EXPLORING FAMILY SUPPORT FOR ADOLESCENTS AFTER REHABILITATION FOR DRUG ABUSE

by

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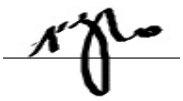
DECLARATION

I declare that **Exploring family support for adolescents after rehabilitation for drug abuse** is my own work and that all the sources that I have used or quoted have been indicated and acknowledgement by means of complete references and that the work has been not submitted before for any other degree at any institution.



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ABSTRACT

Despite the fact that a lot of information exist in the literature regarding factors leading to drug abuse, consequences of drug abuse for adolescents; little exists that focuses on family support for adolescents after rehabilitation. The purpose of this study was to explore family support for adolescents after rehabilitation for drug abuse. The study was based on semi-structured interview based qualitative research.

Findings during interviews was that the families have no clear understanding or are not skilled as to how to continue supporting the adolescents after they are discharged from the rehabilitation centre. What was also interesting according to the participants was that even in the rehabilitation centres families are not made part of or involved during the rehabilitation process.

There is a need to make the rehabilitation centres aware that families need to be involved during the rehabilitation process of the adolescent so that it becomes easy for the families to continue supporting the adolescents after they have completed the rehabilitation process.

Key words

Family support; drug abuse; adolescent; rehabilitation; relapse.

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- To my children Mfundo, Njabulo and Nhlakanipho, thank you for your encouragement. My mother for her words of wisdom and support.

- These acknowledgements would not be complete without an expression of heartfelt appreciation to my husband, Bhungani Mzolo, for being patient and supportive from the beginning to the end.

Dedication

I dedicate this study to all the families who have suffered and are still suffering from the scourge of drug abuse especially nyaope.

It is my hope that they'll find strength and new hope from the work we did together during this research.

To adolescents who are addicted to nyaope and other drugs:

May God the Almighty grant them the strength to recover from this addiction. May they find the inner will and resolve within themselves to fight and overcome their addiction.

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LIST OF ABBREVIATIONS

AA	Alcoholics Anonymous
FBT	Family-Based Treatment
MFT	Multidimensional Family Therapy
NA	Narcotics Anonymous
TNT	The Naked Truth
SANCA	South African National Council for Alcoholism and Drug Dependence
YRU	Youth Research Unit

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CHAPTER 1

INTRODUCTION AND ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND

The World Health Organization (WHO) (2007:12) defines an adolescent as a young person between 10–19 years of age, who is undergoing physical, psychological and social change. Adolescence is defined as a period of time from the onset of puberty until an individual achieves economic independence (Gentry & Campbell 2002:1). For adolescents, families are a source of care and emotional support. Families are needed for advice and encouragement. Adolescents still require stability in a home environment and a secure emotional base from which to explore and experience the world. This provides them with somewhere to come back to for reassurance, support and unconditional love in tough times. (Price-Robertson, Smart & Bromfield 2010:8).

The use of drugs by adolescents stems from curiosity, peer pressure, physical, emotional and economic deprivation (Nel 2003:3). Pluddemann, Dada and Parry (2013:4787) alleges that alcohol consumption is socially accepted by parents that is why 60% of the 16-year olds already consume alcohol with their parents' permission. The report further states that Nyaope (mixture of rat poison, heroin and dagga) is becoming more popular among the adolescents especially in townships (*The Star* 2013). This report further urges families to be on the look-out for unusual behaviours from their children, including adolescents.

The primary function of the family is to look after and educate the children and, as an institution, the family is regarded as one of the most important agents of socialisation (Du Toit & Van Staden 2009:35). The family environment plays a key role in the development and maintenance of adolescents' behaviour especially family support and encouragement. Behaviour modelling by parents and resources available are important mechanisms through which the families can promote good behaviour (Bauer, Berge & Neumark-Sztainer 2011:601). Families are looked up to for protection and support in

times of troubles and problems. If the family is not well equipped with support strategies it becomes difficult for the adolescents to cope.

Adolescents who live alone or in dysfunctional families where they lack guidance turn to destructive ways as coping strategies such as drug abuse, stealing and alcohol abuse. As a result the support structure gradually weakens until the adolescent is all by himself/herself and only totally dependent on drugs. At some point adolescents' may realise that drug abuse is ruining their lives and opt for rehabilitation. Even after repeated rehabilitation they somehow end up going back to the habit (relapsing).

Much attention has been given to factors which influence drug abuse and in the effects of drug abuse, but less attention has been given to determining the role which families play towards supporting the adolescents after they have been discharged from rehabilitation centres. A decade ago, Coughlin (1991:3) stated that there may be some family factors which play a role in an adolescent's drug relapse after rehabilitation and suggested that more research should be done to explore questions such as: Who does the adolescent live with? How is family support? Is the adolescent being abused or not? This study aims to explore family support for adolescents who take drugs and have been to a rehabilitation centre.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

The use of psychoactive substances by children and adolescents globally is of major concern. (World Health Organization 2007:10). The drug problem in South Africa remains very serious with drug usage being twice the world norm in most cases (Bayever 2009:2). In Gauteng Province of South Africa almost 3 in every 10 pupils-26.9% use illicit drugs (Basson 2012:1). The national statistics released by South African National Council for Alcoholism and Drug Dependence SANCA in 2010 indicate that 8500 patients treated around the country are younger than 21 years. Kotze of Castle Carey Clinic (SANCA) reiterates that 75% of patients treated for drug abuse in their clinic are between the ages 14–16 years (Nkosi & Ndou 2010:6).

Smith, Rodman and Reynolds (2003:3) state that 'family support' was often cited by teens as being the most helpful in quitting drugs and maintaining sobriety. Families may encourage their adolescents to go for rehabilitation or the adolescents themselves may

voluntarily decide to go for rehabilitation, but there is always no guarantee that they will stop completely and clean up their act. According to Malaka (2012:2), most drug rehabilitation centres have a success rate of less than three percent.

The published literature on family support after rehabilitation seems to be minimal if not non-existent despite the fact that families are the core support for their children. According to Lambie and Rotukani (2002) (cited in Smith et al 2003:4), many programmes still do not involve parents as an intricate part of the adolescents' rehabilitation support. Instead the primary emphasis is on the adolescents through traditional rehabilitation resources such as, alcoholics anonymous (AA) or narcotics anonymous (NA) that are often designed for adults without taking into consideration the needs of the adolescents (Berlin 2002 cited in Smith et al 2003:4).

If family involvement can be put at the centre of the adolescents' recovery, it would be easy for the families to support their adolescents even at home after rehabilitation. The Centre for Substance Abuse Treatment (1993) attests to this statement as they confer that "positive family involvement is the best single indicator for adolescent success in rehabilitation". Sometimes the families may feel that the adolescent is solely responsible for their own difficulties, hence they do not see the reason to support them after rehabilitation (Gillum 2009:14).

It is estimated that one out of three adolescents will relapse after rehabilitation termination, yet attention has not been given to determining if family factors play a role in an adolescent resuming drug use after treatment termination. However, it is not clear whether the families are ever involved during the adolescents' rehabilitation programme.

Studies have been conducted on substance abuse, starting with the factors influencing substance abuse to prevention of substance abuse and treatment of the addicted adolescents (Dube 2007:13; Onya, Tessera, Myers & Flisher 2012:353). But the same vigorous attention has not been given to determine the importance of family support for adolescents after drug rehabilitation.

