of the degree of Master of Arts in Clinical Psychology

Faculty of Humanities

University of Cape Town

2019

COMPULSORY DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature:

Signed by candidate

Date: _____31.10.19_____

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

ABSTRACT

Context – The prevalence of problem substance use is a global concern, particularly for adolescents due to their ongoing developmental changes. Amongst other contributory factors, parenting styles adopted by parents and caregivers can either; increase the risks of their children developing substance misuse problems or prevent its onset. Knowledge about the needs and experiences of the caregivers of adolescents who misuse substances is limited and greatly under-researched.

Brief interventions (BIs) have been identified as an effective means of tackling this problem-type behaviour among adolescents, including ‘Teen Intervene’, which was developed in the US. This evidence-based intervention included a parent component which has been found to further enhance the interventions’ positive outcomes.

Rationale – In light of the unique caregiver structures in South Africa, the general neglect of their needs in the South African literature with regards to interventions and the high prevalence of adolescent substance misuse in the Western Cape, exploring these needs within the country’s context is warranted and necessary.

Design and data collection – This was a qualitative study and data for the study was collected in two main phases: through focus group discussions to identify caregivers needs and to explore perceptions of the intervention; and post-intervention interviews with caregivers and adolescents at a 1-month follow-up session.

Findings – Template analysis revealed six main themes: 1) Access to knowledge about substance misuse; 2) Parenting skills; 3) Sources of emotional support; 4) Empowerment for female caregivers; 5) Financial concerns; and 6) Alternative solutions to adolescent’s involvement in the justice system. Caregivers also reported various feelings that are a direct result of their experiences.

Discussion – Caregivers have distinct needs that require designated responses, however, some of these needs can be addressed through their inclusion in treatment interventions for adolescents who misuse substances.

Keywords: caregivers, needs, experiences, adolescent, substance misuse, brief interventions

ACKNOWLEDGEMENTS

Firstly, during the most turbulent and smooth periods of writing my dissertation, God has been my anchor – I will forever be thankful to HIM!

To my parents who have supported my entire academic journey and consistently believed in me – I could not have done it without them both.

My supervisors - Dr Catherine Ward and Dr Tara Carney, thank you both for providing me with academic guidance and support through it all.

To my siblings and friends – many who prayed with and for me, were patient sounding boards and offered a fresh set of eyes throughout the process.

I am also grateful to the South African Medical Research Council and the National Research Foundation for funding the project. The views expressed here are my own, and not those of the SA Medical Research Council or the National Research Foundation.

Lastly, to all the participants – this research was made possible by their willingness to participate and share their experiences.

TABLE OF CONTENTS

INTRODUCTION	1
CHAPTER 1: LITERATURE REVIEW	1
The Caregivers of Adolescents who Misuse Substances and their Needs	3
Brief Interventions and Adolescent Substance Misuse	6
Rationale, research aims and questions	8
CHAPTER 2: RESEARCH DESIGN AND METHODS	10
Study design	10
Setting	11
Context of the Intervention and Data Collection	11
Phase One	12
Phase Two	14
Data analysis	16
Ethical considerations	17
Summary	18
CHAPTER 3: FINDINGS	20
The Caregivers' Self-Identified Needs (Phase One)	20
Access to knowledge	21
Parenting skills	23
The implementation of discipline	24
Communication	25
Managing the psychophysiological domain	25
Suggested sources for emotional support	27
Support groups	27
The role of faith-based organisations	28
Empowerment for female caregivers	29
Financial concerns	30
Family level	30
Community level resources	31
Alternative solutions to adolescent's involvement in the justice system	32
Caregiver and Adolescent Post-Evaluation Interview Findings (Phase Two)	34
Knowledge obtained	34
Parenting skills	35
Alternative forms of implementing discipline	35

Communication.....	35
Provision of emotional support.....	36
The interviewees’ subconscious expectations versus their voiced (unmet) needs.....	36
Changes in the parent/caregiver-child dyad.....	37
Summary and chapter overview.....	39
CHAPTER 4: DISCUSSION and CONCLUSION.....	41
Needs met by RAD-PAL.....	41
Knowledge.....	41
Parenting skills and the parent-child relationship.....	42
Discipline.....	42
Communication.....	43
Emotional support.....	44
Possible Prevention Practices and Alternatives Options.....	45
Introducing prosocial activities.....	45
Juvenile justice & diversion programmes.....	46
The Broader Scale Needs of Caregivers.....	47
Disempowerment and the intersections of gender and class.....	47
Reflexivity.....	49
Limitations and Suggestions for Future Research.....	51
Practical Implications and Recommendations.....	52
Methodological and Theoretical Contributions.....	52
Concluding remarks.....	53
References.....	54
Appendices.....	67
Appendix A.....	67
Appendix B.....	68
Appendix C.....	69
Appendix D.....	73
Appendix E.....	75
Appendix F.....	76
Appendix G.....	77

INTRODUCTION

This paper is founded on the notion that substance misuse affects entire families (Barnard, 2005), so it is therefore, a necessity to acknowledge the specific needs of all those who are affected – be it by the living with an individual who struggles with substance misuse or being the individual who misuses the substances. This chapter lays the foundation of the paper by beginning with a discussion of the literature. It homes in on a gap that has been identified both locally (Groenewald & Bhana, 2015a) and internationally (Smith & Estefan, 2014); that is in relation to the parents and caregivers of adolescents who misuse substances. Thereafter I provide the rationale for this study and state the questions it sought to answer.

CHAPTER 1: LITERATURE REVIEW

Across the globe, the prevalence of problem substance use continues to be identified as an area of concern (Tshitangano & Tosin, 2016), with numerous surveys showing higher drug use and frequency amongst younger than older people (United Nations Office of Drugs and Crime, 2018; Visser & Routledge, 2007). Substance misuse is particularly concerning for adolescents due to the changes they undergo during this developmental phase (Usher, Jackson, & O'Brien, 2007) such as alterations in the brain that impact risk-taking and impulse control, transitioning into high school, as well as a growing preference to spend time with peers as opposed to family (Castellanos-Ryan, O'Leary-Barrett, & Conrod, 2013). This leaves them vulnerable to various social, physical and mental health related risks that may have an increased likelihood of developing into diagnosable substance use disorders (SUDs) (McLellan, 2017; UNODC, 2018). Worldwide, concern is further exacerbated when the impact of SUDs and other mental health disorders on disability amongst adolescents are taken into consideration (World Health Organisation, 2014), with Erskine and colleagues (2015) finding them to be the highest contributors of adolescents' disability-adjusted life years (DALYs); where disability of lived years accounts for 25%, while 0.2% accounts for years lost to premature death.

Given the definitional changes that have emerged in the nomenclature used in the previous and current versions of the *Diagnostic and Statistical Manual of Mental Disorders* (namely, the *Fourth* and *Fifth editions*), the terminology in the literature drawn on in this paper differs. Between these two versions of the *DSM*, the terms substance 'misuse', 'use', 'dependence' and 'addiction' have all been used, with the *DSM-V* collapsing all terms into the umbrella and neutral category of 'SUDs', that are distinguished by varying degrees of

severity (i.e., mild, moderate and severe, American Psychiatric Association, 2013; McLellan, 2017). Although, it is recognised that not all adolescents meet criteria for a diagnosis of a SUD, all forms of problem substance use can be harmful to their wellbeing (Carr, 2016). Considering these aspects, this paper will make use of the term ‘substance misuse’, unless specified as a diagnosable disorder in the literature.

In South Africa, substance misuse is common (Tshitangano & Tosin, 2016). The highest adolescent prevalence rates in the country are generally seen amongst adolescents in the Western Cape (Asante & Lentoer, 2017; Carney, Myers, Louw, Lombard, & Flisher, 2013; Reddy et al., 2013). Between the period of July to December of 2018, the South African Community Epidemiology Network of Drug Use (SACENDU) indicated that eight percent of all patients in treatment in the Western Cape were under the age of 20 ($n=223$) (Dada et al., 2019). However, it must be noted that these figures are limited to those who have access to treatment, suggesting that the figures are likely to be higher in the general population, which further confirms that substance misuse is indeed occurring at problematic and concerning rates amongst adolescents in the Western Cape (Reddy et al., 2013). Given that this is occurring amongst the youth, substance misuse tends to have implications for school attendance, mental health and risky sexual behaviours in the province (Carney et al., 2013; Kalam & Mthembu, 2018), even if full criteria for SUDs are not being met. Despite having some awareness of the harmful impacts of substance misuse, adolescents still seem to have a tendency towards impulsive decision-making and experimental behaviour (Carney et al., 2013; Gladwin, Figner, Crone, & Wiers, 2011) – thus indicating the need for interventions aimed at addressing this behaviour early.

Substance misuse amongst adolescents is also influenced by caregivers¹ and their parenting styles. Styles of parenting that increase the risk of adolescent substance misuse include low levels of monitoring, knowledge and supervision; poor discipline; irregular limit-setting; and authoritarian or laissez-faire parenting styles (Lyter & Lyter, 2003; Pretorius, van den Berg, & Louw, 2003). Other parent-related risk factors for adolescent substance misuse are conflict between parents or between parents and the child (Branstetter, Low, & Furman, 2011), female-headed homes, that are common in the African context (Peltzer, Ramlagan, Johnson, & Phaswana-Mafuya, 2010) or parents’ own substance use: which may

¹ Here, the term ‘*caregiver*’ is inclusive of parents and any other individual who has caregiving responsibilities over an adolescent. Notably, adolescents in South Africa are increasingly being raised by grandparents, other relatives or even older siblings (Hall & Richter, 2018; Profe & Wild, 2017).

unintentionally normalise substance use (Wadolowski et al., 2016). By contrast, parental factors that may protect against substance misuse include authoritative parenting that tends to foster adolescent responsiveness and communication (Calafat, García, Juan, Becoña, & Fernández-Hermida, 2014; Piko & Balázs, 2012); consistent support and discipline, as well as outward expressions of warmth and affection (Branstetter et al., 2011; Matejevic, Jovanovic, & Lazarevic, 2014).

While the experiences and needs of children living with a parent or guardian who misuses substances has been an area of focus in several studies (Kroll, 2004; Solis, Shadur, Burns, & Hussong, 2012; Tedgård, Råstam, & Wirtberg, 2019), information about the needs of parents with adolescents who misuse substances, their experiences or their ability to cope with their adolescents' behaviour is a greatly under-researched topic globally (King, Wagner, & Hedrick, 2002; Orford, Velleman, Natera, Templeton, & Copello, 2013). Locally, South African literature on the topic is even more sparse (Asante & Lentoor, 2017; Groenewald & Bhana, 2015a, 2015b; Masombuka, 2013). This is noteworthy given that the greatest burden of care for populations who misuse substances tends to fall on parents and (in contexts like South Africa) on caregivers (Choate, 2015; Kalam & Mthembu, 2018). Since South Africa has high levels of poverty, unemployment, crime and gang activity, limited access to mental health services and adequate infrastructure, a history of segregation and high rates of substance misuse (Eagar, Cooke, Levin & Wolmarans, 2015; Parchment, Small, Osuji, McKay & Bhana, 2016; Tshitangano & Tosin, 2016; Statistics South Africa, 2018; UNODC, 2018), the caregivers of adolescents who misuse substances in the country are in need of support.

The Caregivers of Adolescents who Misuse Substances and their Needs

The caregivers and family members of people, including adolescents, who misuse substances may experience numerous adverse effects as a direct result of this behaviour. These effects include compromised physical and psychological health, elevated stress levels among parents and caregivers, diminished problem-solving skills and financial strain (Asante & Lentoor, 2017; Groenewald & Bhana, 2015b; Toumbourou, Blyth, Bamberg, & Forer, 2001). Research indicates that marriages and other siblings are often neglected due to the focus placed on the child who is misusing substances, at times fostering resentful feelings towards that individual in these family members (Choate, 2011, 2015; Toumbourou, Blyth, Bamberg, Bowes, & Douvos, 1997). Previous studies have also found that parents (and siblings) are subjected to verbal and physical assaults (Jackson & Mannix, 2003; Usher et al.,

2007). Further, caregivers in both international (Bisetto Pons, González Barrón, & Botella Guijarro, 2016; Usher et al., 2007) and local literature (Asante & Lentoer, 2017; Groenewald & Bhana, 2015a) report feelings of failure, guilt, self-blame, powerlessness and fear, anxiety, as well as embarrassment and shame.

Considering these findings, the stress-strain-coping-support model (SSCS; Orford, Copello, Velleman, & Templeton, 2010), provides a theoretical framework for the current study. The model seeks to de-pathologize and acknowledge the unique experiences of family members (such as caregivers) affected by the substance misuse of an individual they are living with. The emotional and psychological impingements that they continue to be subjected to tend to exacerbate their stress levels (Groenewald & Bhana, 2017; Orford et al., 2013). Over time, these heightened levels of stress are compounded, placing immense strain on the overall health and well-being of the affected family members. In efforts to buffer the toll that this has on them, attempts are made to cope by either putting up with, withdrawing from or standing up to the individual with the substance misuse problem (Orford et al., 2013). This goes together with attempts to seek out and establish quality social support (Orford et al., 2010; 2013). South African studies have found the model to be a useful highlighting the need to develop relevant support interventions while simultaneously seeking to restore fractured filial relationships between mother/parent and child (Groenewald, 2018; Groenewald & Bhana, 2017).

Parenting styles can be a risk or protective factor for adolescent substance misuse, it is therefore imperative to assist caregivers develop parenting styles that are more protective as these will likely be helpful for their adolescents who misuse substances (Toumbourou et al., 2001). What seems essential to highlight in such families is the necessity to address the needs of all parties or of the whole family (Orford et al., 2013; Smith & Estefan, 2014), to ensure holistic and sustainable changes. For the individuals who misuse substances or have SUDs, access to treatment appropriate to the severity of the SUD/substance misuse as well as to the resources needed to aid recovery or alter behaviour are needed. Alongside this, caregivers and indeed other family members would benefit from therapeutic interventions aimed at assisting them to work through the toll that the substance misuse has on their wellbeing.

There is a distinction that has been observed in the limited literature between the ‘needs’ and ‘experiences’ of the caregivers of adolescents who misuse substances. Although certain studies have investigated both concepts together, others have often focused on one

aspect or the other. Here, focus will first be cast on examining caregivers' needs and the experiences that have led to the emergence of such needs, and thereafter on caregivers' experiences of interventions.

The needs of caregivers who suffer adverse and distressing effects from the adolescents' misuse of substances vary and can emerge at the different levels of severity usage. In a previous American study, King and colleagues (2002) found that caregivers needed information to assist them to prevent their children from using substances. A researcher in a recent local study, investigated the support needs of caregivers living with an adolescent who is addicted to a specific illicit substance, 'nyaope' (Masombuka, 2013). The study found that caregivers experienced various fears and feelings ranging from despondency to complete hopelessness, which in turn placed a burden on both the caregivers and the family as a whole. This led to the development of personal needs and attempts at seeking out support from extended family, the police, social workers as well as government services (Masombuka, 2013). These two studies highlight some of the concerns and needs that may arise during the earlier stages of substance usage by adolescents, as well as those that may emerge in the more severe cases of SUDs. Internationally, critiques have been made about many existing interventions for caregivers and family members due to the limited precedence afforded to them in interventions, as they are often incorporated into interventions that are primarily geared towards facilitating the treatment and recovery of the adolescent misusing substances (Orford et al., 2013). While such interventions are important, the unique needs of the caregivers are seemingly overlooked in many cases (Orford et al., 2013). Since the definition of needs is largely context-specific, it may be useful to identify how caregivers define their needs before interventions that address them can be developed and implemented (King et al., 2002).

Qualitative enquiries into the experiences of caregivers living with substance-misusing adolescents, although limited, are more available than those focused on their needs in both the international (Choate, 2011; Jackson & Mannix, 2003; Smith & Estefan, 2014) and South African literature (Asante & Lentoer, 2017; Groenewald & Bhana, 2015a, 2015b). The focus in each of these studies seemed to be on gaining insight of caregivers' first-hand experiences, while the studies could have also considered how to meet or begin addressing the participant-defined areas of need, making this a consistent gap. Internationally, a noteworthy finding that emerged across most of these studies was framed around the parents' perceptions of the services that had been made available to them. Notably, parents often felt

that the services offered either provided inadequate support, were unsuitable for their problems or implied parental blame for their adolescent's behaviour (Choate, 2011; Jackson & Mannix, 2003), suggesting that the services were often perceived as not appropriate. The distinction between what constitutes an 'experience' and a 'need' meant that no South African studies had directly explored the general needs of caregivers living with an adolescent who misuses substances while simultaneously attempting to meet those needs.

Amongst the international studies that examined caregivers' experiences of specific parent- or family-based interventions (Bisetto Pons et al., 2016; Toumbourou et al., 1997; Toumbourou et al., 2001) is *CRAFT (Community Reinforcement and Family Training*, which had been conducted in Spain. Following the ten-session intervention for the parents of substance-misusing adolescents, the experimental group of caregivers showed significantly improved emotional and self-esteem levels (Bisetto Pons et al., 2016). In an Australian study, a brief intervention (BI) for parents, *BEST (Behavioural Exchange Systems Training)* sought to help parents cope better, foster empowerment, promote individuation and lower their levels of guilt, which generated promising findings. An evaluation of the intervention (using an eight-week control group) indicated that the first recipients of the intervention experienced more positive changes in their perceptions of the problem behaviour when compared to the group who received the intervention eight weeks later and had lowered levels of psychological distress (Toumbourou et al., 2001).

Together, these interventions provide promising examples of the positive experiences of caregivers and whole families, with particular focus on the BI that is discussed at length in the following section. However, a limitation observed in these studies is the selection of participants from high-income countries (HICs), which may not be representative of the caregivers in low-to-middle-income contexts like South Africa. Given the number of caregivers living with adolescents who misuse substances in South Africa, as well as the country's specific context, it is necessary to gain a better understanding of their needs and investigate how interventions can begin to address and meet these needs.

Brief Interventions and Adolescent Substance Misuse

Brief interventions (BIs) aim to foster healthier life choice by prompting individuals to either stop, change or prevent engagement in behaviours that run the risk of compromising one's health (Levy & Williams, 2016; Padwa, Guerrero, Serret, Rico, & Gelberg, 2018; Winters, 2016). As regards substance misuse, BIs are founded on motivational techniques for

adolescents who have mild to moderate SUDs (Winters, 2016; Winters & Leitten, 2007; Winters, Leitten, Wagner, & Tevyaw, 2007). Such interventions are valued for their short-term and easily implementable nature, as well as their time and cost utility (Piehler & Winters, 2015). They are also prized for their ability to reach adolescents who do not yet require formalised treatment, such as inpatient facilities for severe SUDs. Accordingly, they are often used to target adolescents still in the school setting as it is unlikely that their substance misuse is severe (Winters et al., 2007). ‘*Teen Intervene*’ is one such intervention. This brief evidence-based program was developed in the USA and it has two main components—two adolescent intervention sessions and one parent intervention session (Winters et al., 2007).

To compare the superiority of the intervention’s outcomes, studies have been done on various adolescents in which some of them received the BI with the adolescent only sessions, while others received the BI, with the adolescent sessions and the parent session. In one study, after being randomly assigned to one of the two BI groups, there were overall reductions in substance use amongst more severe users, (for instance, with adolescents who had a severe cannabis use disorder and a co-occurring psychological disorder (Piehler & Winters, 2015). However, significantly better outcomes were observed amongst the participants who received the BI which included the parent component. Similarly, in another recent randomized control trial (RCT) of the study, the BI adolescents with parental involvement were more likely to have reduced substance misuse at the 12-month follow-up than those who only received the two adolescent sessions.

In view of the positive effects of BIs that have been observed amongst adolescents who misuse substances in high-income countries (HICs) such as the United States, consideration about how to adapt such interventions to also attend to the needs of the caregivers involved may prove useful, particularly in contexts where resources and professional assistance are in limited supply. In low-to-middle income countries (LMICs) like South Africa, the caregiving structures (Hall & Richter, 2018; Makiwane, Gumede, Makoae, & Vawda, 2017) tend to differ from those commonly found in HICs like Australia and the USA; suggesting that interventions for such contexts may need to differ in their constitution and delivery.

Rationale, research aims and questions

Evidenced-based interventions are important because they possess the ability to yield consistently positive results. Accordingly, it has therefore been shown that adherence to the traditional delivery model of an intervention and its main components is the reason for the positive findings generated by such interventions (Chu & Leino, 2017; Padwa et al., 2018). Adaptation is done with the intention of ensuring that the core components of an intervention are maintained, while simultaneously ensuring that the intervention is perceived as acceptable by the community of interest (Padwa et al., 2018; Sorsdahl et al., 2014). Formative work can be done to gather the information required to adapt interventions as it enables researchers to understand the characteristics underlying problem-areas as they are described within specific communities (Nichter, Quintero, Nichter, Mock, & Shakib, 2004). Although ‘Teen Intervene’ has been assessed in HICs, Winters (2016) demonstrated the necessity for researchers to remain mindful of contextual factors as they “may be a fruitful direction for a new generation of preventive interventions” (p. 3), in this case, in South Africa.

Given the high prevalence rates of adolescent substance misuse in the Western Cape (Carney et al., 2013; Morojele et al., 2013), and the gap in the local literature of the needs of caregivers who look after adolescents with substance use problems, , particularly in relation to interventions (Asante & Lentoor, 2017; Groenewald & Bhana, 2015a), the exploration of the needs of this group of caregivers is both warranted and necessary within the South African context. Accordingly, this study seeks to address this gap by investigating the needs of the caregivers whose adolescents misuse substances in a low-income and resource limited community in the Cape Town metropole.

This study forms part of a broader pilot project, thus the aims of the sub-study conducted for this thesis were two-fold and occurred in two independent phases. Phase One consisted of focus groups discussions with caregivers to obtain a sense of their needs and discussed their perceived acceptability of the original intervention. It was important to use focus group methodology as it brought together individuals from common circumstances yet with unique experiences in ways that encouraged disclosure of these experiences (Krueger & Casey, 2014). It also provided a consensus view of the participants’ responses to the intervention and their impressions of its ability to cater to and address the challenges faced in their communities through their co-constructed accounts (Morgan, 2012). Phase Two consisted of individual interviews with caregivers) to capture the participant’s nuanced experiences of the adapted intervention. This tool provided further information on the

feasibility of the intervention. To this end, this study explored whether communication between caregiver and adolescent improved, and whether caregivers were able to develop and use more positive parenting practices after the intervention.

The broader project sought to adapt and test the original version of the brief evidence-based intervention, *Teen Intervene* in an economically disadvantaged community within a low-to-middle-income country (LMIC), and then adapt it to suit a local population in Cape Town. It investigated the needs of caregivers living with an adolescent who misuses substances, explored their perceptions of the original intervention and attempted to provide practical means of assisting caregivers through the adapted version of “*Teen Intervene*” which was subsequently named , *RAD-PAL* (Reducing Alcohol, Drugs and other Problem behaviours among Adolescent Learners). While the current study specifically answered the following research questions:

- 1) What are the self-identified needs of caregivers living with adolescents who misuse substances, with regard to brief intervention services?
- 2) Does the adapted version of “*Teen Intervene*” called *RAD-PAL* meet the needs of such caregivers?
- 3) How does participation in the adapted brief intervention change the parent-child relationship?

CHAPTER 2: RESEARCH DESIGN AND METHODS

This chapter includes an overview of the design used and the methods followed in this study. I begin by outlining the study's design, followed by a description of the broader pilot study that my project formed a part of. I then discuss the recruitment process and describe the community that the participants were drawn from. This is followed by an outline of the data collection methods used and the type of data analysis that was done. Lastly, I describe the ethical considerations related to this study and close off the chapter with a reflexivity section.

Study design

A pragmatic approach was employed in this study. In doing so, the study sought to identify and explore the needs presented in this real-world setting with a focus on what could practically be achieved by adapting and implementing a brief, evidence-based intervention (Goldkuhl, 2012). The study's design was both qualitative and formative in nature. Since the literature has shown that qualitative methods generate valuable and rich accounts for formative studies (Sofaer, 1999), this design provided a suitable approach for this project. Given that the findings made through such methods can inform the changes required for successive versions of an intervention (Gittelsohn et al., 2006), they may become better suited to address some of the issues raised by the target community. In order to obtain the necessary information required for this study's formative aims, qualitative methods were used to gain an understanding of some of the community members' responses to the original version of *'Teen Intervene'* in the form that the intervention was developed in the United States (Carney, Chimbambo, Johnson, Louw, & Myers, 2019; Winters & Leitten, 2007).

Broadly, qualitative research seeks to understand how the population of interest defines phenomena in the social and cultural domains found in a given context (Nichter et al., 2004; Ponterotto, 2005). These methods help to bring some clarity for researchers (as 'outsiders') on how these perceptions are formed (Dwyer & Buckle, 2009), by adopting a stance which perceives the participants as the experts on the topic under investigation. Beyond these reasons, studies that employ this design possess flexibility, which allows the incorporation of emerging aspects or themes (Frankel & Devers, 2000). By taking on an explorative approach, discoveries made in the earliest phases of such studies have a bearing on the stages that are to follow (Frankel & Devers, 2000). Since there is a lack of evidence-based information applicable to the needs of the caregivers of adolescents who misuse substances in the South African context, we were unaware of what they might have wanted from a brief intervention to assist these adolescents. Accordingly, a qualitative approach

seemed to be a good method to use as the participants represented a group that needed more exploratory work, and this method allowed the participants to define and discuss the range of issues that they face.

Setting

In this study, the participants were recruited from the different subdivisions of Delft. Delft is a peri-urban settlement that is situated on the periphery of Cape Town (Watt et al., 2014). It was established during the Apartheid regime in 1989, and though the area does have some newer Reconstruction and Development Program (RDP) housing, it remains a largely informal settlement (Statistics South Africa, 2011). Delft is a mixed community which is approximately half Coloured (51.5%) and half Black African (46.2%; Statistics South Africa, 2011). Following the passing of the Group Areas Act (No. 41 of 1950), it is unusual to find such a blended community in Cape Town, so the settlement was selected for this characteristic: its' racially integrated nature. However, it must be noted that there continue to be differences in the accessibility of services by race, including health services (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009), so it was important to include these two marginalised groups in the study.

The study's sessions were carried out at the South African Medical Research Council (SAMRC) project site in Delft. The site served as a convenient location which simplified the recruitment process, as it is in the targeted community. This enabled relatively quick transportation of the participants to and from the site.

Context of the Intervention and Data Collection

As it was previously stated, my study is part of a broader project which is being managed by the SAMRC. The broader project conducted a pilot study in which the main aim was to administer an adapted version of the brief, evidence-based intervention '*Teen Intervene*' (Winters & Leitten, 2007), and evaluate its feasibility in bringing about any short-term changes in the target community. I will start by describing the broader project's context; thereafter, I will describe how my study was nested within it.

The broader study was comprised of four main phases. The first of these was the formative work which was made up of six focus group discussions that sought to achieve two main goals: to assess the caregiver's needs (in relation to the intervention), and to explore the intervention's acceptability to the caregivers after knowing what the intervention contained. Three separate focus group discussions were held to address each goal respectively, with a

one-week interval separating the two goals. Individual pretesting made up the second phase, and this was followed by the third phase which involved the administration of the intervention to adolescents and main caregiver. During administration there was a baseline appointment, two adolescent intervention sessions and one parent/main caregiver intervention session, as well as a follow-up appointment with field staff members from the SAMRC. The last of the four phases were the post-evaluation interviews which were held upon completion of all the intervention activities. Of the four phases, my study contributed to the first set of focus group discussions and the post-evaluation interviews. Details outlining this study's recruitment process, the eligibility criteria and the procedures followed will be drawn out below.

Phase One

The focus group participants were recruited by the project staff from the SAMRC in Delft. Two SAMRC staff members were trained in administering the screening protocol who made use of community-based outreach methods, guided by a community member. This community member helped with the identification of potential participants. The project staff approached caregivers in the community and asked them if they were willing to answer a few questions. Caregivers were eligible to participate in the study if: 1) they were the main caregivers or parents of an adolescent between the ages of 13 and 17; 2) they knew that the adolescent currently misused drugs and or alcohol, 3) their child was not involved in any other services for their substance use and its associated problems at the time; 4) they resided in the community of interest; 5) they gave informed consent to take part in the study, and 6) they were willing to participate in English peer group discussions. For those who met the criteria and were willing to participate, they were told about what their participation would entail, given information about the study site and were asked to provide their contact details. On the day of the group discussions, the participants were rescreened by the project staff to confirm their eligibility to participate.

Initially, I planned to have about up to 30 caregivers, at most 10 per group, for Phase One of the study. The size of each focus group was ascertained after the participants were rescreened to verify their eligibility on the day of the focus group. Although 28 participants were eligible to participate overall, there were 21 female focus group participants because the other seven had either lost interest or were unavailable on the day. Nineteen were mothers and two were grandmothers, some of whom were also fostering an adolescent who misused substances.

Focus group discussions. Focus groups are a commonly used qualitative data collection method worldwide (Lambert & Loiselle, 2008). They are prized for their ability to depict what transpires in the interactions between participants, highlighting how they collectively make sense of various phenomena (Wilkinson, 1999; Wilkinson, Joffe, & Yardley, 2004). This method also captures the day-to-day means of communication and interactions that exist within communities (Wilkinson, 1999). Investigators bring participants together on the basis of either existing systems or for having similar experiences (such as living with a substance misusing relative), with the aim of deepening their understanding of the topic of enquiry (Stewart, Gill, Chadwick, & Treasure, 2008; Wilkinson, 1999).

By fostering a space in which all views are welcomed, researchers can take note of the way participants respond to what the others bring to the room (Wilkinson, 1999), making it a suitable technique for the study. It is likely that the emergence of similar experiences may alleviate some of the feelings of shame the caregivers may have, in turn enabling them to discuss their own experiences. This may also shed light on the nuances of their experiences as well, providing for a richer narrative.

The three semi-structured focus groups were comprised of some open-ended, explorative questions with probes to elicit conversation around the topic of interest (see Appendix A and B). Table 1 below details the size of each group and the participant's demographic information.

Table 1. Demographics for focus group discussion caregivers

Focus Group	Number of participants*	Age range (years)
1	6	28 - 75
2	7	
3	8	

* Of the 21 focus group participants one identified as Black, while the other 20 identified as Coloured (of mixed-race ancestry)

Most of the study's proceedings (which included the consent process and the group discussions) were carried out in English which meant that the language medium chosen could be understood by the participants (who came from a mixed community), the principal investigator for the pilot study (TC) and myself. When the participants would veer off in Afrikaans, they were gently reminded to speak in English. In the reflexivity section I will discuss the possible implications that this may have had on the study's findings. TC facilitated the group discussions while I observed the participant's interactions, and

occasionally contributed to the discussions by asking them to expand on and clarify some of the issues they had raised.

Procedures. Upon arrival at the site, the participants were provided with refreshments and given some time to settle. They were then handed two copies of the consent form: one was to be signed and handed back to the project staff and the other blank copy was to be taken home for future reference. The forms had information about the study details pertaining to their participation rights and the contact details of those they might need to call if any study related problems were to arise. Either TC or I read through the consent form with the participants, providing them with clear instructions about where their signature, full name or initials were required. During this process, the participants were informed that the session would be audio recorded and were also asked to consent to this. Once they had agreed to all the terms and were comfortable to proceed, the recorders were switched on and the discussions commenced.

During the group discussions, the participants, TC and I sat in a circle, thus creating an interactive space that encouraged open engagement between the different parties present (Wilkinson, 1999). All the procedures lasted between an hour to an hour and a half for each session, while the recorded part of the discussions ran between 50 to 76 minutes. The participants were provided with a grocery voucher valued at R150 at the end of each session and they were also transported to and from the site by project staff members.

Phase Two

The adolescents for this phase of the study were recruited using community-based outreach which was done by the MRC project staff and awareness of the study was raised through the placement of fliers at the Delft Matrix Clinic. The potential participants were screened and those who met the eligibility criteria and agreed to participate were given consent forms to take to their caregiver requesting permission for them and their caregiver to participate in the intervention. The adolescents needed to have met the following criteria: were attending school at the time of the intake; were misusing substances (which was measured using the Personal Experience Screening Questionnaire (PESQ); Carney, Myers, & Louw, 2016); were not receiving any other substance use and problem-oriented behaviour services; and were between the ages of 13 and 17 years. The main caregiver was required to consent to both their own and their child's participation before the adolescent could participate in any study related activities.

Post-evaluation interviews. Semi-structured interviews are the most frequently used qualitative tool (Diccio-Bloom & Crabtree, 2006; Wilkinson et al., 2004). Interview guides for such interviews are often comprised of several questions and associated probes that seek to gain meaningful responses which are left to the investigator to interpret (Diccio-Bloom & Crabtree, 2006; Wilkinson et al., 2004).

There are several advantages associated with this method. Firstly, their open-ended structure grants the participants the chance to respond to the topic under investigation by describing their own personal experiences; this allows the investigator to understand how meaning is made on a personal level (Wilkinson et al., 2004). Gill and colleagues (2008) also state that such interviews are flexible, which enables participants to expand on points that may not be possible with more limiting methods (such as structured interviews). They also allow researchers to make discoveries they might have otherwise overlooked if they had followed a stricter guide (Gill et al., 2008).

In keeping with the aims for this study, the interviews were used to verify whether the caregivers felt as though their needs had been met by the intervention (while remaining cognizant of the needs discussed by the Phase One caregivers, Appendix D). The interviews were also used to investigate whether there had been any changes in the parent-child dyad post their participation in the Intervention. I recruited five main caregivers and five adolescents ($n=10$). Table 2 below contains the interview participant's demographic information.

Table 2. Demographics for the interview participants

	Males	Females
Caregivers*	1	4
Adolescents	2	3

* The caregivers at this stage had the following relationship to the adolescent who received the intervention; aunts (2), grandmother (1), mother (1) and father (1)

Procedures. Given that the Phase Two caregivers were already part of the study (having taken part in the intervention), they did not undergo screening before their interviews and since data saturation was reached during the interviews I was not required to recruit more participants. The interviews were scheduled immediately after the participants' one-month follow-up sessions. Since I conducted them, I received training from TC prior to commencing to ensure that I was prepared for the sessions. TC guided me through the interview guide and

modelled how to phrase the questions in an open-ended manner, as well as probe for further responses.

The Phase Two participants were given refreshments when they arrived at the site. I then gave them a consent form which I read through in their presence and then guided them through signing (once they gave their informed consent to participate in the study). Shopping vouchers valued at R100 were given to the caregivers and adolescents at the end of their interview to compensate them for their time and express our gratitude for their participation. The interviews varied in length, with the longest one lasting 37 minutes.

Data analysis

The data collected from the focus groups and the individual interviews were analysed using the same method. Thereafter, template analysis was used to thematically analyse the study's findings (Brooks, McCluskey, Turley, & King, 2015). Traditionally, this is done by compiling a set of *a priori* themes, that is the themes that are expected to be seen within the data set. These are then placed in a template that is applied to some of the qualitative texts that are to be analysed (Brooks et al., 2015). Based on the preliminary findings of the analysis, changes are made to the template to make it better suited for the remaining data set. This final template is then used to analyse the rest of the data.

The study's initial template (with the *a priori* themes) was informed by the King and colleagues (2002) and Choate (2011) studies (Appendix E). The themes from these studies were combined, placed within the first template and indicated what to look out for and expect from my own findings. These two articles were selected because of their explicit focus on parent's needs in relation to their children's substance use. The study's emerging themes were identified, ranked and coded according to which results answered the research questions (Brooks et al., 2015). These findings were then compared to the *a priori* themes to identify any discrepancies between the original template and the needs that were raised by the participants which were then incorporated into the template.

Based on the literature review, the initial *a priori* themes were: communication skills; training spaces for parents; community awareness campaigns; explanations for the confidentiality upheld between therapist and adolescent clients; coping skills and workshops outlining differing parenting styles and the importance of discipline, regulation and limit-setting. The template was also informed by the Phase One group discussions, however, it was expected that the caregivers from the post-evaluation interviews would also have wanted staff to tell them their children's results as confidentiality may have been perceived as an alliance

between the staff and the adolescents. Generally, it was thought that the caregivers from the two Phases would discuss similar needs, so the same template was used for the interviews. Analysis of the focus group discussions led to the expansion of the study's expected themes which we felt would account for the findings from both Phases of my study.

Recordings from the focus group discussions were transcribed by myself, and the transcripts were reviewed independently by TC to assist with translating the Afrikaans verbatim, and to clarify what I could not hear. Two of the three transcripts were read closely several times to get a general sense of the needs, concerns and experiences of the caregivers in the sample. Thereafter, they were analysed and coded. With each transcript, I grouped together and highlighted the themes in a Word document (Hoeck & van Hal, 2012), using a different colour for each theme. Thereafter, I modified the initial template. The emergent themes from the first two focus groups were incorporated into the initial template and the *a priori* themes that did not seem to be applicable to this population group were discarded. This modified template was then used to analyse the last transcript.