1.3 STATEMENT OF THE RESEARCH PROBLEM

Van der Westhuizen (2007:5) states that although treatment programmes exist, and an increase in treatment demand indicates that programmes are being utilised, as high relapse potential still exists. In support of this Gorski (2001:1) cited in Van der Westhuizen (2007:5) indicates a relapse rate after treatment of 78% for adolescents. Many rehabilitation programmes as mentioned by studies Berlin (2002), Lambie and Rotukani (2002), Rowe, Parker-Sloat, Schwartz, and Liddle (2003) cited in Smith et al (2003:4), reported that rehabilitation programmes do not involve families as part of the treatment approach. The primary emphasis is still on the individual adolescent through traditional treatment approaches such as the Narcotics Anonymous, South African National Council for Alcohol and drug dependence (SANCA) or Rehabilitation organisations.

It costs the government R130 billion rand per year to look after this adolescent who keeps on going in and out of rehabilitation (Bayever 2009:4). The revolving door syndrome on the adolescents is a cause for concern as adolescents are the future of the nation. Therefore, there is a strong need for the research to be conducted in order to explore the involvement of families in supporting the adolescents after rehabilitation.

The researcher embarks on this project with the aim of exploring the family support of the adolescents after drug rehabilitation.

1.4 SIGNIFICANCE OF THE STUDY

The incidence of adolescents who are involved in risk behaviours especially drug abuse is escalating. For instance, In Gauteng almost 3 in every 10 pupils (26.9%) use illicit drugs (Basson 2012:1). In agreement Kotze of Castle Carey Clinic (SANCA) reiterate that 75% of patients treated for drug abuse in their clinic are between the ages 14–16 years (Nkosi & Ndou 2010:6). The researcher embarks on this study with this worrying statistics in mind. Although at some point the adolescents become aware of their addiction, they seek help by going for rehabilitation, and others are sent by their families. However, most of these adolescents relapse soon after discharge from rehabilitation or treatment centres.

Van der Westhuizen (2007:7) indicates her concern as she states that treatment programmes are available and utilised, but the relapse high rate and potential relapse, as well as the impact resulting from relapse remains a cause for concern. The researcher noted that there are studies that indicate involvement of families of adolescents who are abusing drugs during rehabilitation, and she wondered if the families are well equipped to deal with these adolescents after they have been discharged from rehabilitation or treatment centres.

The researcher hopes that this study will assist to show the importance of involving families during treatment, and also empower them with skills to support adolescents after they are discharged from rehabilitation centres so as to prevent relapse.

1.5 DEFINITIONS OF KEY CONCEPTS

1.5.1 Addiction

Addiction is a condition characterised by overwhelming desire to continue taking a drug to which one has become habituated through repeated consumption because it produces a particular effect. This is usually an alteration of a mental status (Atrens 2001:325)

1.5.2 Adolescent

The World Health Organization defines an adolescent as a young person between 12–19 years of age, who is undergoing physical, psychological and social change (WHO 2007:12). It is a period of time from the onset of puberty until an individual achieves economic independence (Gentry & Campbell 2002:1).

1.5.3 Drug abuse

It is the abuse of illegal drugs or misuses of prescription or over the counter drugs for at least a year with negative consequences (Du Toit & Van Staden 2009:70).

1.5.4 Drug rehabilitation

It is a process of helping someone to live without drugs after they have been addicted to them (Chiuzzi & Liljegren, 2008:303).

1.5.5 Family

It refers to a group consisting of a set of parents and children. It is a group of people related to one another by blood, marriage, adoption or socialisation (Du Toit & Van Staden 2009:56).

1.5.6 Nyaope

It is a street drug which is a mixture of rat poison, a bit of heroin and dagga (The Naked Truth (TNT) 2012).

1.6 RESEARCH AIM/PURPOSE, OBJECTIVES AND QUESTIONS

This section discussed the purpose of the study, research objectives and the research questions.

1.6.1 Purpose

The purpose of this study was to explore family support for the adolescents after drug rehabilitation.

1.6.2 Research objectives

The objectives of this study are to:

- Explore and describe the involvement of families in supporting their adolescents after drug rehabilitation.
- Describe factors involved in the support of families for adolescents after drug rehabilitation.

1.6.3 Research questions

- What is the extent of family involvement in supporting adolescents after drug rehabilitation?
- What are the factors involved in the support of families for adolescents after drug rehabilitation?

1.7 RESEARCH APPROACH

In order to answer the questions posed above, **qualitative approach** will be employed because it is deemed more appropriate to explore the involvement of families in supporting the adolescents after rehabilitation. According to Savin-Baden and Major (2013:11), qualitative research is a form of social inquiry that focuses on the way people interpret and make sense of their experiences and the world in which they live. Researchers use qualitative approaches to explore the behaviour, perspectives and experiences of the people they study. Polit and Beck (2008:219). The research design and methodology used in this study will be explained in detail in Chapter 3.

1.8 ETHICAL CONSIDERATIONS

LoBiondo-Wood and Haber (2010:117) suggest that ethical practice in research is the demand for the protection of human participants. In order to be in line with this statement the researcher will consider the following ethics:

1.8.1 Permissions to conduct the study

Before data collection permission was sought and granted by three entities, namely: the Department of Health Higher degrees Committee of the University of South Africa (Annexure A); the Second Chance Recovery Centre (Annexure B); and each study participant (Annexure C).

1.8.2 Informed consent

Informed consent is a legal embodiment of the idea that a researcher should provide information to the participants about the potential risks and benefits of participating in a study and should make clear their rights as participants so that they can make informed decisions about whether to take part in the study or not (Guba & Lincoln in Savin-Baden 2013:323). LoBiondo-Wood and Haber (2010:254) added that the study purpose, procedures, risks, discomforts and expected duration of participation should be clearly outlined to allow for the participant to make an informed decision. In view of the above information the researcher engaged with the participants and gatekeepers, and explained all the above information including the fact that the participants have the right to withdraw at any time during the study. This was done during the introduction interview. The consent form that needed to be signed was comprehensively designed with all the information (Annexure C).

1.8.3 Protection from harm

Maree (2013:301) proposes that the researcher should make sure that participants are not exposed to any undue physical or psychological harm. Therefore the researcher was honest, respectful and considerate towards all participants. During the interview one of the participants started to cry and the interview was discontinued and the participant was allowed to calm down. The participant then recused herself and was referred for counselling.

1.9.4 Right to privacy and confidentiality

According to Burns (2000) cited in Maree (2013:301), both the researcher and participants must have a clear understanding regarding confidentiality of the results and findings of the study. This was achieved through use of pseudonyms instead of the participant's real names; the data shared during the study were kept private so that only the researcher and her supervisor had access. Audio recordings used during the study were destroyed once the study was completed. The results of this study are presented in an anonymous manner so as to reinforce the participants' privacy.

1.9 SCOPE OF THE STUDY

The study was limited to only one rehabilitation centre in a township in Pretoria, the Government seat of the Republic of South Africa.

1.10 STRUCTURE OF THE THESIS

The thesis is structured according to chapters as follows:

Chapter 1: Orientation to the study

Chapter 1 gives an orientation to the study where background, research problem, aims and objectives, significance of study were discussed.

Chapter 2: Literature review

This chapter comprises the literature reviewed in order to situate the study within previously conducted studies. Numerous data sources were searched such as journal articles, books, newspapers, researches done on the topic and an internet search was also done.

Chapter 3: Study Methodology

In this chapter the methodology used in the study is discussed. Research approach, design, data collection and data analysis strategies are discussed in details. Issues of trustworthiness are also discussed.

Chapter 4: Findings and discussion

Findings of the study are presented in Chapter 4. The findings are also discussed in connection with the studies done by previous researchers.

Chapter 5: Conclusions, recommendations and limitations

General conclusions of the study are given. The chapter also discusses the recommendations as they emanated from the study findings and the limitations of the study.

1.11 CONCLUSION

Chapter 1 provided a comprehensive overview of the study. The Background, problem statement, purpose and objectives of the study were discussed in this chapter. Ethical considerations were also shared.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Literature review is a comprehensive summary and critical appraisal of the literature that is relevant to the research topic (Whittaker 2012:24). Whereas, Rebar, Gersch, Macnee and McCare 2011:206) state that literature review is a synthesis of the literature that describes what is known or has been studied regarding the particular research question or purpose, and also consists of a synthesis of existing published research. Sanin-Baden and Major (2013:112) further define literature review as a review that is intended to establish the context for a qualitative research study. Hart (1995) cited in Savin Baden and Major (2013:112) and LoBiondo-Wood and Haber (2010:57) state that literature review should contain critical analysis of previous research studies and sometimes non-research based literature on the topic of investigation.

Literature review gives the researcher an opportunity to study the work of other researchers who have studied and researched the same topic, thus identifying the gap that needs to be closed. Whittaker (2012:24) alluded to the above statement as he states that literature review presents the reader with what is already known in that particular field and identifies traditional and current controversies as well as weaknesses and gaps in the topic. Literature review identifies and compares earlier studies in order to avoid duplication and at the same time assists the researcher identifies and fills in gaps that exist in the topic. Unfortunately, the researcher found limited literature on family support for adolescents after rehabilitation for drug abuse. The researcher undertook the study to investigate and gain insight into family support for adolescents after rehabilitation, possible gaps on adolescent treatment and involvement of their families and ultimately to make recommendations on treatment and family involvement and support.

For the purpose of this study the researcher will review literature on the following aspects, central to the topic:

- Family
- Family support
- Adolescence
- Rehabilitation
- Drug abuse

The researcher read journal articles, monographs, books, and theses relevant to family support for adolescents after drug rehabilitation. Concepts used in the study were revisited and further defined in the context of reviewing the literature.

2.2 FAMILY

Schaefer (2010: 312) defines a family as a set of people related by blood, marriage or some other agreed-on relationship or adoption, who share the primary responsibility for reproduction and caring for members of the society. The family is the primary context in which the child learns and develops. (Szapoznik et al 2003 cited in Lewis, Dana & Blevins 2011:169).

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Families need to develop a close relationship with their children and give adolescents freedom or independence so that it becomes easy for the adolescents to talk or open up to them when they have problems. Some parents give adolescents complete freedom with no limitations; with the hope of gaining the adolescent's love and attachment. In contrast, Luthar (2006) cited in Robinson, Mandleco, Olsen and Hart. (2011:14) indicate that poor parental monitoring and limit setting are linked to negative outcomes in adolescents. The negative outcomes include antisocial behaviour, substance use and sexual risk-taking

Luthar (2006) further states that although the limit set by parental monitoring may provoke tension as the adolescent negotiates the struggle between developing autonomy and continuing the bond with parents. On the other hand, Valerie et al (2011:5) argue that authoritative style of parenting develops and maintains a close warm relationship with their children, while at the same time establishing structure and guidelines that are enforced as necessary. According to Ramirez, Hinman, Sterling, Weisner and Campbell (2012:37), the influence of the family remains important over time.

he role of parents remains important as Price-Robertson et al (2010:3) state that adolescents still require stability in a home environment and a secure emotional base from which to explore and experience the world. Du Toit and Van Staden (2009:35) further state that the primary function of the family is to look after and educate the children and, as an institution, the family is regarded as one of the most important agents of socialisation. Parents and families have a most direct and lasting impact on children's learning and development of social importance. Families are crucial partners in promoting positive social skills (Adams & Baronberg 2014:118).

Sometimes risky behaviours like drug abuse by family members, especially parents, may be the cause of adolescents abusing drugs and relapsing after treatment or rehabilitation. The development of drug abuse is strongly related to negative family environments that include parents with drug abuse problem, high level of family conflicts, fewer positive family experiences and poor limit setting (Ramirez et al 2012:37). In support of this statement, Ray (2013:4) states that children of alcoholics and drug addicts are at a higher risk for developing addiction themselves. They tend toward self-destructive behaviour and are at risk for developing a low self-esteem, trouble forming relationships and high levels of codependency traits. Individuals that grow up in a family where there is substance abuse are at significantly higher risk of developing substance abuse because of genetic and environmental factors. (Lander, Howsare & Byrne 2013:194). Family conflicts and detachments can result in greater susceptibility to peer pressure, which, in turn, may elevate the risk for adolescent drug use (Hamilton, Danielson, Mann & Paglia-Boak 2012:48).

According to Liddle (200) cited in Lewis et al (2011:169) a theory of change denotes the following:

Adolescent developmental psychology and psychopathology research has determined that:

- The family is the primary context of healthy identity formation and ego development.
- Peer influence operates in relation to the family's buffering effect against the deviant peer subculture.

- Adolescents need to develop an interdependent rather that an emotionally separated relationship with their parents.

2.3 FAMILY SUPPORT

People influence their social environment and are influenced by it in return. When they develop substance abuse problems, the issues are not limited to them alone but affect all their social systems. The system that tends to be mostly recognised as closely associated with addictive behaviours is the family (Lewis et al 2011:168).

An individual, particularly an adolescent, cannot be separated from the family. As a result adolescents with a substance abuse problem, need support from their families. The study conducted by Bahr, Marcos and Maughan (1995) cited in Ramirez et al (2012:37) noted the importance of family bonds but that such bonds are moderated through peers i.e. adolescents with strong family bonds are less likely to have peers who use drugs. Adams and Baronberg (2014:1) state that when parents are involved students (adolescents) achieve more, exhibit a more positive attitude and behaviour and feel more comfortable in new settings.

It is therefore important that the family gives the adolescent support so that he/she is not tempted to go back to abusing drugs. ‘Family support’ was often cited by teens as being the most helpful in quitting drugs and maintaining sobriety (Cleveland, Feinberg, Botempo & Greenberg 2008:157). Lewis et al (2011:168) state that family system has the potential to influence the outcome of treatment for the adolescent and the family system itself can be seen as an appropriate target of change. Wu et al (2004) cited in Ramirez et al (2012:37) point out that less supportive and less structured family environments are associated with greater problem severity in adolescents at intake to treatment. Hamiliton, Danielson, Mann and Paglia-Boak (2012:46) state that family factors such as good parental support, and monitoring, high parental involvement, good parental-adolescent relationship and living in an intact family have been associated with lower risk of drug use.

It has been noted that the majority of the rehabilitation institutions only concentrate on treating the adolescent with no involvement of the family (parents) which might contribute to poor support after rehabilitation. Robinson, Power and Allan (2010:1)

agree with this statement as they state that individual treatment may not address the parent's concerns if an adolescent does not articulate them. Sally (2006) cited in Robinson et al (2010:4) claims that it was unclear as to whether family involvement in treatment is more effective than addressing family issues in individual treatment with the youth.

Therefore family therapy can be of utmost importance for families with an adolescent in rehabilitation centres as families would also learn coping mechanisms and how to support their adolescents. Robinson et al (2010:1) state that there is evidence that supports the use of family therapies to address other adolescent problem behaviours. Some of these family therapies are family-based treatment (FBT) and multidimensional family therapy (MFT) which centres on family therapy as a pathway to adolescent well-being. According to Liddle (2000) cited in Lewis et al (2011:169), a multidimensional change perspective holds that symptom reduction and enhancement of prosocial and normative development functions in problem adolescent occur by:

- Targeting the family as the foundation for intervention.
- Simultaneously facilitating curative processes in several domains of functioning and across several systemic levels.