The individual interviews were transcribed by field staff from the SAMRC who did not conduct the interviews. For these transcripts, TC and I coded the first eight separately, then discussed our findings. Again, I went through the texts and highlighted the sections that answered my study's questions. Our codes were similar, so I proceeded to code the final two transcripts and the write up commenced.

Although Phase One of this study sought to primarily identify the widely held needs of the participants from this community, it was noted that the caregivers frequently gave unsolicited responses about their feelings and the physiological effects that they often experienced. For that reason, a separate template was compiled to account for their feelings as they also seemed to reflect the participants' need for help in dealing with issues they experience as a result of their adolescent's substance misuse (Appendix F).

Ethical considerations

Ethics approval for this study was granted by the SAMRC Ethics Committee, (Appendix G) and the Faculty of Humanities Research Ethics Committee of the University of Cape Town.

Certain measures were taken to ensure the protection of the participants' rights. Firstly, the project staff and I were required to sign confidentiality agreements prior to engaging with any participants, in which we agreed to not disclose any participant information. Furthermore, confidentiality was upheld by keeping the files with the participants' contact details in a double-locked cabinet, separate from the files that contained

their study related information. On these files, each participant was assigned a client number in order to keep their identities separate from all the study's documents and findings. The participants' names were also removed from the transcripts (each of which were encrypted with a password), and they were assigned an identification code that was comprised of a few letter and numbers, and this enabled the anonymisation of the transcripts and recordings. Additionally, the recordings were stored in double-locked cabinets that only the project staff have access to for other study activities. Although the recordings were initially kept on a password-protected computer, once transcribed they were deleted. The caregivers and adolescents were asked to sign consent forms before participating, and both voluntary participation and 'internal' confidentiality (Saunders, Kitzinger, & Kitzinger, 2015) were re-emphasised during this process. Separate confidentiality forms were signed by the focus groups participants (refer to Appendix C) and it was also stated that the information shared in the group was not to be divulged outside of the session.

Generally, this was a low risk study; however, it was noted that some of the questions might evoke feelings of discomfort as they dealt with personal family matters that were often not openly discussed. To counter this, the participants were informed that they did not have to answer any questions that they were not comfortable with answering, told that they did not have to mention personal information and urged against discussing the content of the focus group discussions outside of the venue. Additionally, a list of referral services was made available to each focus group participant and the opportunity to have a one-on-one conversation at the end of the groups was offered.

In the long run, these participants are likely to benefit from the study as their responses may aid the development of interventions that are better suited to meeting the needs of caregivers in this and similar communities. Additionally, the hope remains that the intervention will contribute to reducing the rates of substance misuse amongst the adolescents in this community if it is shown to be feasible and implementable on a larger scale.

Summary

To summarize, this chapter discussed the contexts of both my study as well as the broader pilot study and outlined the data collection tools used at the different phases of my study. The focus group discussions provided a general idea of the caregiver needs, while the individual interviews enabled us to draw more on the unique experiences of the participants

to assess whether their needs had in fact been met by the intervention. The following chapter will report the study's findings.

CHAPTER 3: FINDINGS

In this chapter I will describe the themes that emerged from the analysis of the three focus group discussions which formed Phase One of the study. I will proceed to discuss the findings from Phase Two which were drawn from the individual post-evaluation interviews.

It is important to remain mindful of the context in which this study was located: a low-income community populated by similar numbers of Black African and Coloured inhabitants (which is uncommon in many parts of the country, particularly in Cape Town; Muyebe & Seekings, 2011). Accordingly, this highly integrated community serves as a prime location for many studies (Oldfield, 2004; Seekings, 2011), including this one. Given that the area is also characterised by high rates of crime, poverty and unemployment (Statistics South Africa, 2011; Watt et al., 2014), I anticipated that the participants' responses would also be informed by these issues. The caregivers represented in Phase One described the various issues they believed they needed; however, it was apparent that only a limited number of these issues could be addressed and met by an evidence-based brief intervention. The range of the participants' needs will be discussed with a view to what the intervention could seemingly assist with, while simultaneously highlighting the gaps that still exist for the caregivers in this community. These gaps will be discussed in detail in the following chapter.

The Caregivers' Self-Identified Needs (Phase One)

Six main themes were identified from the focus group discussions. The first was *access to knowledge about substance misuse* – where the participants discussed having limited access to what they perceived as necessary information. Second were *parenting skills* – here, the caregivers outlined some skills that they believed to be essential for improving the fulfilment of their roles in relation to their adolescents. *Sources of emotional support* formed the third theme in which the participants suggested ways of accessing assistance they thought would be useful for their emotional well-being. The fourth theme emerged through a strong narrative that came to be understood as the *desire to empower the female caregivers in the community*. *Financial issues* that have affected families' abilities to access basic needs and services was the fifth theme. The sixth and final theme impressed as a seemingly desperate call for a way to find *assistance for their substance misusing children without incurring legal consequences*. While some of the subthemes that emerged were in keeping with those that had been identified in the existing literature and were thus used to compilation of the original template, others did not.

It is worth noting that no single theory seemed to completely account for the study's Phase One findings. As earlier stated, Orford and colleagues (2010, 2013) SSCS model is used to consider such caregiver's (and substance users') experiences in non-stigmatizing and non-pathological ways. Additionally, principles from the Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner, 2001) and Maslow's hierarchy of needs (Maslow, 1954) were taken into consideration and used conceptually as organising frameworks. In this case Bronfenbrenner's Ecological model was used to organise caregivers' accounts in relation to the different systems at play in their lives—which spanned from their immediate environments to the wider systemic institutions and bodies found in their community (Bronfenbrenner, 2001). It was also important to consider how these various systems influenced each other. In terms of Maslow's hierarchy of needs, I looked at which of the needs were given precedence and how this in turn affected the participants' abilities to fulfil their role as caregivers.

Note that all quotations in this paper are presented verbatim and going forward, ellipsis '...' indicate prolonged silences or instances where the participant's voices trailed off, square brackets [...] are used in cases where certain aspects of the participant's speech were lapsed for brevity's sake, and round brackets () contain actions or assumed and translated phrases.

Access to knowledge

From the responses provided in two of the focus group discussions, the participants appeared to be concerned about how little some of the caregivers in the community seemed to know about substance misuse. They also wanted to know how to provide caregiving more efficiently. In one instance, participants reported the need for “awareness programmes” which were to include both caregivers and adolescents. A suggestion about the possible structure of such programmes and how often they should be held was made by one of the participants whose suggestion seemed to be based on her understanding of the nature of her adolescents' substance misuse:

Participant 4, Focus Group 3: Uhm, telling them about the drug abuse and the alcohol abuse. What's the dangers and the effects of it, and so forths and... Don't just do it once a month, try to do it twice a week, as regular.

Similar sentiments about a lack of knowledge were shared in Focus Group 2 when the participants were asked about which skills they thought they needed to help them deal with the challenging issues that they often face in relation to their adolescent's behaviour. The

following suggestion was put forth by one caregiver, “I think more education for the, for for, our parents.” (Participant 3, Focus Group 2).

It was further revealed that some of the participants had come to know about certain initiatives that had been implemented in the community to raise awareness. An example of such an initiative was the non-profit organisation (NPO), ‘Bounce Back’. Participant 2 (Focus Group 3) spoke highly about the NPO, stating that those who had attended had been enabled to “see how you can make a change in the community. They learn (teach) you how to, how to be that change actually.”

Although some awareness was shown by some of the participants, it seemed that the current initiatives are still severely lacking, and one the participants were under the impression that many caregivers in the community remain unreached and unknowledgeable about substance misuse and its consequences:

Participant 7, Focus Group 2: Even me, as I'm 50 years old but I don't know about drugs. I learn it now, now [...] that it's not something good for the kids. And we as parents, even I try at home. [...] So, we must help our kids.

Although it was inferred by some of the participants that the provision of awareness programmes would bring about desirable behavioural changes in the adolescents misusing substances in the community, the extant literature has shown that information alone has little, and in some cases, no effect on changing or preventing substance misuse or other health-related behaviours (Kelly & Barker, 2016; Thompson & Kumar, 2011). Possible explanations for this will be discussed in the following chapter.

The group discussions also shed light on some of the seemingly, widely held yet incorrect beliefs about substance misuse and the effects that they may have on the individual who misuses them. Some of the participants responses suggested that these misperceptions have been part of the community's views for decades, resulting in some caregivers responding with a lack of urgency to their adolescent's substance misuse. For instance, one of the commonly held beliefs about dagga² included the misperceptions that: “dagga is not a drug”, and that “dagga makes you clever.” This was reflected by some statements made in the Focus Group 2 discussion, such as:

² Dagga is one of the numerous names for cannabis that is used in South Africa. This range of names are a result of the country's heritage (du Plessis, Visser & Smit, 2013), where different population groups have come to use specific terms for the different drugs.

“The first myth about dagga was when, even when we (were) young and I think it started there, [...] and that became a innocent thing. So, that’s why we as parents never got serious about this because we started living the lie of the myth. [...] That was an open door in our generation [...]. Now we see the children we thought okay, it’s just experimenting, it’s just dagga, [...] but I think from there, we never thought that dagga will be a craving for something stronger. So, I also think it’s a lot of ignorance [...] We were never told the danger of that thing”.

To address this issue, it was suggested that the services of experts in substance misuse be employed in the community. Two participants in particular felt that experts would have the essential information required to inform the caregivers in the community about the adverse consequences that substance misuse, and inferred that they may even have the influence to make a difference:

Participant 6: If I would have known that, sit in a meeting and, and, and really call parents and say come in let us *call a(n) expert* in and say, come and really tell us man!”

Participant 2: Introduce us [...]. Tell (us) of what it’s about.
(Focus Group 2)

These responses implied that the participants come from a generally closed off community where the wrong information has been, and in some instances, continues to be circulated. Other statements were made that suggested this, for instance: “So you know, those type of things (like) information. Things are still being [...] its being, getting lost by the grapevine” and “They hear by word of mouth”. Notably, evidence of an ongoing oral culture in this community was also observed in the post-evaluation interviews. Even though it seems that this is a community that is perpetuating such information as a norm, the participants identified expert knowledge and intervention as a means of beginning to demystify the false impressions that are held and spread about substance misuse in this community.

Parenting skills

Across the three focus group discussions, the participants discussed several obstacles that they encounter on both an intra- and interpersonal level. Their challenges seemed to affect their parenting competencies, so I interpreted these responses as the need for varying skills which the caregivers regarded as necessary for effective parenting. Broadly, the subthemes encompassed the following skills: discipline, communication and the management of the psychophysiological reactions elicited by their adolescents’ substance misuse. In some instances, these needs were only implied.

The implementation of discipline. It was evident that many of the participants had strong opinions about the recent changes in legislation regarding discipline and corporal punishment. They seemed to perceive the removal of the defence for “reasonable chastisement” in homes by the High Court (“South African High Court”, 2017) as undermining of their power as caregivers. Although corporal punishment had already been banned in schools for many years (see s10(1) *South African Schools Act 84 of 1996*) it was an ongoing practice in many households, at times tending to physical abuse. Notably, the new court ruling left many of them feeling unsure about *how* else to discipline their adolescents. They expressed that they had not been provided with alternative disciplinary skills which in turn meant that many of the focus group caregivers were still convinced that corporal punishment remains the most effective means of discipline:

Participant 6: You don't feel you don't have a right. You know. And uh, parents doesn't know their rights anymore since the thing of 'you can't hit me' came in. That has all [...] taken a *big* chunk away.

Participant 3: It is! It is.

Participant 8: And they...it's like the children they know that we mustn't hit them.

Participant 6: So, they (are) using that as a weapon against us now

Participants: Ja!

Participant 3: Like one day, I did hit my boy. And he's like 'I'm going to the police station now because you did hit me.'

(Focus Group 2)

Despite the general support shown for the use of corporal punishment, there seemed to be some concern about the possible legal implications they could incur from making use of it. This emerged in a back-and-forth interaction between two mothers. One of them appeared willing to tell her daughter to leave home in order to maintain peace in her marriage, and for the sake of the safety of her younger children, while the other strongly disapproved; stating that doing so would equate “Sending the child right into the hands of the enemy” (Participant 7, Focus Group 3). The participants’ disapproval seemed to be founded on the sense of control she managed to maintain in her household through her use corporal punishment which the other participant did not have. The group was then asked what other methods caregivers are using to discipline their adolescents:

Participant 2: Swear (at them) because the cops can't come pick you up for swearing {laughs}. But if you, if you *beat them up*, you're going to jail.

Participant 7: Can I be honest? My son is 14. He's very bigger than me, but I ask him to bend. I ask him to bend and I whip him. [...] I've said to him if you should go and call the police, that's, then you tell the police to give you a home!' So, I tell him to bend over [...] and I give him as much as I feel is appropriate for him.

Participant 2: Ah, then *you must get a round of applause* (sarcastic laughter sarcastically). [...] I'm not prepared to go to jail because I have other children. I have small children that still needs me, so I'd rather just say 'There's the door! Go!' [...] but it's not the same. *You can say 'Bend down, let me give you a whipping'*. In my house you can't say that! Are you with me?!
(Focus Group 3).

The responses in the excerpt suggest that discipline is and continues to be perceived through punitive lenses by the caregivers in this community, which in turn alludes to a rather traditional understanding of discipline. Although caregivers are not allowed to use what they consider to be conventional forms of punishment, their need remains as caregivers are left wondering how else discipline can be instilled in their homes, as illustrated below:

“...we need to come back into the table with government. [...] They didn't structure punishment, they just taken it away. [...] How much has that take away our, *my* power as a mother?!”

She later said, “*Lots* of abuse came out because of punishment in, in homes and stuff but I think they need to bring it back but with a different frame [...] or just put something in place. How to hit your child, or give you a manner of doing it, but that needs to come back.”

(Participant 6, Focus Group 2)

Communication. Open communication with adolescents was identified as a crucial skill in Focus Group 2. When asked what the participants felt was required to be better caregivers, one of the first responses showed that communication was viewed as playing a profitable role that communication can play in offering guidance: “If there is a communication between you and your child, you can sit with your child, you can discuss problems. You, he can tell you what he wants or what he needs. *It's a most important thing in a household.*” (Participant 4, Focus Group 2).

Similarly, the responses from Focus Group 3 indicated that the participants also valued the role of communication. In this group, the participants were asked about how substance misuse affected their relationship with their child, with one caregiver stating, “Communication is also fading. There's no communication.” (Participant 5, Focus Group 3). However, some of the participants in this group also reported that they were unaware of any organisations or facilities in the community that were currently assisting caregivers with communication. In the following chapter, the gap filled by *RAD-PAL* in this regard will be highlighted.

Managing the psychophysiological domain. The participants in all three focus groups repetitively discussed feelings of intense emotional strain experienced by some of the caregivers that often affected their ability to moderate their own feelings towards their

adolescents. Although the participants were not explicitly asked about their feelings, unsolicited, these came across strongly in each group. An array of feelings and effects that emerged were stress, fear, anger, guilt, blame, hurt, loss, depression, hopelessness and embarrassment, verifying what has been found in both international (Orford et al., 2013; Smith & Estefan, 2014; Usher et al., 2007) and local studies (Groenewald & Bhana, 2015a). The reported feelings further illuminate the links drawn in the SSCS model between stress and strain, as well as the importance of investigating and attending to such caregiver's experiences (Groenewald, 2018). Some participants also reported experiencing physiological side effects that had at times required medical intervention:

Participant 1: Sometimes I can't sleep; I *sit* in the bed and I...I just talk with God and I get sick and then I lie like this! I feel my head goes like this... (dropped her gaze and held her head)
(Focus Group 1)

Participant 3: I said I end up in a trauma for, for, for my child. My sugar went (high)
(Focus Group 3)

In other instances, the intensity of these feelings sometimes resulted in caregivers saying things they later regretted : “And sometimes you you you you uhm, sommer (just as well), say stuff that you don't mean, like ‘You sommer (may as well) smoke you to death’, something like that, [...] sommer say to the child.” (Participant 1, Focus Group 3). Another participant expressed a similar degree of frustration and seeming hopelessness:

Participant 4: I, I can't even focus, I c-, I can't, really! [...] The other day I said to him, “I'm gonna pour boiled water in your sleep, in your ears! Gonna see, I'm gonna put boiled water in.” Because sometimes they, they can really provoke you that much, eish! [...] Stress and the depression and all this stuff. But you need to keep your post [...] But there just comes a day when you just crack and...ja.
(Focus Group 1)

The lack of access to healthy spaces in which to process strong, unprocessed feelings was shown. From the responses provided, it seemed that caregivers' ability to parent effectively, allot time for self-care or be uniquely attuned to their other children is often compromised. Many of the participants also had heightened levels of concern for their adolescents' well-being as they did not always know their whereabouts, which were exacerbated by the prominent levels of crime and violence found within the community:

We sit with a lot of anger that weakens us. And if we can have help to get rid of the anger, because the anger does weaken us. You know a seker (*certain*) taken away our mind sets of thinking... [...] we don't have patience because we are not...it's almost like because, so when do you get time for yourself?! So, we've been getting children, we've been through circumstances, we live in fear all the time when my child leaves the house. [...] when you hear a shooting, isn't it my child? Fear weakens us. [...] But you know, we (are) so full of anger we take that anger out on our children. (Participant 6, Focus Group 2).

While this theme was not in the original template, the participants' responses indicated that some caregivers were aware about how some of the feelings they often experience compromise their well-being and likely exceed what would be deemed acceptable if they were to be acted on.

Suggested sources for emotional support

The need for emotional assistance or 'an open ear' was shown by many participants who acknowledged the toll that their adolescent's substance misuse had on their emotions, as depicted in the following statement: "A shoulder to cry on... A shoulder to cry on. Even if it's just someone... Hopefully a stranger they can just pour their hearts out to." (Participant 2, Focus Group 3). Some of the attempts they had made to cope better with the effects of their adolescent's substance misuse emerged throughout the discussions.

Support groups. The value of coming together with other caregivers who share similar experiences to their own was highlighted in the discussions. In doing so, the participants felt that belonging to such communities could afford them the opportunity to learn about others in ways that help them to feel isolated in their experiences, while also drawing insight that may help them in their own homes. This is in keeping with the literature on 'communities of feeling' as they provide collective and mutual spaces for meaning-making through challenging circumstances, such as the death of a child (Riches & Dawson, 1996). One mother thought that caregivers would be better positioned to attend to the needs of their other children and family members after having their personal needs acknowledged and attended to, "So I will say yes. If we can have emotional help. Get more speaking about us. Where did I lose myself? What has happened [refers to herself]? I, nobody never spoke to me!" (Participant 6, Focus Group 2).