Particular behaviours, emotions and thinking patterns known to be related to problem formation and continuation are replaced by new behaviours, emotions and thinking patterns associated with appropriate intrapersonal and familial development.

Family based therapies are considered among the most effective current treatments for adolescent substance abuse reiterate Carr 2009; Carey & Oxford 2008 as cited in Robinson et al 2010:6). Huey and associates (2000) cited in Hogue and Liddle (2009:138) showed that adherence to fundamental principles of family therapy predicted improved family relations and decreased affiliation with delinquent peers. In addition, changes in these two outcomes mediated the relation between treatment adherence and reduced delinquent behaviour in the adolescents. In support of this statement, Hogue and colleagues (2006a) cited in Hogue and Liddle (2009:138) found that greater use of core family and adolescent focused treatment technique were associated with greater reduction in adolescent internalising and externalising symptoms, as well as improvement in family cohesion and conflict up to one year after treatment.

Family therapy assists the parents and their adolescents to work cooperatively towards a common goal of recovery for the adolescent and support for the parents. At the same time interactions between the parents and the adolescent improve. Liddle (1999) cited in Hogue and Liddle (2009:138) states that family based treatment model demonstrated the ability to enact behavioural changes in parenting and family interactions. Significant improvement in the quality of in-session parenting behaviours observed between the first three sessions versus the last three sessions of treatment were linked to post treatment reduction in drug use. (Schmidt 1996 cited by Hogue & Liddle 2009:138).

Brody et al (2012), Foxcroft and Tsertsvadze (2011) and Miller et al (2012) cited in Mackery-Amiti, Boodram, Ouellette and Bailey (2012:3) state that parental involvement has been found to be beneficial in a variety of substance abuse treatment and prevention programmes. Brown (2008) cited in Robinson et al (2010:6) states that a therapeutic alliance with both adolescents and parents (family) is the key to successful treatment, although this may be a difficult balance in practise especially if the family feel threatened by their possible role in the adolescents' drug abuse problem.

2.4 ADOLESCENCE

Adolescence is a time when most children begin to form a solid sense of identity, a fuller sense of self awareness and greater feelings of confidence. For many adolescents, this can mean that they feel freer to express themselves, giving voice to any of the range of emotions that they feel at a given time (Bukatko 2008:531). Ellis et al cited by Dodge and Albert (2012:1) describes adolescence as a high-stakes transformation from the safety net of one's parents to the bold-and-brave world of adulthood.

It is during this period that the adolescents may start to have conflicts with parents and engaging in risky behaviours e.g. sexual behaviour, substance abuse, theft and truancy. Arnett (1999) cited in Bukatko (2008:540) reiterate that increased conflict with parents and the initiation of more risky and socially destructive behaviour are part of this developmental period.

During this period friends become very important and tend to have more influence as compared to family. As such the adolescent would do anything that friends are doing

especially risky behaviour. Ali and Dwyer (2010), Branstetter, Low and Furman (2011) cited in Ramirez et al (2012:37) agree with this statement as they state that having friends who use drugs and alcohol is an important determinant drinking behaviour and drug use. Ramirez et al (2012:37) further state that peer influences clearly increase during adolescence and may become the most critical factor.

Sometimes adolescents who are abusing drugs may realise that what they are doing is wrong and want to change their lives by going for rehabilitation. Gunter and Abdel-Salam (2013:24) agree that for treatment to work, the adolescent must recognise the problem that they have and be motivated and ready to change. The family may take the adolescent for rehabilitation but at times it may never help the adolescents as the latter may feel pressured or coerced to get treated. In affirmation Klag et al (2010) cited by Gunter and Abdel-Salam (2013:24) states that adolescents who are not motivated feel controlled, pressured or coerced by outside forces which in turn reduces their interest and motivation to engage in any activity.

2.5 REHABILITATION

Rehabilitation is the way of restoring good and acceptable behaviour. The *Chamber's 21st Century Dictionary* (1996:1175) also defines rehabilitation as the means to restore someone to a former state or to bring something back to good condition.

Studies refer to rehabilitation as intervention or treatment for instance, Effective intervention for substance using adolescents (Carney & Myers 2012:9) and family-based treatment for adolescent substance abuse (Hogue & Liddle 2009). For the purpose of this study rehabilitation will be referred to as treatment as most studies use this word 'treatment'. For treatment to be effective some aspects need to be taken into consideration i.e. early detection and intervention, format to deliver treatment i.e. individual or group treatment, duration of treatment and in-patient or out-patient bases.

In their review of the impact of early detection and intervention Carney and Myers, (2012:8) state that early detection and treatment of adolescents before they need specialised treatment or face unwanted consequences such as incarceration provided strong evidence in support of its effectiveness. Therefore to ensure that adolescents

are reached early Carney and Myers (2012:8) suggest that they should be targeted while still at school and in a number of other places.

Some treatment centres provide treatment on individual or group bases over a long or short period. Whereas other treatment centres prefer to include families of the adolescents during treatment. Lewis et al (2011:130) see that group treatment format across multiple sessions has great effectiveness and potential compared to individual treatment because it focuses on building interpersonal relations and quality of social skills. They further state that members of the group benefit from the feedback and insight of other group members. Gunter and Abdel-Salam (2013:23) are of the same opinion that the treatment modality called “therapeutic community” in which residents live together and social and psychological change is facilitated by peer communities. In contrast Carney and Myers (2012:8) state that interventions or treatment delivered in groups does not have any desired effect on behavioural outcomes. For example, treatment delivered in an individual format across multiple sessions had a much greater effect on the frequency of substance use than those delivered in a group format.

Hogue and Liddle (2009:127) state that family therapy is a safe, acceptable, viable and promising approach for adolescent drug problem. Henggeler et al (2006) cited in Hogue and Liddle (2009:132) alluded to the findings that family based therapy has superior outcome effect for drug use compared to group or community-based therapy.

Researchers agree with the fact that single treatment session was ineffective as compared to multiple treatment session (Carney & Myers 2012; Gunter & Abdel-Salam 2013; Hogue & Liddle 2009; Strong et al 2011). In-patient or in-house facilities for treatment are well suitable for adolescent treatment as compared to outpatient facilities where adolescents have to travel every day for treatment. Watermeyer (2013:2) states that adolescents feel helpless as they have to come to the treatment centre everyday faced with a high cost of travelling and have to go back out into the communities where their friends are all using drugs and the drug merchants and the drugs are always easily available.

Beda and Heflinger (2007) cited in Gunter and Abdel-Salam (2013:24) state that for treatment to be effective adolescents need to have motivation and readiness for treatment so that it can yield treatment success. Motivation is affected by cognitive,

emotional and physical factors internal to the adolescent, including dissatisfaction with their lifestyle, recognition that drug abuse is causing many of these difficulties, and desire to change drug abuse behaviours states Rosen, Hiller, Webster, Staton and Luckefield (2004) cited in Gunter and Abdel-Salam (2013:24). As a result adolescents who are motivated are more likely to experience more positive outcome and are less likely to relapse post treatment. In support of this assertion, Aromin et al (2008), Jainchill et al (2005), Morral et al (2004) cited by Gunter and Abdel-Salam (2013:31) suggest that it is possible that adolescents who complete a treatment programme are less likely to use substance after treatment.

According to Hser et al (2001), Jainchill, Hawke, De Leon and Yagelka (2000) cited in Gunter and Abdel-Salam (2013:24), state that treatment retention is another critical element associated with positive adolescent treatment outcomes. Neumann et al (2010:15) reiterate that unfortunately, despite the positive impact of treatment retention on post treatment outcomes, only half of adolescents who enter treatment actually complete it. Treatment retention is critical because it helps to ensure the adolescent has received a sufficient dose of treatment, says Gunter and Abdel-Salam (2013:24

2.6 DRUG ABUSE

Lewis et al (2011:33) define a drug as any substance that alters the structure or function of some aspect of the user. Lewis et al (2011:4) further define drug abuse as consuming mood altering drugs that have an undesirable effect on an individual's life or on the life of others. Rassool (2009:5) defines drug misuse as something, often an illegal substance that causes addiction, habituation or a marked change in consciousness. The negative effect may involve impairment of physiological, psychological, social or occupational functioning.

Adolescents are grappling with drug abuse concerns which often have environmental stressors that go beyond the norm. The drug use behaviour came into being in settings that facilitated experimentation. Once the problem arose they become subject to the stigma frequently imposed on drug users and their attempt to obtain help in overcoming the abuse is difficult (Lewis, Dana & Blevins (2011:19).

Over and above experimenting, adolescents may abuse drugs because they are easily available at home. Griffin et al (2011) cited in Gunter and Abdel-Salam (2013:24) state that family dynamics like history of parental abuse, peer influence are the precursors for drug use. However if the adolescent is aware or has insight of his problem it becomes easy to seek help. Klag et al (2010) cited in Gunter and Abdel-Salam (2013:12) affirm the above statements and states that adolescents who have no insight may feel controlled, pressured or coerced by outside forces, which in turn reduces their interest and motivation to engage in an activity.

According to Rassool (2009:34-40) there are many models and theories that explain the use or misuse of substances as discussed below.

Moral theory

According to this theory, individuals are responsible for their behavioural choices and their own recovery as a result much of the stigma faced by individuals with a drug problem is based on this moral notion that labels anyone with a drug misuse habit as a 'bad person'. This is where the victim-blaming approach is evident and the focus of intervention is the control of behaviour through social disapproval, spiritual guidance, moral persuasion or imprisonment.

Disease theory

This theory maintains that addiction is a disease due to the impairment of either behavioural or neurochemical process or both. It holds that drug addiction is unique, irreversible and progressive disease and its primary symptom is inability to control consumption. This approach implies that recovery from drug misuse can be sustained only through the goal of total abstinence within support from self-help group movements e.g. Narcotics Anonymous.

Genetic theory

A number of studies have suggested that alcohol or drug addiction is the result of genetic or induced biological abnormality of physiological, structural or chemical nature. Problem drinkers have a 50 per cent chance of having at least one member of their

family becoming dependent on alcohol and 90 per cent chance of two or more family members dependent on alcohol (Miller 2006:191).

Psychoanalytic theory

This theory is derived from the work of Freud based on the components of the self. Adaptive behaviour requires the harmonious functioning of the id, ego and superego (the self) and these components change during the stages of psychosexual development. Drug abuse and other pathological conditions are attributed in the conflicts in these stages of development, resulting in destructive interactions among the three components of the self. Therefore the aetiology of drug dependence is assumed to develop from sensual satisfaction (avoidance of pain or anxiety), conflict among id, ego and superego. In order to avoid pain and anxiety drug abuse is assumed to provide this relief.

Behavioural theory

According to this theory, the use of psychoactive substances is viewed as acquired behaviour, a response that is learned through the process of classical conditioning (Pavlovian's conditioning), operant conditioning (Skinner) and social learning. In classical conditioning, dependence is in part acquired through the process of associative learning that is, the desire to use drugs may be the result of specific factors associated with the use of a particular substance.

Social learning theory

This theory provides an explanation of how behaviour (adaptive or maladaptive) is formed and maintained through the process of positive and negative reinforcement.

Personal theory

Personal theory stresses the importance of personal traits and characteristics in the formation and maintenance of dependence. Sher et al (1991) cited in Rassool (2009:39) state that traits such as hyperactivity, sensation-seeking, antisocial behaviour and impulsivity have been found to be associated with substance misuse.

Sociocultural theories

These theories include sub-theories like systems, family interaction, anthropological, economic, gateway and availability theories. In the systems theory behaviour is determined and maintained by the ongoing demands of interpersonal systems in which an individual interacts. The aetiology is based on behaviour observed in family contexts such as behaviour resulting from the interactions between relevant significant others. Steinglass's (1987) work supports the idea of alcoholism as a 'family disease' or 'family disorder'. The availability theory suggest that the greater the availability of drugs or other psychoactive substances, the greater the prevalence and severity of substance use problem in society.

2.7 CONCLUSION

A variety of literature sources was consulted in this chapter, including books, journal articles, internet policy documents, relevant doctoral dissertations and interviews with subject specialists. The chapter focused on the following themes: Family, adolescence; support and drug rehabilitation.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

Methodology refers to the procedural rules for the evaluation of research questions and validation of the knowledge gathered. Whittaker (2012:114) further clarifies that methodology should answer the following questions: Who? What? When, Where? Why? and sometimes How? Chapter Two reviewed literature on what is said concerning family support for adolescents after rehabilitation for drug abuse. The purpose of this chapter is to outline the empirical process to be followed. Whittaker (2012:114) concurs with this statement as he states that the methodology section should address the following areas: overall research approach and methods, sampling, analysis, ethical issues and limitations.

This chapter will thus explain research design and methodology, population, sampling, data collection and data analysis. In Chapter 1 the researcher indicated that qualitative approach will be employed in this study. This chapter also discusses the rationale for using the qualitative approach and presents the research design. Holloway and Wheeler (2010:78) point out that qualitative research adopts a person-centred and holistic perspective. They further argue that the approach advocated an understanding for human experience, which is important for professionals who focus on caring, communication and interaction.

3.2 RESEARCH QUESTION

The functions of a research question is to explain specifically what the study is intended to learn or understand , help the researcher focus the study and give guidance for how to conduct the study (Maxwell 2013:75). Savin-Baden and Major (2013:99) assert that research questions are interrogative sentences that highlight the phenomenon to be studied, indicate what the researcher wishes to know about it and identify clearly what the researcher intends to learn.

A research question emanates from the research problem and should be closely related to the research goals and objectives. In this regard, research questions are not the starting point or controlling piece of the design, to which all other components must conform; instead they are at the centre of the design, the heart or hub of the component which connects most directly to all of the other components (Maxwell 2013:4). Thus the present research problem, as described in Chapter 1, led to the question that the researcher wanted to answer through this study. The task of the researcher was to explore family support for adolescents after rehabilitation for drug abuse. Therefore, the researcher made use of a research question for the purpose of this study.

The research question flowing from the research problem and related to the goal and objectives was:

What is the extent of family support of adolescents after drug rehabilitation?

3.3 GOAL/AIM AND OBJECTIVES

Following the research problem and research question, the goal and objectives of the proposed study were as given below.

3.3.1 Goal/aim

The researcher aimed to explore family support for adolescents after drug rehabilitation.

3.3.2 Objectives

In order to realise the research goal, the objectives for this research study were to:

- Identify and describe the involvement of families in supporting their adolescents after rehabilitation for drug abuse.
- Describe factors involved in the support of adolescents after rehabilitation for drug abuse.