The empowering nature of discussing shared experiences was observed as one of the participants began to encourage the other caregivers to attend support groups as a source of emotional assistance: "It's like having like this groups and talking and everybody, and then maybe give advice to one another or something...this is what I do. Maybe that can help you."

(Participant 4, Focus Group 3). Similar findings were observed in a local study on the mothers of substance-dependent individuals, who also acknowledged that their ability to fulfil their occupational roles improved after discussing the emotional and psychological toll of their experiences (Wegner, Arend, Bassadien, Bismath, & Cross, 2014). However, it was also evident that the participants wanted frequent and ongoing help, and they sensed that there was a community obligation to provide meeting places for caregivers to gather as often as they deemed fit:

Participant 2: ... It's not enough. It's not enough. Because to...have the support group there and to see the parents like once a week, I mean, what is happening for the next 6 days? How is that parent going through the next 6 days?

T: Okay. So, more services...

Participant 2: More services.

T: ...are needed like, more regular services? What do the rest of you think about that?

Participant 2: Maybe home visits.

(Focus Group 3)

This was also seen in Focus Group 2:

Participant 6: Why is there no *visible* place? [...] Were there not supposed to be centres?! Were there not supposed to have been equipped with a counselling office, with a support group for parents?

The role of faith-based organisations. The centring role of religion was noted amongst the participants. In each group discussion, at least one participant referred to the church and their expectations of it as an institution, thus highlighting its' influential role for certain individuals in the community. This finding further reiterates what was observed by Wegner and colleagues (2014) in which church involvement and faith were considered anchoring rituals in some of the lives of such parents. However, some of the participants in this study felt that the church ought to be more involved, and more intentional about catering to the needs of this group of caregivers:

Participant 6: We've got big, big churches! Monday to Friday the doors are closed.
(Focus Group 2).

Participant 2: Can go speak to the churches, they must keep their doors open. At night we can go [starts chuckling] pray.
(Focus Group 3).

Even though Participant 2 laughed while making the above stated remark, she later said, "If you don't drink, you don't do drugs, you go to church.....you have family sessions,

stuff like that! What more do you need?!” This seemed to reveal that she believed church attendance had the potential to change behaviour. Similar perceptions were observed when another participant suggested that involvement in church activities such as Christian youth ministries would be helpful for adolescents struggling with substance misuse. While many of the participants seem to be utilising the church and whatever support groups they come by, caregivers’ support needs did not appear to be sufficiently catered for. It was important to note that the ongoing nature of the emotional challenges that caregivers undergo meant that their need for emotional support could not be solely met by their *RAD-PAL* session.

Empowerment for female caregivers

Substance misuse has a disempowering effect on whole families (Orford, Velleman, Copello, Templeton, & Ibanga, 2010). The caregivers either explicitly or implicitly spoke about how they felt that their experiences with their adolescent had robbed them of their ability to exercise authority in the home. One mother stated, “You know what?! We need to take back our parents’ uh, power. And that is where the first thing that our children manipulates.” (Participant 6, Focus Group 2).

Two other mothers further commented on how they felt it is the female caregivers in particular, who tend to grapple with feelings of inadequacy:

Participant 6: So, we need to be targeted and helped for saying ‘If I can strengthen the mother, the household will be strengthened.’ If I can give that mother, her *worth* back. (Focus Group 2)

Participant 4: We just, we just need our woman pride back. Sometimes the children and the circumstances make us also unworthy and that we are failures and...you know? That we... (whispers)
(Focus group 1)

The participants were asked whether caregivers in the community (who are predominantly female) are currently perceived as role models. Although some of them believed that mothers could be role models, they were under the impression that this ability had been challenged by the apparent gender-based disempowerment and inequality faced in their communities, which left them feeling that their ability (as female caregivers) to be influential in this regard, had been greatly diminished.

Financial concerns

Family level. As anticipated, monetary matters emerged as an area of great concern for the participants in all three focus group discussions. TC explored how the participants perceived and described a “perfect world”, the caregivers responded by saying:

Participant 5: Like the money can just rain! (Participants laugh)

Participant 7: So, you can have money, money, money...there can be enough of everything in the house.

Participant 5: Not (just) to feed them but...

Participant 6: Just to provide for (them).

Participant 5: Not things like bad habits... but (not) just to provide...

Participant 4: To provide for them.

(Focus Group 1)

With access to limited financial resources, the ability to cater for their family’s basic needs such as food in some cases, is difficult. Although the participants reported that many caregivers wanted to generate income for their families, there were limited or no employment opportunities in the community. Notably, the limited opportunities seen in this study were in keeping with the levels of deprivations also seen on a broader economical scale. A 2011 South African census showed that well over a third of those who qualified for the labour force from the Delft community were unemployed (41.33%; Studylib.net, 2013). The effects of unemployment are most directly experienced in the home environment, at times being used as an excuse for adolescent substance misuse and problem behaviour. As a result, the study found that unemployment was closely linked to feelings of disempowerment and vice versa:

Participant 4: What I meant by empowerment is...is like uhm, for me [...] come let’s talk about me, even as an individual [...] because my boys are using that as an excuse: "Ja mummy! Ons kom nie huis toe (*we are not coming home*).” If I can get a job, maybe to provide then I know they [...] can't tell me “daar was nie kos nie”, (*there wasn't any food*) [...] that's what I mean.

(Focus Group 1)

The participants also discussed how financial constraints affected their ability to access certain services that have been made available for families facing substance misuse related challenges, that is treatment or rehabilitation centres. This finding was in keeping with a trend seen in the 2012-2013 study conducted by the National Institute for Crime Prevention and the Reintegration of Offenders (NICRO) where both the ability to afford and access services that are available is greatly limited (Jules-Maquet, 2015). This reality was reflected

by Participant 2 who stated, "...at the end of the day, it cost *money* which the parents don't have." (Focus Group 3).

The financial issues raised by the study participants are suggestive of what is occurring on a larger scale within this area. Having limited access to financial resources was a running thread throughout all the focus groups, however, this is an example of a range of a demanding need that cannot be catered to by a brief intervention like '*RAD-PAL*'.

Community level resources. Comments made during the discussions further revealed that a degree of expectation that has been placed on the government. Specifically, one of the participants indicated that community members are looking to the government to play an active role in establishing options that would keep the children and adolescents in the community engaged in activities that keep them proactively engaged:

Participant 3: Maybe if the government can give more facilities for the kids. Maybe like a, like a community centres (or) stuff.
(Focus Group 3)

The caregivers also reported that they wanted help (from external sources) that would facilitate their ability to deter their children from participating in substance misuse. The participants stated that there were few facilities and activities in the community, and those that were available often fell outside of many caregivers' financial means:

Participant 4: There's, there's nothing for the parents to, to, to guide the children not to do wrong things. Because there is no... There is no community centres they can go to, to play freely, or there's no parks where they can go.
Participant 3: Because everything you must have to pay now!
(Focus Group 2)

Underlying the need for greater government involvement was the notion that a lack of prosocial activities leaves adolescents at a higher risk of getting involved in problem-type behaviours such as substance misuse. This was voiced by Participant 2 (Focus Group 3) who said, "And even if you ask the child, why d' you do this? They will say boredom. They bored!" Similar sentiments were expressed by one of the interview participants. One of the adolescent participants from Phase Two suggested futures interventions incorporate games in order to "take their mind off, like they have to go smoke dagga now. Like games just to make them busy." (Female Adolescent 2) Overall, these responses show why the government is expected to get more involved since many caregivers lack the necessary resources required to address the problem.

Alternative solutions to adolescent's involvement in the justice system

The caregivers discussed some of consequences following their adolescents being caught in possession of drugs. It was noted that some of the participants had contrasting views about police involvement and the justice system. For instance, some of the caregivers acknowledged that they wanted some form of legal assistance that would not result incur the repercussions associated with arrests, court appearances and convictions, such as criminal records. In this case, one mother said that caregivers wanted a structured space where these issues could be addressed:

Participant 6: ...But if I knew there was an advice office, no parents would like to take his child to jail! No parent would like to go and open a case. I don't wanna go there!

(Focus Group 2)

Another participant made similar remarks, but in this case suggested that the police collaborate with caregivers from the community to assist in deterring adolescents from substance misuse by explaining the possible consequences it could have on their present and futures lives:

Participant 2: I'm saying, if the police cooperate with parents, (it) will make a huge difference... They don't have to lock them up but at least come and talk to the child and tell him what is gonna happen if he continues to do [...] stuff like that.

(Focus Group, 3).

These responses seemed to be suggestive of a future hope that their adolescent would (one day) stop misusing substances. This was suggested by a caregiver who expressed her long-term fear namely, that incurring a criminal record (during a life stage that was hopefully experimental) is likely to hinder future prospects:

Participant 6: but everything is now a lot of our children being picked up *just for one dagga*. And then they have a criminal record. You go to court, *big big cases*, its gone! There's no reference of it, but when your child wants to go study, that child has gone through a different place. There that child sit with a criminal record.”

(Focus Group 2)

The annual report compiled by NICRO (2016) showed that nearly one fifth (18.1%) of all those implicated in justice system within the Western Cape were under the age of 18. Other NICRO statistics reported that 38.8% of all offenders who reported substance misuse

were unemployed at the time (Jules-Maquet, 2015). It has also been found that the challenges faced by released offenders stem from the harsh circumstances they are released into, that is, having limited skills in an economy where many are already competing for employment, academic opportunities are hard to come by and housing is seldom available (Singh, 2016). Consequently, there is a desperate need for help, however, it seems that many caregivers fear the legal repercussions.

By contrast, one mother reported that she had actively sought out police involvement to obtain protection against her son's aggressive outbursts. She was advised to get an interdict, which she did, as she felt that there were no alternatives. In this case, getting an interdict was perceived as the solution, indicating the lengths that certain caregivers are willing to go out of feeling helpless and frustrated:

Participant 7, Focus Group 3: You know when I found out that my son was aggressive, nè? (*you know what I mean?*) [...] I spoke to him and he don't want to listen. [...] So, I call the police, they said, no he's underage and whatsoever. [...] then he told me [...] you must go for the interdic(t). [...] So, we go to court and [...] that boy is very changed today in that house [...] He got manners. [...] That interdic(t) is *very important*.

Caregiver and Adolescent Post-Evaluation Interview Findings (Phase Two)

In this section, data is presented on which needs the brief intervention met, the caregivers' unmet expectations following the intervention and the changes that were fostered in the parent-child relationship.

Notably, some of the findings from the two phases concurred despite using independent methods and different sample groups, which was shown by the consensus needs that had promisingly been met by the intervention (with an independent group of participants). These were: knowledge-related matters, parental skills and the provision of emotional support. The findings also spoke to some of the financial issues that had been raised during Phase One.

Knowledge obtained

Some of the interview participants showed some satisfaction with the interventions' outcomes and expressed their gratitude when discussing how much they felt they and their adolescents had learnt from the intervention. For instance, Caregiver 4 (Female) reported that she was particularly appreciative of how the adolescent sessions had clearly defined the harmful effects and possible future implications of substance misuse: "yes they learn something about the drugs, and the dangers of the drugs." Similarly, Caregiver 2 (Female) said that her own session had enabled her to identify some of the symptoms associated with substance misuse which she had initially been unaware of: "There are things that I didn't know before. Like how can you see if your child is using drugs?" She later stated that her participation in the study also brought her granddaughter's patterns of substance misuse to her awareness:

Caregiver 1 (Female): I'm very glad to be part of the project because you as a parent doesn't know what your children's doing outside. You only know what your child is inside. And I'm so glad I could've find out what was happening to my child outside.

Another participant, Caregiver 3 (Female) (who was both an elderly aunt to one of the adolescent participants, and a grandmother to a number of other children) attributed her gratitude to what she described a generational gap that has resulted in the older generation being largely unaware of the common challenges currently being faced by the youth. She reported that the intervention was informational and had contributed to making her a better-suited caregiver to those in her care:

Caregiver 3 (Female): But I get something all the session I get something that shape me to pick up my grandchildren...ja (yah) to raise them. Because it's different now because everything has changed. I must change also, and I try and try to change. I'm changing. Yes.

It was noted that most of the interview participants explicitly reported that the intervention addressed some substance misuse knowledge gaps despite not being asked whether this was a need they had when coming for the intervention.

Parenting skills

One of the study's main goals for the caregiver session was to provide them with skills that they were encouraged to put into practice at home. Some of the participants' responses showed that they had gained insight that had been exposed to approaching their parenting from alternative angles. This was mainly evidenced in how they spoke about discipline and communication.

Alternative forms of implementing discipline. When discussing the intervention during one of the post-evaluation interviews, Caregiver 5 (Male) reported that he had attempted to exercise his parental agency differently:

Caregiver 5 (Male): I'm trying hard to do... I try to... *be strong*. If she asks me a question, I say "No you (you) can't, it's not right" or whatever and I give it to her then she... But *I'm trying to be stronger to let her understand* "No that is wrong and it stay wrong."

Another participant described a shift in how harshly she used to reprimand the children in her care:

Caregiver 1 (Female): I used to swear when I talk to them, *I used to do things very roughly*. So, I've said now, I've learnt them to be humble and to be disrespect... and to be respectful to one another so that we can...

Interviewer: talk, actually?

Caregiver 1 (Female): Yes.

These findings show that the intervention offered the caregivers alternative disciplinary practices, and when adopted, helped them to exercise less harsh parenting practices which included limit setting and disciplining after feelings of anger had subsided. It is likely that both methods may not have been considered as options of discipline prior to the intervention.

Communication. Communication was discussed as an area which many caregivers felt they lacked skill in. During the interviews, two participants reported that they acquired

better communication skills from their intervention session. They reported that that had also actively attempted to practice these skills at home post the intervention. This was seen in Caregiver 1 and 3's statements:

Caregiver 1 (Female): I also learnt how to..., how to..., how to, uh, express myself. I was also a person who never want to talk, I keep things for myself but now I can praat (*talk*) on.

Caregiver 3 (Female): I give myself time first to talk with [nephew's name] about the drugs and everything. [...] They taught me how must I start to talk to him.

Provision of emotional support

Only one Caregiver explicitly reported that their need for emotional support had partially been met by the intervention, while the rest of the participants emphasised their ongoing need for (longer-term) emotional support, for instance:

Caregiver 2 (Female): there's a lot of people who are having some of the problems. [...] I think you're supposed to make a plan. Tell us on Saturday "I will call you guys from 1 o'clock until half past one, two we're gonna talk about these things." I'd like to do that.

The interviewees' subconscious expectations versus their voiced (unmet) needs

The interview participants caregivers were each asked whether they felt some of their expectations were not met, and aside from their direct answers given to this question, I noted when they either explicitly or implicitly hinted at some unmet expectation or disappointment. Interestingly, four of the five caregivers initially indicated that they had come for the intervention with no expectations. However, Caregiver 4 (Female) reported that she felt she did "get something" from the intervention. It seems that her response was given to counter the notion that she had left her session feeling like there were things that she had hoped for but had not received. In the same way, Caregiver 1 (Female) also expressed similar sentiments: "No, there was nothing that I didn't get whenever I came. Whatever I brought up here, I walked out with something. Even if it's a, a, whatever, I walk out with something." By contrast, Caregiver 5's (Male) initial response revealed that he had come with expectations, but later recanted his statement and reported no expectations:

Caregiver 5 (Male): ...maybe if I can say... (the) people can maybe, I don't say they have to or they must, if they maybe can... say "Okay [...] there is people you can go to, to find better job or maybe get a better skill to do better work [...] that should be

more helpful. Then you can go to your boss, “Okay, it’s not to say I don’t want to do your work *but now you can’t force me to do it.*”

Some of the broader socioeconomic factors emerged in his response as it was clear that he had come hoping for a referral or skills that could help him to qualify for a better paying job, despite concluding: “*I didn’t expect (anything) the only thing, the better thing they give you is [...] a better knowledge to think about in the future to say how to get... how you can handle anything.*”

Although Caregiver 3 (Female) also said that she did not have any expectations, she (and some of the other participants) spoke about the vouchers, the refreshments that were provided and the clothing donations they received from the project staff. It was interesting to observe the exact moments that these comments emerged during the interviews. The refreshments and vouchers (which were aspects that were not related to the intervention itself) were often discussed when the participants were asked about what they had found most helpful about the intervention:

Caregiver 5 (Male): *The nicest thing* was when, like the last session when I come, the lady was so open to say “Okay, you can maybe have pair of shoes” and everything because whenever they can give you something which means it makes, make you happy as well.

Caregiver 1 (Female): No, the programme was very helpful up til, til now. Up til today, when I sat, I can smile I can take to Shoprite my voucher and I can buy for my children something to eat. I can provide for them on the, on the table.

What became evident is how the participants’ material needs tended to overshadow the others needs they had, which is in keeping with Maslow’s hierarchy which stipulates that the physiological and safety needs, namely man’s most basic needs, must be addressed before consideration can be given to the more ‘luxurious’ needs (Maslow, 1954).

Changes in the parent/caregiver-child dyad

Regarding the caregiver and child bond, I was particularly interested in tracking the relational engagements that followed the intervention so, I drew from both the adolescents’ and caregivers’ interviews. Changes were reported in a few ways, some of which were identified as areas of need during the group discussions, and later as met needs by the interview participants.

All but one of the Phase Two participants reported that their relationships with their child or their caregiver had undergone some general positive changes. However, it was noted

that some of the participants had reported having generally good relationships even prior to their participation in the intervention. Accordingly, the changes seemed more significant for only some of the participants. One adolescent reported that her relationship with her father had initially been highly conflictual; reporting that she moved back to his house after the intervention. Prior to that she would only visit for brief periods at a time.

Other positive relational changes were noted throughout the different interviews:

Caregiver 3 (Female): I see the change, I see the change! [...] the old boy is gone!

Male Adolescent 2: Before I came here, we will - when I told her that I have a substance problem my grandmother did - I feel like - didn't see me as that child anymore. But now (...) we are back like the old days.

It is worth noting that the most frequently reported changes were in communication, with six participants reporting one of two things. Either, that there was an increase in the frequency of their communication or, that there had been an evident ease in their ability openly express themselves:

Caregiver 4 (Female): ...it's easy to communicate with the child and talk to a child, talk that this one I don't want it.