3.4 RESEARCH METHODOLOGY

Polit and Beck (2012:12) define research methodology as the techniques researchers use to structure a study and to gather and analyse information relevant to the research question. On the other hand Streubert-Speziale and Carpenter (2011:366) state that methodology is an important component of the research and it is critically important that it flows from the developed background and significance and that it be congruent with the desired product of the project.

3.4.1 Research approach

In order to answer the question posed above, **qualitative approach** was employed because it was deemed more appropriate to explore the involvement of families in supporting the adolescents after drug rehabilitation. This research study was concerned with understanding rather than explaining family support for adolescents after rehabilitation, and it entailed the exploration of reality from the perspective of the families to the situation. Holloway (1997:2) cited by Savin-Baden and Major (2013:11) agrees with the above statement as he states that the aim of qualitative research is to understand the social reality of individuals, groups and cultures.

Streubert-Spreziale and Carpenter (2011:20) attribute the following six characteristics to qualitative research:

- A belief in multiple realities.
- A commitment to identifying an approach to understanding that supports the phenomenon studied.
- A commitment to the participant's viewpoint.
- The conduct of inquiry in a way that limits disruption of the natural context of the phenomena of interest.
- Acknowledged participation of the researcher in the research process.
- The reporting of the data in the literary style rich with participant commentaries.

Therefore qualitative research uses narrative descriptions of persons and fits the reality of the cases studied. On the other hand, quantitative research is defined as a process

that is systematic and objective in its ways of using numerical data from only a selected group of population to generalise the findings to the population that is being studied. Maree (2013:145). In contrast; Savin-Baden & Major (2013:12) assert that qualitative research has a more or less subjective and personal orientation.

3.4.2 Research design

According to Maxwell (2013:2) in qualitative study, research design should be a reflexive operating through every stage of a project. When deciding on a research design, the researcher considered the fact that family support for adolescents after rehabilitation for drug abuse has not been fully explored. The researcher therefore made use of a research question to guide data collection. Exploratory research design was thus selected as best suited to the research question being asked.

Walliman (2001:219) asserts that it is appropriate to select the type of research design as it indicates and relates to the goal of the study. Chapter 1 explained the reasons for the choice of the specific designs for this study. The following description explains how the designs related to the goal of the study:

3.4.2.1 Exploratory research

Exploratory research begins with a phenomenon of interest, but rather than simply observing and describing it, exploratory research investigates the full nature of the phenomenon, the manner in which it is manifested and other factors to which it is related (Polit & Beck 2012:18). This study explored the possibilities for further studies regarding the concerned group, as the literature and previous studies indicated a limited focus on the experiences of drug addicted adolescents regarding relapsing after treatment, thus indicating a need for further elucidation of the topic.

3.4.3 Population and sampling

This section will discuss the population of the study and the sampling and sample size used.

3.4.3.1 Population

Population is a group about which the information is gathered and conclusions are drawn, it should be clearly defined in respect of person, place and time as well as other factors relevant to the study (Polit & Beck 2008: 330). Leedy and Ormrod (2005:206) cited in Van der Westhuizen (2007:13) state that in qualitative research study, the population includes all the persons about whom the inferences are to be drawn.

The **total population** is defined by Polit and Beck (2012:273) as the entire aggregation of cases in which a researcher is interested. For this study the researcher is interested in studying families of drug abusing adolescents between the ages of 18–21 years, living in Mamelodi Township and who have previously attended rehabilitation and relapsed. From the total population the researcher will target a certain population of families of adolescents who have attended a drug rehabilitation programme. Polit and Beck (2012:274) define **target population** as the aggregate of cases about which the researcher would like to generalise. For this study the researcher will use families of adolescents who had or attend the Second chance Recovery centre in Mamelodi, a location in Pretoria (The seat of South African Government).

3.4.3.2 Sampling

Sampling in qualitative research is the procedure used to identify participants who have experience with the phenomenon of interest to the researcher and who will bring detail and complexity to the study (Rebar et al 2011:111). Additionally, a **sample** is a subset of a population comprising those selected to participate in a study (Polit & Beck 2012:742). A sample for inclusion in the study was selected from the aforementioned population. The criteria for inclusion in the study were as follows:

- Family members who live in Mamelodi Township.
- Families of adolescents who are between the ages of 18−21years.
- Families of adolescents who are abusing drugs and have been to the Second Chance Recovery Centre within a year of study.

The proposed criteria for exclusion in the study will be as follows:

- Families of adolescents younger than 18 years even though abusing drugs.
- Families of adolescents who have never been to rehabilitation even though abusing drugs.
- Families of adolescents who have been to other rehabilitation centres and not the centre where the current study was conducted.

3.4.4 Methods of data collection

Sewell (2006:1) cited by van der Westhuizen (2007:39) state that methods of data collection should assist the researcher in the attempt to answer the reserch question(s), and to understand the world from the participants' point of view. Polit and Beck (2012:532) concur that the primary method of collecting qualitative data is by interviewing study participants and further state that in qualitative studies, data collection is more fluid than in quantitative research and decisions about what to collect evolve in the field. According to De Vos (2011:347), qualitative studies typically employ unstructured and semi-structured interviews. As such, the researcher plans to use the abovementioned methods.

3.4.4.1 Interviews

The data collection method and instrument was an interview; comprising open-ended questions. An interview is defined as conversation with the purpose of gaining an understanding of the perspective of the person being interviewed (Fox & Bayat 2007:101). Interviews were conducted to ensure better return rate and to be able to translate the questions for respondents who do not understand English. The method allowed the researcher to explain some of the questions better to ensure that the respondents understood them correctly. The researcher tape-recorded the interviews, and kept field notes.

The advantages of interviews include the fact that they tend to yield in-depth information and are relatively easy for the interviewee to complete. This is particularly so when they are well-designed; resemble a normal conversation; do not require the interviewee to complete any form; and they have credibility among those working in the field. (Savin-

Baden & Major 2013:371). On the other hand, the researcher also identified the following disadvantages of interviews: they are time consuming and resource intensive; are dependent upon both the quality of the questions and the honesty of the participants; and they provide only the perspective of the interviewee, rather than the perspective of a group of individuals. The researcher considered both the advantages and disadvantages and concluded that the advantages of qualitative interviews outweighed the disadvantages and therefore suited the goals and objectives of this study.

3.4.4.1.1 Unstructured interviews

Unstructured interviews are conducted without utilising any of the researcher's prior information experiences or opinions in a particular area. Polit and Beck (2008:392) observe that unstructured interviews are conversational or interactive and are the mode of choice when researchers do not have a clear idea of what it is that they do not know. Researchers use unstructured interviews to elicit information in order to achieve understanding of the participant's point of view or situation (De Vos 2011:348). Unstructured interviews have the following characteristics:

Participants will be allowed to answer in their own words and from their own perspectives.

- They are not confined to per-specified response options.
- This yields narrative data which are submitted to qualitative, non-numerical data analysis.

3.4.4.1.2 Semi-structured interviews

Semi-structured interviews are defined as those organised around an area of particular interest, while still allowing considerable flexibility in scope and depth (De Vos 2011:348). Researchers use semi-structured interviews in order to gain detailed picture of the participants' belief about, or perceptions or accounts of a particular topic. De Vos (2011:352) further explains that with semi-structured interviews the researcher will have a set of predetermined questions on an interview schedule but the interview will be

guided rather than dictated by the schedule. De Vos (2011:351) further suggest that during the interview the researcher needs to get the participants to do the following:

- Open up and express ideas
- Express ideas clearly
- Explain and elaborate on ideas
- Focus on issues at hand rather than wander onto unrelated

For this study the researcher used semi structured interviews as in annexure C.