Caregiver 1 (Female): I could've just stared at my child and I didn't say anything, and then afterwards³ I try to convince her to speak to me so then we can be open-ended to one another.

Female Adolescent 3: ja and now ever since I started the sessions I'm not scared to speak to my mother, I feel free. Before I used to be scared. I didn't even sit with her and chat – we chat. But now we are – I can chat I sit with my mother and chat. Yabo? (*You see!*) So that's it.

Although the study did not necessarily endeavour to include real-world parent-child dyads because of the time period in which the study could be completed, in addition to the random selection of the post-evaluation interviews. However, the study had two dyads, a mother and daughter, as well as a father and his daughter. A striking finding was observed between one of these two dyads whose accounts about improved communication corroborated the other's despite being interviewed at least one week apart. Similar findings were also noted between the study's second dyad, with the adolescent reporting that “me and

³ Here, “afterwards” meant after participating in the intervention.

my daddy start to talk” (Female Adolescent 2), while her father also described his newfound ability to talk to his daughter as one of the skills he had learnt during his session. He further expressed his appreciation for his intervention session which modelled ways of communicating as he felt that the ways caregivers relate with their adolescents are a replication or enactment of those that existed between themselves and their own parents:

Caregiver 5 (Male): I can’t be open to talk to my mother [...] I would like if my mother was here.

Responses provided by one study’s second dyad also showed that the intervention sessions highlighted areas for both parties to consider and work on. Caregiver 5 (Male) said “She tries to listen, yes, but she wasn’t like that before but now she tries to listen...”.

Correspondingly, when asked which activities she found most helpful, his daughter stated:

Female Adolescent 2: Then I just try stuff at first (that) I didn’t do but then I tell her I did, and it worked. Me and my daddy now have a(n) open relationship, he understands me now and I must try to understand him when he say “no” because every time he say no I say “You always say no, no, no.” But now I understand why he had to say no.

Outside of the dyads, two caregivers further reported that their children had become more respectful, and while I had not seen any of their adolescents, some of the adolescents who I did interview gave responses that corresponded with these reports; discussing what they used to do or how they used to speak to their caregiver:

Female Adolescent 2: Let me make an example. When he skel (*moan*) at me, I want to say something back (laughs) but then I just keep my mouth. But I never did that.

Considering the scale of the intervention, the changes reported in the parent-child relationship were rather substantial and warrant the exploration of these changes beyond a one-month follow-up session to investigate how sustainable changes brought about the intervention in a low-income setting can be.

Summary and chapter overview

In this chapter, I discussed the findings from the individual interviews in which I identified the needs that the brief intervention can meet and ways in which the parent-child relationship can be informed. The interviews revealed that the intervention was generally

informative, provided parenting skills that led to favourable outcomes in the parent-child relationship and provided caregivers with some much-needed emotional support. Table 3 below summarises the needs that were identified in the study, those which were subsequently met in Phase Two and those that remained unmet by the end of the study's proceedings.

Table 3: The needs reported and discussed by the study's caregivers

Reported needs – Themes (Phase One)	Reported needs – Sub-themes (Phase One)	Needs met by the intervention – Themes (Phase Two)	Needs met by the intervention – Sub-themes (Phase Two)	Needs beyond the scope of the intervention
1. Knowledge	-	1. Knowledge needs	-	Female empowerment
2. Parenting skills	<ul style="list-style-type: none"> • Communication • Discipline • Managing the psychophysiological 	2. Parenting skills	<ul style="list-style-type: none"> • Communication • Alternative forms of discipline 	Financial concerns
3. Emotional support	<ul style="list-style-type: none"> • Group support • Faith-based institutions 	3. Emotional support		Solutions for juvenile justice
4. Female empowerment	-			
5. Financial concerns	<ul style="list-style-type: none"> • Family level • Community level resources 			
6. Solutions for the justice system	-			

CHAPTER 4: DISCUSSION and CONCLUSION

The diverse caregiver needs identified in this study reflected some of the complex ways in which factors at the contextual and societal levels as well as inter- and intra-personal factors interact and impact on each other. This chapter discusses these interactions by illustrating the interlinked and co-dependent nature of the different needs that emerged. I begin with a discussion of the needs that were reportedly met by the brief intervention, followed by suggested preventative practices that may be implemented for at-risk adolescents. I then outline the needs that were raised but not addressed by RAD-PAL given that it is a brief, individual level intervention. For the findings that fell into this latter category, possible avenues for attending to these needs in future will be proposed. Under each section, I summarise the study's main finding and compare it to the existing literature. The chapter concludes with a discussion of the study's limitations, contributions and implications for both practice and future research.

Needs met by RAD-PAL

Knowledge

The need for information which was extensively expressed throughout both phases of the study reflected how the ability to access and attain knowledge is influenced by broader factors, such as the way in which information is obtained and shared in the community. Most of the caregivers from both phases shared similar views in that they felt that there was a general lack of adequate knowledge about the effects of substance misuse and its symptoms. This lack was further highlighted in the discussions about the drug myths that have circulated in the community, specifically the notion that cannabis is harmless. Interestingly, none of the interview participants discussed these myths. However, this finding is in keeping with the common misperceptions about cannabis that have been cited in the extant literature (Office of National Drug Control Policy, 2005; Selamu, Abreha, & Feyissa, 2017).

What seemed apparent was that the participants', and possibly even the community members', perceptions had contributed to the social norms associated with cannabis use, with some of the caregivers reporting their own cannabis use in their younger years due to similar misperceptions. This is indicative of the direct impact that contexts have on which information gets disseminated within them. Such characteristics are common to 'disorganised communities', in line with 'social organisation theory' (Sampson, 1992). The theory posits that certain characteristics weaken community cohesion that then leads to the development of different perceptions about what constitutes conventional behaviour; this results in the

inability to establish shared values, and may facilitate the spread of inappropriate norms such as condoning the use of cannabis (Sampson, 1992; Warner, 2003). It is possible that similar characteristics have contributed to the various attitudes and misperceptions about cannabis use in this community which suggests that the community-wide provision of education on cannabis and its effects would be beneficial.

Although most of the Phase Two participants felt they had gained information about substance misuse from the intervention, some still reported the need to know more. This seemed to be underpinned by the assumption that ‘common sense and knowledge’ are required to change behaviour, which was shown by many participants’ repetitive comments about their conviction that individuals would act differently once they knew more. Similarly, Kelly and Barker (2016) indicated that people tend to misleadingly believe that information alone can change behaviour. This stance is erroneous as it overlooks the challenges associated with what has become normative behaviour, as well as the ongoing support required to sustain the efforts to make these changes (Kelly & Barker, 2016).

The knowledge-related changes after participating in the intervention (*RAD-PAL*) warrant the investigation of the longer-term sustainability of such changes since these positive findings were observed, despite the small number of participants.

Parenting skills and the parent-child relationship

Discipline. Discipline practices reported by the participants had been seemingly informed by intergenerational and cultural factors, as most of the caregivers were found to adhere to the use of corporal punishment which their own parents had used in their earlier years. Similar findings have been reported in international literature (Bailey, Hill, Oesterle, & Hawkins, 2009; Gershoff, 2010). The use of corporal punishment by the study’s participants seemed to be reinforced by the apparent and widespread acceptance of corporal punishment as normative for these families in this economically disadvantaged community. In the U.S. context, parents with similar backgrounds were more likely to use physical discipline (Pinderhughes, Dodge, Zelli, Bates, & Pettit, 2000), as was the case in a study conducted on 24 developing countries, where discipline practices were also found to be related to being economically disadvantaged (Lansford & Deater-Deckard, 2012). Internationally, caregivers from lower socioeconomic contexts were more inclined to use corporal punishment because of a particularly strong belief in the value and necessity of corporal punishment (Ispra & Halgunseth, 2004; Straus, 2010) which was often exacerbated by their experiences of immense stress (Pinderhughes et al., 2000). Within the study, one of the salient findings were

the caregivers' high levels of stress. While some of participants had strong convictions about the use of corporal punishment, a notable number showed a willingness to learn alternative methods if these were provided.

Notably, many of the caregivers seemed generally unaware of alternative disciplinary approaches, corroborating what has been reported in other local studies (Breen, Daniels, & Tomlinson, 2015; Dawes, De Sas Kropiwnicki, Kafaar, & Richter, 2005). This was partially attributed to the low levels of education found in certain areas (Dawes, et al., 2005). The need to ensure that caregivers are taught alternative practices has been demonstrated, giving emphasis to low-income individuals because of the effects that structural factors (such as poverty) have in shaping disciplinary practices (Dietz, 2000; Halpenny, Nixon, & Watson, 2010). It was therefore unsurprising that the Phase One participants reported that they felt stuck in a society that had "taken away" the only means they had perceived to be an effective discipline tool.

Favourably, the interview participants felt they were able to use the alternative disciplinary strategies taught in their intervention session at the one-month follow-up mark. This finding holds promise for *RAD-PAL* as a means of beginning to shift caregivers' perceptions and approaches to discipline in this low-income setting. The participants reported their newfound ability to monitor their adolescents' behaviour as well as set limits and goals, which is in keeping with one of the original interventions' principle aims (Piehler & Winters, 2017; Winters, Fahnhorst, Botzet, Lee, & Lalone, 2012).

Communication. The intervention provided caregivers and their adolescents with communication skills that contributed to improvements in the parent-child relationship. Not only had the intervention's aim to improve communication skills between family members been evidenced at follow-up (Piehler & Winters, 2017), the intervention had also provided a service that was identified by the Phase One participants as one that was necessary but previously unavailable. Promisingly, these improvements were reported by both the adolescent and adult participants alike.

Taken together, the changes seen in the parent-child relationship suggest that *RAD-PAL* offers a step in the right direction for caregivers in low-income communities like Delft. The substance misuse risk factors associated with corporal punishment and poor communication in the study were lowered and replaced with skills that seemed to foster a better relationship. Considering these findings alongside the factors that have seemingly normalised the practice of corporal punishment, bringing about positive changes that are maintained over time in relational practices may require multiple initiatives that offer

opportunities to consolidate new practices (Nation et al., 2003; Wandersman et al., 1998). Although this would be beyond the scope of this brief intervention, the changes found in the study warrant further exploration in the future.

Emotional support

Most of the participants reported overwhelming feelings that often compromised their mental, and sometimes physical, health. Notably, the participants were being affected by more than their adolescents' behaviour, with unemployment, gender discrimination and the presence of gangsterism and violence in the community further exacerbating the state of their wellbeing. This is in keeping with studies that have shown that the high rates of HIV/AIDS, socioeconomic inequality, and violence contribute to the country's high incidence of mental health problems (Burns, 2011; Mellins et al., 2017).

Many of the participants felt supported and therapeutically assisted by the intervention. This was an interesting finding as the *RAD-PAL* caregiver session was not necessarily aimed at providing a therapeutic service. However, it was evident that the participants experienced the session as a holding space, suggesting that spaces in which such caregivers can feel seen and attended to offers some emotional relief and support. This finding concurs with the SSCS model (Groenewald, 2018; Orford et al., 2010; 2013) in that the study's participants were able to draw support in a space that fostered the opportunity for the participants to share their experiences, and possibly draw strength from one another. What remained important for these participants, and likely for caregivers in similar positions, is the quality of the support they receive and their ability to cope with their experiences going forward. A similar finding was made in an international study where participation in a brief parenting programme helped the participants consider their various needs and establish connections with other caregivers, which in turn afforded them solidarity and the opportunity to form ongoing bonds that facilitated better coping (Toumbourou et al., 2001).

This finding further illustrated the evident need for emotional and mental support beyond the duration of the intervention, also making the need for mental health practitioners and other service providers apparent. This need was also observed in a study which sought to provide an intervention designed to help family members cope with their relatives substance misuse, but there too, the necessity of ensuring that such needs do not continue to be neglected was highlighted (Orford et al., 2013). Even though poor mental health has been found to make considerable contributions to the global burden of disease (Vigo, Thornicroft, & Atun, 2016), there are gaps between the demand and supply of suitable services and

qualified personnel: with the most pronounced shortages reflected in peri-urban settlements like Delft, (Mellins et al., 2017) and other rural locations in LMICs (Burns, 2011; Vergunst, 2018).

Services offered by lay counsellors have been found to lower mental health issues amongst HIV infected individuals (Petersen, Hanass Hancock, Bhana, & Govender, 2014). It is possible that lay counsellors may well be a useful resource for caregivers who face other issues, such as raising a child who misuses substances. Task-shifting seeks to bridge this mental health service gap (Sibeko et al., 2018) by equipping lay counsellors with skills (inclusive of learning how to be non-judgemental and work collaboratively) and training them to facilitate support groups for caregivers in the community. However, it is important to remain mindful of the social factors that are encountered by community members (which will likely continue to affect their wellbeing, Thurman, Kidman, & Taylor, 2014), as well as the remuneration, supervision and support needed for the service providers (Sanjana et al., 2009). The limited resources available in Delft and similar communities may make it difficult to attend to the needs of all parties, nonetheless, past evidence suggests that the benefits warrant the investment (Petersen et al., 2014).

Possible Prevention Practices and Alternatives Options

Introducing prosocial activities

While the study's findings showed promising results in the adolescents' reported substance misuse, it was often still perceived as an enjoyable pastime, suggesting that social norms and limited pro-social activities available in the community have aggravated the present rates of substance misuse in the community. 'Boredom' and limited engaging activities were given as possible explanations for the prevalence rates by the participants. Although this finding cannot be generalised, it is possible that substance misuse has been perpetuated and entrenched in areas that happen to be populated by specific race groups, again illuminating some of the ongoing impacts of the Apartheid era. This has also been observed in other studies, where higher levels of boredom amongst Black and Coloured adolescents tended to stem from living in low-resourced communities, which are often stimulation deficient (Wegner, 2011; Wegner, Flisher, Muller & Lombard, 2006; Weybright, Caldwell, Ram, Smith, & Wegner, 2015), also as a result of the spatial effects of Apartheid. This finding further highlights the link between poverty and the development of substance misusing behaviour. A similar link has been reported in the literature (Kalichman et al.,

2006). In this study, the effects of poverty on infrastructure were inclusive of but not limited to the lack of recreational spaces.

Although adolescent substance misuse was largely regarded as an area of concern amongst the study's participants, it was also depicted as a conventional, yet not necessarily healthy, pastime for many of the adolescents, and even the caregivers in the community. Weybright, Caldwell, Ram, Smith and Wegner (2016) showed that 'healthy leisure' is principally a social construct and suggested that community members can define and model healthier pastime activities which can be replicated by the adolescents in the community. It is therefore a research imperative to investigate the perceptions that have contributed to normative behaviour. In addition to the need to make prosocial activities available, it is necessary to shift what seems to be the societal condoning of substance misuse as a means of socialising.

Consideration ought to be given here to whether boredom and limited stimulating activities are the main factors fuelling this problem-behaviour in the area. A better understanding of what constitutes normative pastime behaviours may provide a stepping-stone towards helpful responses, whether this will entail making enjoyable and stimulating activities accessible or the development of educational programmes that will address community perceptions from an ecological perspective. At present, the South African National Sport and Recreation Plan (NSRP) outlines long-term goals for sports and recreation in the country (Department of Sport and Recreation, 2012), which corroborates the literature that has shown positive substance misuse findings when sport is used to curb this behaviour (Naidoo, Mangoma-Chaurura, Khan, Canham, & Malope-Rwodzi, 2016; Pauperio, Corte-Real, Dias & Fonseca, 2012).

Juvenile justice & diversion programmes

While the adolescents' behaviours were a cause for concern for the study's caregivers, they were hopeful that the substance misuse was a temporary and experimental phase. As a result, they feared that coming into conflict with the police and juvenile justice system because of their problems with substance misuse meant that their children's prospects of having bright futures would be hindered. Evidence supports this fear since convictions have been found to have long-standing and highly restrictive consequences (Singh, 2016).

By contrast, feelings of desperation and hopelessness meant that some of the participants were willing to involve the police and, in some instances, go to court to get interdicts against their children to help stop their substance misuse. Similar evidence has been

reported in studies where parents asked the police to speak to their children in the hopes that it would alter their behaviour (Thesnaar, 2011; Usher et al., 2007), although this was sometimes done reluctantly (Groenewald & Bhana, 2015a).

Irrespective of which stance the study's caregivers held, what remained consistent in their discussions was the need for some form of assistance with their adolescent. A South-African based prevention intervention, NICRO's '*safety ambassador program*' might be a possible preventative avenue. This peer-led initiative is administered in schools located in high-risk areas and is aimed at averting crimes from being committed on school premises by identifying at-risk peers, as well as advising them against a life of crime and participating in anti-social behaviour (NICRO, 2016). NICRO's annual report (2016) indicated the initiative had been successfully implemented in 17 schools. However, I did not find reviews or comparison studies on the interventions' outcomes (be it between different groups of adolescents or over a long period of time), and so there is need for rigorous, longitudinal and evidence-based investigation before it can be considered to have evidence of effectiveness (Mutongwizo, Leoschut, & Burton, 2015).

Diversion programmes are another approach that can be used for adolescents who misuse substances and run the risk of coming into conflict with the law, since they offer services that also addressed the need identified in Phase One for alternative solutions to adolescent's involvement in the justice system. Again, there appear to be few alternatives, and even fewer that are evidence-based, so this too needs urgent attention (van der Merwe & Dawes, 2012)

There is a general need for a policy shift that cannot be overlooked. Without the implications of being involved in gangsterism becoming more stringent, and drugs becoming less available, the long-term consequences of substance misuse may well continue to be dismissed. Ultimately, there are no shortcuts to meeting this need, but the literature does suggest several ways in which the needs of caregivers and their adolescents could be met.

The Broader Scale Needs of Caregivers

Disempowerment and the intersections of gender and class

Many focus group participants revealed that the caregivers in the community often felt disempowered by their adolescents' behaviour. Although there was only one male caregiver in the study, the traditional perception of females being the primary caregiver seemed to shine through as it was female participants who voiced the need for empowerment. In light of the wealth of evidence about the gender inequality seen in South Africa (Patel,

Knijn, & van Wel, 2015; de Wet & Parker, 2014) it was not entirely surprising that the challenges with childrearing that emerged seemed to be gendered. The participants' comments about feelings of 'failure' and a lost sense of 'worth' alluded to the notion that successful childrearing, which is epitomised by "well-behaved children", is largely the mother's responsibility. From this perspective, blame for problems with adolescent substance misuse are often pinned on female caregivers. This has also been observed in local and international literature (Groenewald & Bhana, 2017; Jackson & Mannix, 2004).