3.4.5 Process of data collection

This section describes the process of data collection. The process includes the preparatory phase, pilot testing and the structure of the interviews.

3.4.5.1 Preparatory phase

The researcher wrote an invitation letter to the Second Chance Rehabilitation Centre to participate in the study (Annexure B). Included in the letter was a request to have an interview with the staff members to enable the researcher explain the purpose of the study; the criteria for inclusion; and also to request the staff members to participate in the study as gatekeepers. This would enhance the researcher's capacity to regulate access to the participants.

3.4.5.2 Pilot testing

Maxwell (2013:66) is of the opinion that the use of pilot testing in qualitative research is to develop an understanding of the concepts and theories held by the people you are studying. Holloway and Wheeler (2010:341) refer to pilot testing as a small scale trial run of a research interview or observation.

Two participants who did not make the final population of the study were interviewed a week before the actual interviews. In the pilot study no difficulties were encountered. Participants found the questions to be clear and the responses were spontaneous.

3.4.5.3 Structuring of the interviews

The researcher prepared a written topic guide to enable her to include all areas that needed to be covered. This view was supported in literature as Polit and Beck (2012:537) noted that researchers intending to use semi-structured interviews must read broadly and then write a list of comprehensive questions to use as a guide.

Savin-Baden and Major (2013:359) agree with this statement and further state that the researcher should not only follow preset questions but include additional questions in response to participant comments and reactions.

The researcher interviewed the participants in a safe and familiar environment namely the treatment centre. The interview room in the centre was suitable as it allowed for privacy and comfortable sitting arrangements. The researcher enhanced participants comfort by having a relaxed casual conversation with each and every participant before commencement of the interviews.

3.4.5 Data analysis

Savin-Baden and Major (2013:434) define data analysis as an ongoing process that involves breaking data into meaningful parts for the purpose of examining them. The ultimate goal of qualitative data analysis is to make sense out of the data (Merriam 2009:203). Polit and Beck (2012:556) concur with this statement and state that the purpose of data analysis is to organise, provide structure and elicit meaning from data. As such the purpose of data analysis in this study will be to measure family support for adolescents after rehabilitation for drug abuse.

Data collection and analysis occur simultaneously, rather than analysing after data are collected (Polit & Beck 2012 556). Qualitative researchers often scrutinise their data carefully and deliberately, reading the data over and over in search of meaning and understanding. Once the data collected become repetitive, a point of data saturation is reached (Schurink cited in De Vos 2005:304). Qualitative analysis uses words rather than numbers as the basis of analysis, moving from concreteness to increasing abstract (inductive reasoning).

3.4.5.1 Method of data analysis

Qualitative content analysis was conducted as this study is not based in any specific tradition (Polit & Beck 2012:564). The choice of this method of data analysis assisted the researcher to work through all transcripts in order to transform data into a workable form. All the interviews were tape-recorded and transcribed verbatim. Field notes were also be added to the transcripts.

3.4.5.2 Steps in data analysis

Data analysis for this study was in four outlined steps.

Step 1: The researcher organised and prepared data for analysis. The process included verbatim analysis of transcripts and making notes according to categories.

Step 2: The researcher listened thoroughly to the recorded information and made some interpretations.

Step 3: The researcher then coded themes and subthemes. Each piece of data was classified accordingly.

Step 4: The themes were generated. The transcripts were also given to an independent coder and the researcher and the independent coder agreed on themes.

3.4.6 Method of data verification

To establish trustworthiness of the study and to validate the findings and subsequent conclusions, the trustworthiness of qualitative data obtained through the study was based on Guba and Lincoln framework (1994) cited in Polit and Beck 2012:584-585). The following aspects of the framework were addressed:

3.4.6.1 Credibility

Guba and Lincoln in Polit and Beck (2012:584) advise about the level of confidence in the truth of the findings for the particular participants, data or content and interpretation of them determined credibility. Therefore the researcher employed credible interviewing skills like clarifying, focusing to ensure that the findings are a true reflection of the participants' relations and views regarding family support for adolescents after rehabilitation for drug abuse. The researcher returned to the participants to share interpretation of findings and to confirm the accuracy of the findings from their perspective as the people who are living the experience.

3.4.6.2 Dependability

Guba and Lincoln in Polit and Beck (2012:584) refer to stability of data overtime, meaning that the findings should be consistent if the inquiry were to be replicated with the same participants in the same context. As such the researcher ensured that she documented any changes that occured as the research was going on.

3.4.6.3 Transferability

According to Guba and Lincoln in Savin-Baden (2013:475), transferability infers that findings may have applications in similar situations elsewhere, therefore to ensure this notion the researcher considered the degree to which the findings of the study are applicable to other groups, participants or context.

3.4.6.4 **Confirmability**

This criterion suggests that the researcher has remained neutral during data analysis and interpretation. Guba and Lincoln in Savin-Baden (2013:475) In order to remain neutral the researcher set aside her experiences and views about family support for adolescents after rehabilitation for drug abuse thus refraining from any bias during data collection, analysis and interpretation.

3.7 CONCLUSION

This chapter discussed the methodology used in the study. Descriptions of the methods used to ensure trustworthiness were also indicated in this chapter.

CHAPTER 4

RESEARCH FINDINGS AND INTERPRETATIONS

4.1 INTRODUCTION

The purpose of this study was to explore family support for adolescents after rehabilitation for drug abuse. The researcher found a gap in the literature regarding family support for adolescents after rehabilitation for drug abuse. Through the research, the researcher attempted to obtained information from the people who have or are experiencing this situation.

The sample for this study was drawn from the population of all the families of the adolescents who were on rehabilitation for drug addiction. The demographic data of this sample is discussed in section 4.2 of this chapter.

The protocol for data recording was the use of tape recordings to record the verbal data obtained from the interviews, and field notes to obtain the non-verbal data. The verbal and non-verbal data were transcribed directly after the interview and resulted in six (6) transcripts. Fox and Bayat (2011:73) postulate that interviews are a considered way of learning about people's thoughts, feelings and experiences; therefore observation for non-verbal cues is important. The researcher made use of qualitative content analysis as this study is not based in a specific tradition (Polit & Beck 2012:564).

The researcher maintained confidentiality of data collected by making sure that the transcripts, audio tape recordings and notes are kept under lock and key and that she is the only one who holds the key. Furthermore the transcripts in the laptop which was zipped and allocated a pass word so that the researcher is the only one who knows the pass word. The researcher identified and analysed data under the following categories: demographic data, interview data and observational data.

4.2 DEMOGRAPHIC DATA ANALYSIS

The demographic details of the five (5) participants in this study are displayed in Table 4.1.

Table 4.1 Demographic analysis

PARENTS/PARTICIPANTS				
NO	**MARITAL STATUS**	**EMPLOYMENT STATUS**	**AGE**	**GENDER**
1	M	Employed	42yr	F
2	D	Employed	37yrs	F
3	M	Employed	48yrs	F
4	M	Employed	44yrs	F
5	S	Employed	29yrs	M

ADOLESCENTS				
AGE	**GENDER**	**REHAB FREQUENCY**	**MONTHS IN REHAB**	**CHILD/PARENT RELATIONSHIP**
21 years	M	Twice	6 months	Son/good
18 years	F	Twice	4 months	Daughter/good
20 years	M	Twice	5 months	Son/good
20 years	M	Once	4 months	Nephew/good
18 years	M	Twice	5 months	Nephew/good

4.2.1 Marital status

Three of the participants were married. The assumption is where parents are married there will be support for the adolescent and for each other (Barrera & Li 1996:313). However during the interviews the participants indicated that they and their adolescent children were not receiving any support from their spouses. Failure for spousal support was more pronounced in situations where the male partner was a stepfather.