Consequently, special attention ought to be paid to female caregivers because of the social expectations that have been placed on them (Smith & Estefan, 2014). Although researchers have also shown that fathers also feel undermined by their adolescent's substance misuse (Barnard, 2005; Orford et al., 2010), an emphasis on empowerment of female caregivers may be particularly important in South Africa: for instance, where well over one third of Delft's households are reportedly female-headed homes (43.3%; Statistics South Africa, 2011).

The participants who addressed the topic of female empowerment also represented a particular social class. Intersectionality theory posits that the constructions of gender, class and race have social implications that intersect in complex ways that neither of these constructs ought to be considered in isolation (Crenshaw, 1994). Furthermore, poverty and its associated experiences are informed by race and gender (such as women of colour) and class (that is low socioeconomic status, Crenshaw, 1994). All these intersections were seen and implicated in this study. A recent local study showed that poverty continues to be experienced in ways that are prejudiced against women in post-Apartheid South Africa, confirming the gendered experiences of poverty that women face (Posel & Rogan, 2012). In order to make strides towards empowering women, Kabeer (1999) stated that notable shifts need to occur on individual and structural levels as they are equally dependent on each other and fundamental for the attainment of empowerment.

Support groups and 'safe spaces' have been shown to provide HIV infected women (Mundell, Visser, Makin, Forsyth, & Sikkema, 2012) and female teachers, carers and mothers (de Wet & Parker, 2014) with spaces in which a sense of empowerment is fostered through collective meaning making. Even though these studies were not conducted with female caregivers of substance misusing adolescents, the findings suggest that it is worth exploring the benefits of providing support groups for such women in these communities (Hoeck & van Hal, 2012). Overall, female caregivers need support that will help them separate their adolescent's substance misuse from their notions of what define 'successful' parenting. Here, the SSCS model would first assist caregivers to rid themselves of self-blame while also

providing them with the support that such caregivers so desperately need to help them cope (Orford et al., 2013). Accordingly, future research, local organisations, mental health practitioners and lay counsellors ought to consider these factors, holding in mind the ways poverty and gender continue to interact and impact the lives of women in such contexts.

Reflexivity

Berger (2015) defines reflexivity as the researcher's critical confrontation of their "situatedness", coupled with an awareness of the effects that their positionality might have on the research process. Additionally, it requires researchers to be cognisant of the influence that their position may have on how the questions are framed, how the data is collected and analysed, and on the space that they and the participants occupy during the research process (Berger, 2015). In light of this, it is necessary to consider how reflexivity impacts all stages of any qualitative study (Kacem & Chaitin, 2006).

During the formative phase of the study (Phase One), I had not critically considered what my position as a (young), foreign, black, middle class and educated woman may have had on the research process. However, I noted that the participants seemed to be consciously aware of TC's race (i.e., White) and I reflected on how this in turn may have informed some of the assumptions they held. Their conscious awareness can be illustrated by the following comment:

Participant 2: My eldest son, [his name], okay he turned 52 no. He said 'Mama, I think you made a very big mistake to get married again. We *had* such a wonderful Papa, and this papa is *too white for us*. He's...he's like you (gesturing at TC). He's white... (Participants chuckle)
(Focus Group 1)

From this statement, there seemed to be notable racial assumptions and beliefs amongst the participants. In making use of the pronoun 'us', it was suggested that those who do not look like them are 'othered', which seems to be in keeping with the country's Apartheid history. This othering may give rise to the anticipation that the challenges encountered within this community may not be understood by those who do not look like them. Overall, the focus group participants seemed to remain open about discussing their personal issues throughout their sessions. It is possible that this was enabled by the fact that there was a facilitator and co-facilitator (that is, TC and me) present in the sessions, which may have helped the participants to focus on the topics at hand as opposed to any racial

differences. My presence may have offered a connection point of sameness based on our similar racial grouping.

Since I was not accompanied by TC during the Phase Two interviews, I was more aware of my positionality. I was also made aware of the participants' perceptions of me as a young, black woman who had managed to escape the lifestyle and circumstances that many of the female adolescents in the communities are currently facing. I recorded reflexive notes during the interviews and took note of the things that were exchanged between the participants and myself before starting the recorders. I will now describe some of these instances.

There was a notable interplay between my nationality, race, class and (perceived) age in the room. Given that each participant had a follow-up assessment with an SAMRC staff member (who fluently spoke both English and isiXhosa and was conversant in Afrikaans), it became apparent, that many of the participants (who were predominantly Black African) struggled to make sense of my inability to speak isiXhosa (the local indigenous language) despite my race. This limitation at times meant that I was unable to understand the emotive responses the participants wanted to use. Retrospectively, this was also observed in the group discussions. It is possible that some of the nuances in participants' experiences may have been lost as a result of this because it has been shown that the language used on a day-to-day basis "carries the full range of human emotions" (Caldwell-Harris, 2014, p. 2). In spite of this, I attempted to use my clinical skills to empathically engage with the participants in these moments by expressing my awareness of the limitations they were facing in expressing themselves and I encouraged them to share their responses in whatever way they could manage.

By contrast, in an interview with one of the younger female adolescents (aged 14), I noted that my gender helped her experience a level of comfort and freedom with me, as she disclosed personal information despite being explicitly informed that the interview session solely sought to explore her experience of the intervention. After her interview, she asked me if I had a baby and was shocked when I said I did not. As we continued to talk, I became aware that she assumed that I lived in the community. She proceeded to note that many girls (who I assumed to primarily be of Black African descent) had babies early in adolescence. This participant said she thought I was 19 years old (which was a common assumption made by the other adolescents I had interviewed). These interactions seemed to make me more relatable which may have contributed to a more holistic depiction of the circumstances

commonly faced in a community rife with substances, poverty and limited opportunities that seem to disadvantage young females.

There are also a few things I observed as a clinical psychologist in training that are worth acknowledging. Despite my attempts to maintain a neutral stance in my interactions with the participants, I was particularly moved by the challenges experienced from raising an adolescent who misuses substances. Consequently, I was appreciative of the semi-structured guide of the interviews as it aided my ability to continually steer and gather the information that formed the foundation of my study.

Limitations and Suggestions for Future Research

The primary limitation of this study's design was that being qualitative meant it was conducted with a small number of caregivers and adolescents, and so the findings cannot be generalised because the participants may not be representative of all the caregivers in the community. However, the design did enable a detailed exploration of the caregivers' needs and a thorough discussion about what aspects of the intervention worked and did not work for them. Future studies may counter this by administering the intervention on a larger scale with other low-income caregivers from different areas in the region, eventually extending into other provinces, and studying the experiences of caregivers as that is done.

A second limitation that was most notable during the individual interviews was language. None of the participants was a first-language English speaker which meant that they really struggled to express themselves: sometimes even stating their desire to comment in the languages with which they felt most comfortable. This was, however, necessitated because I do not speak any local languages. As a result, it is possible that the study did not fully capture the full scope of the participant's experiences. In future, attempts should be made to confirm the formative findings and possibly even the adaptations in the most common indigenous languages to gain a more holistic understanding of caregivers' subjective experiences and needs.

The findings from the study, although only conducted on a small-scale and with a few individuals from the community, provided promising results. Firstly, caregivers have distinct needs, however, some of their needs may be met by their inclusion in adolescent substance misuse treatment interventions. Secondly, meeting these needs may be done through relatively low-cost interventions.

Practical Implications and Recommendations

Given the range of needs identified in the study and the interventions' limited capacity to address those needs, I will now suggest a number of approaches that can be adopted to bring about an eventual and more permanent shift in these caregivers' areas of concern. Firstly, psychosocial interventions can be developed and rolled-out to improve the mental health of parents and caregivers, alongside treatment interventions for adolescent substance misuse. Secondly, media campaigns may be used to raise community awareness regarding substance misuse. This would be done to begin the widespread demystification of myths about substance misuse using media campaigns, which are a cheap and easy means of reaching multitudes.

With regard to unemployment, researchers can explore the effectiveness of income-generating interventions for parents from low-resourced areas since poverty that has been shown to impinge upon their abilities to meet their most basic needs, and hence to affect their parenting. Such interventions should explore their potential to address poverty, to address parenting, and to address adolescent substance misuse. For instance, the programme Parenting for Lifelong Health for Adolescents focuses on parenting and includes some economic strengthening interventions and has been shown to reduce adolescent substance use (Cluver et al., 2017). Lastly, norms interventions to shift perceptions about the roles of women are sorely needed, and their implementation may improve the lives of caregivers.

In seeking to achieve shorter-term goals, religious institutions may play an instrumental role in attaining these aims. By collaborating with other stakeholders, religious sites can be used to offer a number of services which could be inclusive of: providing support groups for caregivers, at the very least by providing a venue for meetings, but also by electing individuals to be trained in basic psychosocial support by health and health staff (Sibeko et al., 2018). Trained individuals would offer caregivers with the psychological assistance they need. This could likely be sustained with relative ease as they would be accessing resources that are already established. Religious sites may also act as sites where accurate information about substance misuse and how to cope with it can be made available for the caregivers in the community. What remains key here is to utilise the available resources in a context where options are very limited.

Methodological and Theoretical Contributions

This study made a number of contributions. Firstly, intersectionality theory was used to illuminate the irrefutable impact that structural drivers, such as poverty, have on the lives

of the caregivers (especially the female caregivers) and of substance misusing adolescents in Delft on multiple levels (Shelton, Goldman, Emmons, Sorensen, & Allen, 2011). In doing this, the findings provide future researchers with a deepened understanding of some factors to remain cognisant of when seeking to intervene in the lives of populations that are impinged on by multiple structures, with each one requiring infiltration before sustainable changes can be derived.

Furthermore, making use of qualitative methods highlighted both individual and contextual level needs. This is significant as the use of semi-structured guides privileged the participants, thus allowing both caregivers and adolescents to provide information in *their* own voices. Accordingly, the study obtained insight into the experiences of mothers whose narratives have generally been privileged in the literature (Smith & Estefan, 2014), but has extended the scope of focus to include caregivers (who have proven to be an even greater under-researched group.)

Finally, the qualitative approach used enabled the generation of information that can be used to develop culturally appropriate interventions for caregivers who find themselves living with a substance misusing adolescent. Significantly, the generated information not only encourages participants' willingness to get involved, and it also improves future interventions' overall effectiveness (Lachman et al., 2016).

Concluding remarks

In this thesis, caregivers were provided with a platform to be involved in the adaptation of an intervention for adolescents who misuse substances. Their responses provided promising findings that proved to be mutually beneficial and insightful for the lives of caregivers and adolescents, regarding adolescent substance misuse in low-income areas. Some of the various contextual and structural issues that impact caregivers' lives were also brought to light which provided information that can be used to strengthen interventions, making the information relevant to researchers, policy makers and to the field of psychology as a whole.

References

- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Arlington, VA: Author.
- Asante, K., O. & Lentoer, A., G. (2017). Use of crystal methamphetamine among male adolescents in Cape Town, South Africa: Caregivers' experiences. *Substance Abuse Treatment, Prevention and Policy*, 12(18). <https://doi.org/10.1186/s13011-017-0102-9>
- Bailey, J. A., Hill, K. G., Oesterle, S., & Hawkins, J. D. (2009). Parenting practices and problem behavior across three generations. *Developmental Psychology*, 45(5), 1214-1226. doi:10.1037/a0016129
- Barnard, M. (2005). *Drugs in the family: The impact on parents and siblings*. Glasgow: Joseph Rowntree Foundation.
- Berger, R. (2015). Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research*, 15(2), 219-234.
- Bisetto Pons, D., González Barrón, R., & Botella Guijarro, Á. (2016). Family-Based Intervention Program for Parents of Substance-Abusing Youth and Adolescents. *Journal of Addiction*, 2016, 1-8. doi: 10.1155/2016/4320720
- Branstetter, S. A., Low, S., & Furman, W. (2011). The influence of parents and friends on adolescent substance use: A multidimensional approach. *Journal of Substance Use*, 16(2), 150-160.
- Breen, A., Daniels, K., & Tomlinson, M. (2015). Children's experiences of corporal punishment: A qualitative study in an urban township of South Africa. *Child Abuse & Neglect*, 48, 131-139. doi:10.1016/j.chiabu.2015.04.022
- Bronfenbrenner, U. (2001). Ecological models of human development. In M. Gauvain & M. Cole (Eds.), *Readings on the development of children* (3rd ed., pp. 3-8). New York: Worth Publishers.
- Brooks, J., McCluskey, S., Turley, E., & King, N. (2015). The utility of template analysis in qualitative psychology research. *Qualitative Research in Psychology*, 12(2), 202–222.
- Burns, J., K. (2011). The mental health gap in South Africa – A human rights issue. *The Equal Rights Review*, 6, 99-113.
- Calafat, A., García, F., Juan, M., Becoña, E., & Fernández-Hermida, J. R. (2014). Which parenting style is more protective against adolescent substance use? Evidence within the European context. *Drug & Alcohol Dependence*, 138, 185-192.
- Caldwell-Harris, C. L. (2014). Emotionality differences between a native and foreign language: Theoretical implications. *Frontiers in Psychology*, 5, 1055.

- Carney, T., Chimbambo, V., Johnson, K., Louw, J., & Myers, B. (2019): The adaptation of an evidence-based brief intervention for substance-using adolescents and their caregivers, *Psychotherapy Research*, doi: 10.1080/10503307.2019.1656352
- Carney, T., Myers, B., & Louw, J. (2016). Reliability of the GAIN-SS, CRAFFT and PESQ screening instruments for substance use among South African adolescents. *South African Journal of Psychiatry*, 22(1).
- Carney, T., Myers, B. J., Louw, J., Lombard, C., & Flisher, A. J. (2013). The relationship between substance use and delinquency among high-school students in Cape Town, South Africa. *Journal of Adolescence*, 36(3), 447-455.
- Carr, A. (2016). *The Handbook of Child and Adolescent Clinical Psychology* (3rd ed.). Third Avenue, New York: Routledge.
- Castellanos-Ryan, N., O'Leary-Barrett, M., & Conrod, P., J. (2013). Substance-use in Childhood and Adolescence: A Brief Overview of Developmental Processes and their Clinical Implications. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, 22(1), 41–46.
- Choate, P., W. (2011). Adolescent addiction: What parents need? *Procedia – Social and Behavioural Sciences*, 30, 1359-1364.
- Choate, P., W. (2015). Adolescent alcoholism and drug addiction: The experience of parents. *Behavioural Sciences*, 5, 461-476.
- Cluver, L. D., Meinck, F., Steinert, J. I., Shenderovich, Y., Doubt, J., Herrero Romero, R., ... Gardner, F. (2018). Parenting for Lifelong Health: a pragmatic cluster randomised controlled trial of a non-commercialised parenting programme for adolescents and their families in South Africa. *BMJ global health*, 3(1), e000539. doi:10.1136/bmjgh-2017-000539
- Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009). The health and health system of South Africa: Historical roots of current public health challenges. *The Lancet*, 374(9692), 817-834.
- Chu, J., & Leino, A. (2017). Advancement in the maturing science of cultural adaptations of evidence-based interventions. *Journal of Consulting and Clinical Psychology*, 85(1), 45-57.
- Crenshaw, K., W. (1994). Mapping the margins: Intersectionality, identity politics, and violence against women of color. In M. A. Fineman & R. Mykitiuk (Eds.), *The public nature of private violence* (pp. 93-118). New York: Routledge.
- Dada, S., Burnhams, N., H., Erasmus, J., Lucas, W., Parry, C., Bhana, A., Pretorius, S.,

- Weimann, R., TB HIV CARE, Anova Health Institute, University of Pretoria & OUT Wellbeing. (2019). *Monitoring alcohol, tobacco and other drug abuse treatment admissions in South Africa*. Tygerberg, Cape Town: South African Medical Research Council. <https://www.samrc.ac.za/sites/default/files/attachments/2019-10-16/SACENDUFULLReportPhase45.pdf>
- Dawes, A., De Sas Kropiwnicki, Z., Kafaar, Z. & Richter, L. (2005). *Corporal punishment of children: A South African national survey*.
Department of Sport and Recreation. (2012). *National Sport and Recreation Plan*. Retrieved from https://www.westerncape.gov.za/assets/departments/cultural-affairs-sport/nsrp_final_august_2012.pdf
- Diccio-Bloom, B., & Crabtree, B., F. (2006). The qualitative research interview. *Medical Education*, 40(4), 314-321.
- Dietz, T. L. (2000). Disciplining children: Characteristics associated with the use of corporal punishment. *Child Abuse & Neglect*, 24(12), 1529-1542.
- Dwyer, S., C. & Buckle, J., L. (2009). The space between: on being an insider-outsider in qualitative research. *International Journal of Qualitative Methods*, 8(1), 54-63.
- Eagar, D., Cooke, R., Levin, J., & Wolmarans, M. (2015). Developing an approach to accounting for need in resource allocation between urban and rural district hospitals in South Africa. In: A. Padarath, J. King & R. English (Eds.), *South African Health Review 2014/15* (pp. 100-114). Durban: Health Systems Trust.
URL: <http://www.hst.org.za/publications/south-african-health-review-2014/15>
- Erskine, H. E., Moffitt, T. E., Copeland, W. E., Costello, E. J., Ferrari, A. J., Patton, G., ... Scott, J. G. (2015). A heavy burden on young minds: the global burden of mental and substance use disorders in children and youth. *Psychological medicine*, 45(7), 1551–1563. doi:10.1017/S0033291714002888
- Frankel, R. M., & Devers, K. J. (2000). Study design in qualitative research-1: Developing questions and assessing resource needs. *Education for Health: Change in Learning & Practice*, 13(2), 251-261.
- Gladwin, T., E., Figner, B., Crone, E., A., & Wiers, R., W. (2011). Addiction, adolescence, and the integration of control and motivation. *Developmental Cognitive Neuroscience* 1, 364-376.
- Gershoff, E. T. (2010). More harm than good: A summary of scientific research on the intended and unintended effects of corporal punishment on children. *Law and Contemporary Problems*, 73(31), 31-56.

- Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Methods of data collection in qualitative research: interviews and focus groups. *British Dental Journal*, *204*, 291-295.
- Gittelsohn, J., Steckler, A., Johnson, C. C., Pratt, C., Grieser, M., Pickrel, J., . . . Staten, L. K. (2006). Formative research in school and community-based health programs and studies: “State of the art” and the TAAG approach. *Health Education & Behavior*, *33*(1), 25-39.
- Goldkuhl, G. (2012). Pragmatism vs interpretivism in qualitative information systems research. *European Journal of Information Systems*, *21*, 135-146.
- Groenewald, C. (2018). ‘It was riotous behaviour!’: Mothers’ experiences of adolescents’ conduct while abusing drugs. *International Journal of Mental Health Nursing*, *27*, 1564–1573.
- Groenewald, C., & Bhana, A. (2015a). “It was bad to see my [child] doing this”: Mothers’ experiences of living with adolescents with substance abuse problems. *International Journal of Mental Health and Addiction*, *14*(5), 646-661.
- Groenewald, C., & Bhana, A. (2015b). Using the lifegrid in qualitative interviews with parents and substance abusing adolescents. *Forum: Qualitative Social Research*, *16*(3) Retrieved from <http://search.proquest.com/docview/1720067529>
- Groenewald, C., & Bhana, A. (2017). Mothers’ experiences of coping with adolescent substance abuse: A phenomenological inquiry. *Contemporary Nurse*, Retrieved from <https://doi.org/10.1080/10376178.2017.1361854>
- Hall, K., & Richter, L. (2018). Introduction: Children, families and the state. In H. Hall, L. Richter, Z. Mokomane & L. Lake (Eds.), *South African Child Gauge 2018* (pp. 22-31). Cape Town: Children’s Institute, University of Cape Town.
- Halpenny, A., M., Nixon, E., & Watson, D. (2010). *Parents’ perspectives on parenting styles and disciplining children* (p. 53-100). Dublin: The Stationery Shop.
- Hoeck, S., & van Hal, G. (2012). Experiences of parents of substance-abusing young people attending support groups. *Archives of Public*, *70*(1), 11.
- Ispa, J. M., & Halgunseth, L. C. (2004). Talking about corporal punishment: Nine low-income African American mothers’ perspectives. *Early Childhood Research Quarterly*, *19*(3), 463-484.
- Jackson, D., & Mannix, J. (2003). Then suddenly he went right off the rails: Mothers' stories of adolescent cannabis use. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, *14*(2), 169-79.

- Jackson, D., & Mannix, J. (2004). Giving voice to the burden of blame: A feminist study of mothers' experiences of mother blaming. *International Journal of Nursing Practice, 10*(4), 150-158.
- Jules-Maquet, R. (2015). *Exploring substance use among South African adult and young offenders 2015*. Retrieved from <http://www.nicro.org.za>
- Kabeer, N. (1999). Resources, agency, achievements: Reflections on the measurement of women's empowerment. *Development and Change, 30*(3), 435-464.
- Kacen, L., & Chaitin, J. (2006). The times are a changing: understanding qualitative research in ambiguous, conflictual and changing contexts. *Qualitative Report, 11*(2), 209–228.
- Kalam, A., & Mthembu, T. G. (2018). Parents' experiences of parenting an adolescent abusing substances. *Social Work, 54*, 469-480.
- Kalichman, S. C., Simbayi, L. C., Kagee, A., Toefy, Y., Jooste, S., Cain, D., & Cherry, C. (2006). Associations of poverty, substance use, and HIV transmission risk behaviours in three South African communities. *Social Science & Medicine, 62*(7), 1641-1649.
- Kelly, M. P., & Barker, M. (2016). Why is changing health-related behaviour so difficult? *Public Health, 136*, 109-116.
- King, K. A., Wagner, D. I., & Hedrick, B. (2002). Parents' reported needs in preventing their children from engaging in alcohol, tobacco, and other drug use. *American Journal of Health Education, 33*(2), 70-86.
- Kroll, B. (2004). Living with an elephant: Growing up with parental substance misuse. *Child & Family Social Work, 9*(2), 129–140. <https://doi-org.ezproxy.uct.ac.za/10.1111/j.1365-2206.2004.00325.x>
- Krueger, R., A., & Casey, M., A. (2014). *Focus groups: A practical guide for applied research* (5th ed.). Thousand Oaks, California: Sage Publications.
- Lachman, J., M., Sherr, L., T., Cluver, L., Ward, C., L., Hutchings, J., & Gardner, F. (2016). Integrating evidence and context to develop a parenting program for low-income families in South Africa. *Journal of Child and Family Studies, 25*(7), 2337-2352. <https://doi.org/10.1007/s10826-016-0389-6>
- Lambert, S., & Loiselle, C. (2008). Combining individual interviews and focus groups to enhance data richness. *Journal of Advanced Nursing, 62*(2), 228-237.
- Lansford, J. E., & Deater-Deckard, K. (2012). Childrearing discipline and violence in developing countries. *Child Development, 83*(1), 62-75. doi:10.1111/j.1467-8624.2011.01676.x

- Levy, S., J., L., & Williams, J., F. (2016). Substance use screening, brief intervention, and referral to treatment. *Pediatrics*, *138*(1), [e20161211].
<https://doi.org/10.1542/peds.2016-1211>
- Lyter, L. L., & Lyter, S. C. (2003). Why some youth don't use alcohol: Protective factors and implications for parenting skills. *Journal of Social Work Practice in the Addictions*, *3*(2), 3-23.
- Makiwane, M., Gumede, N. A., Makoae, M., & Vawda, M. (2017). Family in a changing South Africa: Structures, functions and the welfare of members. *South African Review of Sociology*, *48*(2), 49-69.
- Maslow, A. H. (1954). *Motivation and personality*. New York: Harper & Row.
- Masombuka, J. (2013). *Children's addiction to the drug "nyaope" in Shoshanguve township: Parents' experiences and support needs (Unpublished master's thesis)*. University of South Africa, Pretoria, South Africa. <<http://hdl.handle.net/10500/11903>>
- Matejevic, M., Jovanovic, D., & Lazarevic, V. (2014). Functionality of family relationships and parenting style in families of adolescents with substance abuse problems. *Procedia - Social and Behavioral Sciences*, *128*, 281-287.
- McLellan, A., T. (2017). Substance Misuse and Substance use Disorders: Why do they Matter in Healthcare? *Transactions of the American Clinical and Climatological Association*, *128*, 112–130.
- Mellins, C. A., Kauchali, S., Nestadt, D. F., Bai, D., Aidala, A., Myeza, N., . . . Davidson, L. L. (2017). Validation of the client diagnostic questionnaire to assess mental health in South African caregivers of children. *Clinical Psychology & Psychotherapy*, *24*(1), 245-254.
- van der Merwe, A. & Dawes, A. (2012). Interventions for young offenders: What we know about what 'works' in diversion programmes. In C. L. Ward, A. van der Merwe & A. Dawes (eds.), *Youth violence sources and solutions in South Africa* (pp. 319-346). Cape Town: UCT Press.
- Morgan, D., L. (2012). Focus groups and social interactions. In J. F. Gubrium, J. A. Holstein, A. B. Marvasti & K. D. McKinney (Eds.), *The SAGE handbook of interview research: The complexity of the craft* (2nd ed., pp. 161-176). Thousand oaks: SAGE Publications, Inc.
- Morojele, N. K., Myers, B., Townsend, L., Lombard, C., Plüddemann, A., Carney, T., . . . Nkosi, S. (2013). *Survey on Substance Use, Risk Behaviour and Mental Health among Grade 8-10 Learners in Western Cape Provincial Schools, 2011*. Retrieved from South

- African Medical Research website: <http://www.mrc.ac.za/sites/default/files/files/2016-06-28/SurveySubstanceUseRiskBehaviours8-10LearnersWCprovince%202011.pdf>
- Mundell, J. P., Visser, M. J., Makin, J. D., Forsyth, B. W., & Sikkema, K. J. (2012). Support group processes: Perspectives from HIV-infected women in South Africa. *Qualitative Research in Psychology, 9*(2), 173-187.
- Mutongwizo, T., Leoschut, L., & Burton, P. (2015). Co-ownership and Collaboration: Insights into the Measurement of Impact and Change from Evidence-Based Community and State Violence Prevention Partnerships. *Stability: International Journal of Security & Development, 4*(1), 1-12.
- Muyeba, S., & Seekings, J. (2011). Race, attitudes and behaviour in racially-mixed, low-income neighbourhoods in Cape Town, South Africa. *Current Sociology, 59*(5), 655-671.
- Naidoo, P., Mangoma-Chaurura, J., Khan, G., Canham, & B., Malope-Rwodzi, N. (2016). *Using sport as an intervention for substance abuse reduction among adolescents and young adults in three selected communities in South Africa: An exploratory study*. Cape Town: Human Sciences Research Council and loveLife.
- Nation, M., Crusto, C., Wandersman, A., Kumpfer, K. L., Seybolt, D., Morrissey-Kane, E., & Davino, K. (2003). What works in prevention: Principles of effective prevention programs. *American Psychologist, 58*(6-7), 449-456. <https://doi-org.ezproxy.uct.ac.za/10.1037/0003-066X.58.6-7.449>
- Nichter, M., Quintero, G., Nichter, M., Mock, J., & Shakib, S. (2004). Qualitative research: Contributions to the study of drug use, drug abuse, and drug use(r)-related interventions. *Substance use & Misuse, 39*(10-12), 1907-1969.
- National Institute for Crime Prevention and the Reintegration of Offenders, NICRO. (2016). *NICRO Annual Report 2015-2016*. Retrieved from <http://www.nicro.org.za>
- Office of National Drug Control Policy. (2005). Marijuana myths & facts: The truth behind 10 popular misperceptions. Retrieved from www.ncjrs.gov/ondcpcpubs/publications/pdf/marijuana_myths_facts.pdf
- Oldfield, S. (2004). Urban networks, community organising and race: An analysis of racial integration in a desegregated South African neighbourhood. *Geoforum, 35*(2), 189-201.
- Orford, J., Copello, A., Velleman, R., & Templeton, L. (2010). Family members affected by a close relative's addiction: The stress-strain-coping-support model. *Drugs: education, prevention and policy, 17*(1): 36-43.

- Orford, J., Velleman, R., Copello, A., Templeton, L., & Ibanga, A. (2010). The experiences of affected family members: A summary of two decades of qualitative research. *Drugs: Education, Prevention and Policy*, *17*(1), 44-62.
- Orford, J., Velleman, R., Natera, G., Templeton, L., & Copello, A. (2013). Addiction in the family is a major but neglected contributor to the global burden of adult ill-health. *Social Science & Medicine*, *78*, 70-77.
- Padwa, H., Guerrero, E. G., Serret, V., Rico, M., & Gelberg, L. (2018). Adapting substance use brief interventions for adolescents: perspectives of adolescents living with adults in substance use disorder treatment. *Substance abuse and rehabilitation*, *9*, 137–142. doi:10.2147/SAR.S177865
- Parchment, T. M., Small, L., Osuji, H., McKay, M., & Bhana, A. (2016). Familial and Contextual Influences on Children's Prosocial Behavior: South African Caregivers as Adult Protective Shields in Enhancing Child Mental Health. *Global social welfare: research, policy & practice*, *3*(1), 1-10. doi:10.1007/s40609-016-0042-8
- Patel, L., Knijn, T., & van Wel, F. (2015). Child support grants in South Africa: A pathway to women's empowerment and child well-being? *Journal of Social Policy*, *44*(2), 377-397.
- Pauperio, T., Corte-Real, N., Dias, C., & Fonseca, A. (2012). Sport, substance use and satisfaction with life: What relationship? *European Journal of Sport Science*, *12*(1), 78–80.
- Peltzer, K., Ramlagan, S., Johnson, B., D., & Phaswana-Mafuya, N. (2010). Illicit drug use and treatment in South Africa: A review. *Substance Use Misuse*, *45*(13), 2221-2243.
- Petersen, I., Hanass Hancock, J., Bhana, A., & Govender, K. (2014). A group-based counselling intervention for depression comorbid with HIV/AIDS using a task shifting approach in South Africa: A randomized controlled pilot study. *Journal of Affective Disorders*, *158*, 78-84.
- Piehler, T., F., & Winters, K., C. (2015). Parental involvement in brief interventions for adolescent marijuana use. *Psychology of Addictive Behaviors*, *29*(3), 512-521.
- Piehler, T., F., & Winters, K., C. (2017). Decision-making style and response to parental involvement in brief interventions for adolescent substance use. *Journal of Family Psychology*, *31*(3), 336-346. doi:10.1037/fam0000266
- Piko, B. F., & Balázs, M. Á. (2012). Authoritative parenting style and adolescent smoking and drinking. *Addictive Behaviors*, *37*(3), 353-356.
- Pinderhughes, E. E., Dodge, K. A., Zelli, A., Bates, J. E., & Pettit, G. S. (2000). Discipline

- Responses: Influences of parents' socioeconomic status, ethnicity, beliefs about parenting, stress, and cognitive-emotional processes. *Journal of Family Psychology*, 14(3), 380-400.
- du Plessis, A., Visser, I., & Smit, A. (2013). *Cannabis position paper 2013*. Retrieved from <https://www.daggacouple.co.za/wp-content/uploads/2013/11/SANCWG-Cannabis-Position-Paper-of-2013.pdf>
- Ponterotto, J., G. (2005). Qualitative research in counselling psychology: A primer on research paradigms and philosophy of science. *Journal of Counselling psychology*, 52(2), 126-136.
- Posel, D., & Rogan, M. (2012). Gendered trends in poverty in the post-apartheid period, 1997-2006. *Development Southern Africa*, 29(1), 97-113.
- Pretorius, C., van den Berg, H., S., & Louw, D., A. (2003). Psychosocial predictors of substance abuse among adolescents. *Acta Criminologica: Southern African Journal of Criminology*, 16(4), 1-11.
- Profe, W., & Wild, L. G. (2017). Mother, Father, and Grandparent Involvement: Associations with Adolescent Mental Health and Substance Use. *Journal of Family Issues*, 38(6), 776–797. <https://doi.org/10.1177/0192513X15583069>
- Reddy, S., P., James, S., Sewpaul, R., Sifunda, S., Ellahebokus, A., Kambaran, N., S., & Omardien, R., G. (2013). *Umthente Uhlaba Usamila – The 3rd South African National Youth Risk Behaviour Survey 2011*. Cape Town: South African Medical Research Council.
- Riches, G., & Dawson, P. (1996). Communities of feeling: the culture of bereaved parents. *Mortality*, 1(2), 143-161.
- Sampson, R., J. (1992). Family management and child development: Insights from social disorganization theory. In J. McCord (Ed.), *Facts, frameworks and forecasts: Advances in criminological theory* (pp. 63-93). New Brunswick, NJ: Transaction Publishers
- Sanjana, P., Torpey, K., Schwarzwald, A., Simumba, C., Kasonde, P., Nyirenda, L., ... Thompson, C. (2009). Task-shifting HIV counselling and testing services in Zambia: the role of lay counsellors. *Human resources for health*, 7, 44. doi:10.1186/1478-4491-7-44
- Saunders, B., Kitzinger, J., & Kitzinger, C. (2015). Anonymising interview data: challenges and compromise in practice. *Qualitative research: QR*, 15(5), 616–632. doi:10.1177/1468794114550439

- Seekings, J. (2011). Race, class, and inequality in the South African city. In G. Bridge & S. Watson (Eds.), *The new blackwell companion to the city* (pp. 532-546). Wiley-Blackwell.
- Selamu, L., G., Abreha, E., K., & Feyissa, I., F. (2017). Drug and substance abuse knowledge and attitudes among youth in Addis Ababa, Ethiopia. *Journal of Substance Abuse and Alcoholism*, 5(2), 1056.
- Shelton, R. C., Goldman, R. E., Emmons, K. M., Sorensen, G., & Allen, J. D. (2011). An investigation into the social context of low-income, urban Black and Latina women. *Health Education & Behavior*, 38(5), 471-481.
- Sibeko, G., Milligan, P. D., Roelofse, M., Molefe, L., Jonker, D., Ipser, J., ... Stein, D. J. (2018). Piloting a mental health training programme for community health workers in South Africa: an exploration of changes in knowledge, confidence and attitudes. *BMC psychiatry*, 18(1), 191. doi:10.1186/s12888-018-1772-1
- Singh, S., Balgobind. (2016). Offender rehabilitation and reintegration: A South African perspective. *Journal of Social Science*, 46(1), 1-10.
- Smith, J. M., & Estefan, A. (2014). Families parenting adolescents with substance abuse--recovering the mother's voice: A narrative literature review. *Journal of Family Nursing*, 20(4), 415-441.
- Sofaer, S. (1999). Qualitative methods: what are they and why use them? *Health Services Research*, 34(5 Pt 2), 1101-1118.
- Solis, J. M., Shadur, J. M., Burns, A. R., & Hussong, A. M. (2012). Understanding the diverse needs of children whose parents abuse substances. *Current drug abuse reviews*, 5(2), 135-147.
- Sorsdahl, K., Myers, B., Ward, C., L., Matzopoulos, R., Mtukushe, B., Nicol, A., ... Stein, D., J. (2014). Adapting a blended motivational interviewing and problem-solving intervention to address risky substance use amongst South Africans. *Psychotherapy Research*. DOI: 10.1080/10503307.2014.897770
- South African High Court declares defence of “reasonable chastisement” unconstitutional. (2017, October). Retrieved from <http://www.endcorporalpunishment.org/news/10/2017/south-african-high-court-declares-defence-unconstitutional.html>
- South African Schools Act 84 of 1996. Retrieved from <https://www.gdeadmissions.gov.za/Content/Files/SchoolsAct.pdf>
- Statistics South Africa. (2011). *City of Cape Town - 2011 Census Suburb Delft*. Pretoria:

Statistics South Africa.

- Statistics South Africa. (2018). *Victims of crime*. Pretoria: Statistics South Africa. Retrieved from <http://www.statssa.gov.za/publications/P0341/P03412018.pdf>
- Stewart, K., Gill, P., Chadwick, B., & Treasure, E. (2008). Qualitative research in dentistry. *British Dental Journal*, 204(5), 235-239.
- Straus, M., A. (2010). Prevalence, societal causes, and trends in corporal punishment by parents in world perspective. *Law and Contemporary Problems*, 73(2), 1-30.
- Studylib.net. (2013). *City of Cape Town – 2011 Census Suburb Delft City of Cape Town July 2013*. Retrieved from: <http://studylib.net/doc/10527414/%E2%80%932011-census-suburb-delft-city-of-cape-town-july-2013#>
- Tedgård, E., Råstam, M., & Wirtberg, I. (2019). An upbringing with substance-abusing parents: Experiences of parentification and dysfunctional communication. *Nordic Studies on Alcohol and Drugs*, 36(3), 223-247.
- Thesnaar, C., H. (2011). Substance abuse and domestic violence within families: a pastoral hermeneutical response. *Deel*, 52(Suppl 1), 25-36.
- Thompson, L., & Kumar, A. (2011). Responses to health promotion campaigns: Resistance, denial and othering. *Critical Public Health*, 21(1), 105-117.
- Thurman, T., R., Kidman, R., & Taylor, T., M. (2014). Does investment in home visitors lead to better psychological health for HIV-affected families? Results from a quasi-experimental evaluation in South Africa. *AIDS Care* 26, S2–S10.
- Toumbourou, J. W., Blyth, A., Bamberg, J., Bowes, G., & Douvos, T. (1997). Behaviour exchange systems training: The 'BEST' approach for parents stressed by adolescent drug problems. *Australian and New Zealand Journal of Family Therapy*, 18(2), 92-8.
- Toumbourou, J., W., Blyth, A., Bamberg, J., & Forer, D. (2001). Early impact of the BEST intervention for parents stressed by adolescent substance abuse. *Journal of Community & Applied Social Psychology*, 11, 291-304.
- Tshitangano, T., G. & Tosin, O., H. (2016). Substance use amongst secondary school students in a rural setting in South Africa: Prevalence and possible contributing factors: Original research. *African Primary Health Care and Family Medicine*, 8(2), 1-6.
- United Nations Office of Drugs and Crime. (2018). *World Drug Report 2018*. Retrieved from <https://www.unodc.org/wdr2018/>
- Usher, K., Jackson, D., & O'Brien, L. (2007). Shattered dreams: Parental experiences of

- adolescent substance abuse. *International Journal of Mental Health Nursing*, 16(6), 422-430.
- Vergunst, R. (2018) From global-to-local: rural mental health in South Africa. *Global Health Action*, 11(1). 1413916, DOI: 10.1080/16549716.2017.1413916
- Vigo, D., Thornicroft, G., & Atun, R. (2016). Estimating the true global burden of mental illness. *The Lancet Psychiatry*, 3(2), 171-178.
- Visser, M., & Routledge, L. (2007). Substance abuse and psychological well-being of South African adolescents. *South African Journal of Psychology*, 37(3), 595-615.
- Wadolowski, M., Hutchinson, D., Bruno, R., Aiken, A., Najman, J. M., Kypri, K., . . . Mattick, R. P. (2016). Parents who supply sips of alcohol in early adolescence: A prospective study of risk factors. *Pediatrics*, 137(3), e20152611.
- Wandersman, A., Morrissey, E., Davino, K., Seybolt, D., Crusto, C., Nation, M., . . . Imm, P. (1998). Comprehensive quality programming: The eight essential steps to effective community-directed prevention programs. *The Journal of Primary Prevention*, 19(1), 3–30. <https://doi.org/10.1023/A:1022681407618>
- Warner, B., D. (2003). The role of attenuated culture in social disorganization theory. *Criminology*, 41(1), 73-98.
- Watt, M. H., Meade, C. S., Kimani, S., MacFarlane, J. C., Choi, K. W., Skinner, D., . . . Sikkema, K. J. (2014). The impact of methamphetamine (“tik”) on a peri-urban community in Cape Town, South Africa. *The International Journal on Drug Policy*, 25(2), 219–225.
- Wegner, L., N. (2011). Through the lens of a peer: Understanding leisure boredom and risk behaviour in adolescence. *South African Journal of Occupational Therapy*, 41(1), 18-24.
- Wegner, L., Arend, T., Bassadien, R., Bismath, Z., & Cross, L. (2014). Experiences of mothering drug-dependent youth: influences on occupational performance patterns. *South African Journal of Occupational Therapy*, 44(2), 6-11.
- Wegner, L., Flisher, A. J., Muller, M., & Lombard, C. (2006). Leisure boredom and substance use among high school students in South Africa. *Journal of Leisure Research*, 38(2), 249-266.
- de Wet, A., & Parker, G. (2014) Communities in Conversation: opportunities for women and girls' self-empowerment. *Gender & Development*, 22(1), 109-125.
- Weybright, E. H., Caldwell, L. L., Ram, N., Smith, E. A., & Wegner, L. (2015). Boredom

- prone or nothing to do? distinguishing between state and trait leisure boredom and its association with substance use in South African adolescents. *Leisure Sciences*, 37(4), 311-331.
- Weybright, E. H., Caldwell, L. L., Ram, N., Smith, E. A., & Wegner, L. (2016). Trajectories of adolescent substance use development and the influence of healthy leisure: A growth mixture modeling approach. *Journal of Adolescence*, 49, 158-169.
- Wilkinson, S. (1999). Focus groups: a feminist method. *Psychology of Women Quarterly*, 23(2), 221-244.
- Wilkinson, S., Joffe, H., & Yardley, L. (2004). Qualitative data collection: Interviews and focus groups. In D. F. Marks & L. Yardley (Eds.), *Research methods for clinical and health psychology* (pp. 39-55). London: SAGE Publications, Ltd.
- Winters, K., C. (2016). Brief interventions for adolescents. *Journal of Drug Abuse*, 2(1), 1-4.
- Winters, K., C., Fahnhorst, T., Botzet, A., Lee, S., & Lalone, B. (2012). Brief intervention for drug-abusing adolescents in a school setting: Outcomes and mediating factors. *Journal of Substance Abuse Treatment*, 42(3), 279-288.
- Winters K., C., & Leitten, W. (2007). Brief interventions for drug-abusing adolescents in a school setting. *Psychology of Addictive Behaviors*, 21(2), 249-254.
- Winters K., C., Leitten, W., Wagner, E., & Tevyaw, T., O. (2007). Use of brief interventions for drug abusing teenagers within a middle and high school setting. *Journal of School Health*, 77(4), 196-206.
- World Health Organisation. (2014). *Health for the World's Adolescents – a Second Chance in the Second Decade*. Geneva: Switzerland.

Appendices

Appendix A

Focus Group Discussions for Aim 1

Focus Group interview guide with Parents/Main Caregiver

Thank you for coming today. We really appreciate you being here. Today we want to hear from you about what things are like for parents of alcohol and drug-using adolescents in your community. Remember you do not have to speak about your own experiences, but generally. We will, however, ask everyone to keep what is said in the group confidential. Does anyone have any questions before we begin?

1. What concerns do you think parents in communities like this have about alcohol and drugs affecting their children?
 - a. Probe: How does it affect their behaviour?
 - b. How does it affect their performance at school?
 - c. To what extent do you think parents know whether their children are using Alcohol or drugs or acting in other ways (e.g. fighting) that could get them into trouble?
2. How do you think parents find out that their children are using alcohol or drugs?
 - a. Probe: Tell me about some of the changes in behaviour that may occur?
 - b. What role do other people have in letting parents know about their children's possible alcohol or drug use?
3. What kind of changes do you think may happen in parent-child relationships if adolescents are using alcohol or drugs?
4. How do you think parents usually respond to their adolescents when they find out that they are using alcohol or drugs?
5. What do you think parents can do to stop their children from using alcohol and drugs?
6. Let's talk about what parents having discussions about alcohol and drug use, and other problem behaviours (like skipping school, fighting etc) with their children?
 - a. How often do you talk to your children about these issues?
 - b. What are some of their responses to these issues?
 - c. What are some of the challenges that you have experienced in speaking to your children about these issues?
7. Do you think parents themselves can help their children who are using alcohol or drugs? If so how?
8. What help is available to families in your communities with these problems?
 - a. Prompt: for the adolescent, for the parent
 - b. Are these services useful? (Why/why not)
 - c. Do people use these services (Why/why not)
 - d. What other services/kinds of help would be useful in this community and why
9. What do you think parents personally need in relation to their children's issues?
 - a. What do you think they want help with?
 - b. What, if anything, could help parents cope better?

Appendix B

Focus Group Discussions for Aim 2

Focus Group 2 interview guide with Parents/Main Caregiver

Thank you for coming today. We really appreciate you being here. Today we want to hear from you about what things are like for parents of alcohol and drug-using adolescents in your community. Remember you do not have to speak about your own experiences, but generally. We will, however, ask everyone to keep what is said in the group confidential. Does anyone have any questions before we begin?

[Show participants intervention worksheets]

1. Tell us your thoughts on the intervention that we just showed you.
 - a. Probe: what did you like about it?
 - b. Probe: Was there anything you didn't like?
 - c. What would you change?
2. How could a programme for parents whose children have started to experiment alcohol and drug abuse be useful?
 - a. Prompt: skills, information
 - b. How do you think this programme should be delivered (one-on-one vs group)?
 - c. Who do you think could run this type of programme effectively?
 - d. What content do you think should go into such a programme?
3. How could these programmes be made attractive to parents? What would make them unattractive to parents?
4. What do you think would be the best way to let parents know that such a programme is running?
 - a. Prompt community radio, flyers, are there other places to market the programme?
5. Tell me what location would be more convenient to run such a programme?
6. Let's talk about time and length of programme.
 - a. How many sessions would you be willing and able to attend?
 - b. What time do you think would work best for most parents in the community?
 - c. How long should the session last?
7. Do you have any other suggestions to improve parents' involvement in their children's lives if they are having problems?

Appendix C

Caregiver focus group discussion consent form

Brief Intervention reducing Alcohol and Drug Use and Risk Behaviours in Adolescent Learners in Cape Town, South Africa

Aim 1: Participant Information Sheet and Informed Consent for Focus Groups with Parents or Main Caregivers.

Introduction.

Hello. My name is _____. I am from the South African Medical Research Council (SAMRC). We are asking you to take part in a focus group discussion for the formative phase of our research study. You qualify for this focus group because you are the parent or main caregiver of an adolescent between 13 and 17 years of age who uses alcohol or drugs and is still in school, who lives in one of our target communities and is willing to talk in groups of peers. Before you agree to take part, you should understand what it involves. This form is to help you decide if you would like to take part in this study. If you have any questions, which are not fully explained in this form, please ask the project team. You should not agree to take part unless you are happy about all that is involved.

Why are we doing this?

The purpose of this study is to adapt an intervention for adolescents who use alcohol or drugs. In this phase of the study, we would like to hear your thoughts about problems that young people in your community your children's age may face and barriers to substance use and other services for adolescents and their parents. We will also ask what parents like yourself may need to help their children. The information you provide will be used to adapt an intervention to help parents and caregivers like yourself access these services.

What We're Asking of You.

If you agree to take part in a group discussion, you will be asked to discuss your experiences in your community with helping adolescents and their parents' or caregivers' with their substance use and other problem behaviours, and where they can get services for these problems. Each group will last up to 2 hours. Groups will be audio-taped so that we do not forget any of the information you share with us. We value your input, because the information you provide will help us develop and improve our proposed intervention.

Potential Risks and Discomforts.

There are a few risks with participating in this group discussion. You might feel embarrassed by some of the questions and they may bring back sad or scary memories. There is also a very small chance that someone might reveal information about you to people outside the study. It is ok if you do not want to talk about certain topics. You can also take a break at any time. If you are distressed by any topic or the discussion, we will ensure that you access services to help you cope with these experiences.

Potential Benefits of Taking Part in the Study.

Your participation will help us gain a better understanding of how we can adapt our intervention to address the needs of parents or caregivers like yourself. You may find that participation in this group discussion helps you think about your own behaviours.

Confidentiality and Privacy.

Any information obtained during the consent processes and this group discussion will remain confidential. Anyone who is working with any of the information you give us has to sign an agreement not to share what you tell us. It will be disclosed only as required by law as noted in the following two exceptions: 1) If you tell us that you are about to hurt yourself or someone else, 2) or if you are involved in the neglect and/or abuse of a child. In either case, we will report that information to the appropriate authorities. The MRC ethics committee will have access to your information. Digital recordings of the discussions will be encrypted and stored on a password protected computer for one year, after which they will be destroyed. The only confidential data are information from the consent forms, which will be stored in double-locked file cabinets. The consent forms will be destroyed after one year of completion of these activities.

Participation and Withdrawal.

Participation is voluntary. You can choose not to participate in the focus groups. If you decide to participate, you may choose to stop your participation at any time. There will be no consequences. You may also refuse to answer any questions you do not want to answer.

Who is funding the study?

The study is being conducted by the SAMRC and is being funded by the SAMRC and National Research Foundation (NRF).

Reimbursement

At the end of the group discussion, we will give you a voucher valued at R100 for your time today.

Who to Contact with Questions.

This study has been approved by the SAMRC Ethics Committee and the City of Cape Town. It will be conducted according to the ethical guidelines and principles of the International Declaration of Helsinki, and the South African Guidelines for Good Clinical Practice.

If you have any questions or concerns about the research, please contact Dr. Tara Carney (South African Principal Investigator) at 021 938 0326 or write to tara.carney@mrc.ac.za, or Medical Research Council (MRC) P.O. Box 19070, Tygerberg 7505, South Africa.

Rights of Research Participants.

You can decide you do not want to complete this interview at any time. If you have any questions about your rights as a participant, you can contact the chairperson of the MRC ethics committee, Prof Danie du Toit at 021 938 0687 or email: adri.labuscagne@mrc.ac.za.

Indicating Consent.

Please let us know if you have any questions before signing this consent form. Please initial next to each item to show that you agree/disagree to what is required:

Agree	Disagree	
		I agree to take part in the study, which has been fully described to me, by participating in this focus group discussion.
		I agree to receive a voucher to the value of R100 upon completion of the group discussion.
		I understand that my participation in this study is completely voluntary, and there will be no penalty if I choose not to participate.

Please also provide a full signature to show whether you agree to this discussion being audio-taped.

Agree	Disagree	
		I agree to the discussion being audio-taped

Future Contact

In the future, we may contact you to ask if you want to participate in more study activities. You will complete a separate consent form if you agree to participate.

I consent to be contacted about future study activities (Please check the appropriate box).

Yes

No

DECLARATION BY PARTICIPANT

By signing below, I, _____ (*Participant's Full Name*) agree to take part in the RAR-PAL Brief Intervention Study.

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressured to take part. I also understand that I do not give up any rights by signing below.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.
- I have received a card with information about rights of research subjects and who to contact with questions.

Participant's Signature

Date

Signed at (Place)
(DD/MM/YYYY)

Witness (only if illiterate)

Date
(DD/MM/YYYY)
DECLARATION BY PROJECT STAFF

I, _____ (*Project Staff's Full Name*) declare that:

- I explained the information in this document to _____
(Participant's Full Name)
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that s/he adequately understands all aspects of the research
- I gave him/her a card with information about rights of research subjects and who to contact with questions.

Project Staff's Signature

Date

Signed at (Place)
(DD/MM/YYYY)

Witness (only if illiterate)

Date

Appendix D

Interview guide

Interview Guide for Post-Intervention Evaluation

Introduction. *[Read to participant]*

Welcome. Thank you for coming today. We are going to talk about your experience with the RAD-PAL Study. We are doing this to learn your thoughts and opinions about your experience in the study. This will help us with future studies with adolescents like you.

Before I begin, I would like to remind you that we will be talking about your thoughts about the study experience and sessions. We do not want you to talk personally about any sensitive things, such as sexual behavior, violence or drug use.

There are no right or wrong answers, so we would like you to be honest and open with us. We are interested in hearing about your thoughts and opinions because **you** are the experts. You can refuse to answer any question or not discuss a specific issue that makes you feel uncomfortable. We value your time and will limit this discussion to no more than 1 hour.

Recruitment and Study Experience

- Describe how you were recruited into the study. What are some of the reasons that you decided to take part? (Probe: What made it easy for you to take part in the study?)
- Do you have any suggestions on how recruitment could have been better? (Probes: What did you think about our posters and handouts? Are there other ways to recruit adolescents like you?)
- Did you feel safe and comfortable when you were taken to the project site (Delft matrix)?
- Tell me a little bit about the staff that you were in contact with? (Probes: Were there any challenges in working with the staff? Were they respectful and professional?)
- What was the communication with staff like with you when you were part of the study? (Probes: How often did you communicate with staff? What did you think about the communication—i.e., phone vs. visits?)

Intervention

- Tell us about your experience with the intervention. (Probes: What do you remember about the content of these sessions? Was the material easy to understand? If no, can you think of things we can change?)

- Let us talk about the structure of the interventions. (Probes: What did you think about the length/amount of time each intervention session took? How did you feel about programme being delivered one-on-one? Were the days and times that the interventions were held convenient for you?)
- What did you learn from the programme? (Probe: What skills did you get from taking part in the intervention?)
- Did the intervention make you want to change anything in your life?
- What did you think about the action plan? Was it helpful in reaching your goals? (Probes: What (if any) changes were you able to make? What skills did you practice? What made it difficult to make the changes?)
- What do you think was most helpful/that you liked most about the programme?
- On the other hand, what are two things that stick out the most that were not helpful/that you liked least about the programme?
- What made you come back for the second intervention session (for adolescent participants only)?
- How would you describe your relationship with your caregiver/adolescents? What (if any) things did you notice about your relationship with them before the intervention and after? (Probes: How do you understand those changes?)

Future Directions

- If we were to have a bigger study with this intervention, what would you change? Do you have any suggestions for us on how to improve things in the intervention? (Probe: Any other activities/content to include?)

Ending Questions

Our time is about up. You have provided us with a lot of information in this short amount of time. Thanks again for your time—we really appreciate all of your help.

A short oral summary (2 to 3 minutes) will be given of the key questions and big ideas that emerged from the discussion.

- Is this an adequate summary of the things that we have discussed today?
- Do you have any questions for us?
- Do you have anything to add that we may have missed?

Appendix E***A priori* themes template**

Needs	Anticipated Parental Needs
Communication Skills	
Modelling Behaviour	
Information and awareness	
Understanding confidentiality	
Coping skills	
Discipline and supervision	
Faith	

Appendix F**Feelings template**

Anticipated parental feelings (found in the literature)	Study's parental feelings with example
Stress	
Guilt	
Blame	
Shame	
Loss	
Betrayal	
Depression	

Appendix G

Ethics approval from the Faculty of Humanities

UNIVERSITY OF CAPE TOWN



Department of Psychology

University of Cape Town, Rondebosch 7701 South Africa
Telephone (021) 650 3417
Fax No. (021) 650 4104

11 July 2017

Vimbayinashe Chimbambo
Department of Psychology
University of Cape Town
Rondebosch 7701

Dear Vimbayinashe

I am pleased to inform you that ethical clearance has been given by an Ethics Review Committee of the Faculty of Humanities for your study, *Parents' and adolescent perceptions of a culturally adapted evidence-based program for substance abusing adolescents*. The reference number is PSY2017 -032.

I wish you all the best for your study.

Yours sincerely

Signature Removed

Lauren Wild (PhD)
Associate Professor
Chair: Ethics Review Committee

University of Cape Town
PSYCHOLOGY DEPARTMENT
Upper Campus
Rondebosch