One participant was a divorcee and the other participant was a single mother. This meant that these two participants were responsible for the support of their adolescent children. According to Ceballo and Borquez (2008:529), being a single parent destabilises the socio-emotional growth of a child and may lead to drug use.

4.2.2 Employment status

All the participants are employed. This leaves the adolescents to be alone with their peers with no guidance and control from parents and guardians. Employment has been found to be a precursor for adolescent's reliance on their peers (Laursen 2005:350).

4.2.3 Age

The age of the participants ranged from 29 to 57 years. The youngest participant was 29 years old and was the only male. Among the females the youngest participant was 37 years old, three participants ranged between 42 to 48 years. Three of the participants were in their middle age and two were young adults.

4.2.4 Gender

The criteria for this study did not specify ~~on~~ gender; however, there was only one male participant. This finding augurs well with the research that says females are usually the caregivers in families (Thupayagale-Tshweneagae 2008:352; Shaibu 2013:363).

4.2.5 Rehabilitation frequency

Four adolescents have been to the rehabilitation centre twice already and for one adolescent it was the first time in the rehabilitation centre. It was explained during the interview that even though it was the first rehabilitation in a centre, he has been rehabilitated at home by the family.

4.2.6 Months spent in a rehabilitation centre

The months spent was between 4 to 9 months each at the rehabilitation treatment. The researcher also looked at the rehabilitation period of one adolescent who previously was rehabilitated at home and relapsed and was treated in a rehabilitation centre for 9 months after which according to the interview with the family member recovered completely. Therefore the researcher assumed that the longer the stay in the rehabilitation centre the better the results coupled with family support.

4.2.7 Child/parent relationship

Three of the participants were mothers to the adolescents, one was an aunt and the other was an uncle. All participants stated that they had good relationships with their adolescents.

4.3 CATEGORIES, THEMES ANS SUB-THEMES

Five categories and five themes emerged from the analysis. Some of the themes had more than one sub-theme as shown in Table 4.2 themes and sub-themes were identified as follows:

Table 4.2 Categories, themes and sub-themes

CATEGORY	THEME	SUB-THEME
Frequency	1 Number of times the adolescent was admitted in a rehabilitation institution	1.1 Adolescent came back to the very same place with same old friends
Parental/family involvement	2 Centre involving the family in the rehabilitation process/programme	2.1 Programme only involve the adolescent 2.2 Prayers as the only 2.3 Visiting as
Support system	3 Any support from family, friends or church	3.1 Blamed and judged for spoiling the adolescent 3.2 Being alienated by friends and family. 3.3 The immediate family still believe in the adolescent but the extended family has lost hope
Knowledge of support after rehabilitation	4 Meaning of support or ideas as to how to support the adolescent after rehabilitation	4.1 Provide finance to prevent him from steal and provide for personal needs 4.2 Lack of skill
Parental advice to other parents	5 Advice to parents/ families of adolescents newly entering rehabilitation or completed the rehabilitation programme	5.1 Do research about the centre where you will send the adolescent 5.2 This is overwhelming I cannot give advice 5.3 Family support is very important

Theme 1: Number of times the adolescent was admitted in a rehabilitation institution

The participants indicated that the adolescents under their care had been to the rehabilitation centre twice. The participants also stated that families sent the adolescents to different centres following a relapse.

During the interview the participants indicated that they saw a big change in the adolescent after rehabilitation but they seemed to have no idea as to why the adolescent relapsed after they had been rehabilitated. Goodwin (2000:91-93) cited in Van der Westhuizen (2007:73) refers to the addictive cycle which indicates relapsing as a normal part of addiction and recovery. Participants seemed to attribute the relapse of

the adolescents to the fact that the centre did not have proper treatment programmes for adolescents.

Out of the recorded interviews with the participants the researcher developed sub-themes regarding the number of times that the adolescents were admitted in a rehabilitation institution.

Sub-theme 1.1: Adolescent came back to the very same place with same old friends

The participants' discussion of the adolescent coming back from rehabilitation to the same area where drugs are easily available and to the same old friends who abuse drugs was cited as the cause for relapse.

The **classic conditioning theory of Pavlov** states that people learn addictive behaviour by pairing addictive substances with environmental cues, therefore when the adolescent come back to the same environment with same friends they are bound to trigger the craving. The following statements indicated that this aspect did put the adolescents at risk of relapse:

> "She went there for three months and she came back to the same place and then after four months she went back to her old friends and she relapsed."

> "I moved from our area and it's been three months she's free from the drugs."

During adolescence friends become very important and tend to have more influence than the family, and as such would do anything that friends are doing especially risky behaviour. Ali and Dwyer (2010), Branstetter, Low and Furman (2011) cited by Ramirez, et al (2012:37) agrees with this statement as they state that having friends who use drugs and alcohol is an important determinant drinking behaviour and drug use. Ramirez et al (2012:37) further state that peer influences clearly increase during adolescence and may become the more critical factor.

Another participant continued with the same line of thought in the following statement:

> "Because when they come back, they just come back to the same location or the same place where the nyaope is there."

> "For the few days they will just stay at home and immediately the friends come home and they go out to visit the friends then they go back to taking drugs. It is a vicious cycle."

Theme 2: Centre involving the family in the rehabilitation process/programme

During the interviews the participants indicated that they were never involved in the treatment or programme of rehabilitation. Other participants went further and explained that it was emphasized that during the few weeks of stay in the rehabilitation centre families are not allowed to visit. Robinson et al (2010) are not in favour of this as they state that individual treatment may not address the parent's concerns if an adolescent does not articulate them.

Family based therapies are considered among the most effective current treatments for adolescent substance abuse reiterate (Carr 2009; Carey & Oxford 2008 as cited in Robinson et al 2010:6).

The researcher developed the following sub-themes based on the involvement of the family in the rehabilitation programme:

Sub-theme 2.1: Programme only involves the adolescent

The participants verbalised that the programme only involved the adolescent. As a result they had no idea as to what happens during rehabilitation. According to Satir (2001:26) effective family therapy assists the parents and their adolescents to work cooperatively towards a common goal of recovery for the adolescent and support for the parents.

The following statements by participants gave insight into the fact that there was no family involvement during rehabilitation:

"The first two weeks they never wanted us there they said they were assisting him at least to detox and mostly they told us that they are trying to manage the pain and they don't want us to observe that."

"We were not that actively involved in the treatment that was offered by the centre."

"The answer is yes and no because I do not know often what happens there what kind of processes that they are using to help him maybe if they are the same like the ones before."

"They do call us in to tell us the progress but I don't feel too involved."

"They have never involved me the only thing is they phone me if there was some occasions like a pastor coming."

Sub-theme 2.2: Prayer as the only therapy

During the interviews it came out that mostly what happens in the rehabilitation centre is praying or church service by pastors. The following statements by participants confirmed this fact:

"Because this rehabilitation centre is like a church service they only pray."

"Different pastors come and the adolescents attend the service."

Sub-theme 2.3: Visitation as support

The researcher concluded that the participants saw visiting and offering what is needed as being involved in the rehabilitation programme. The following extracts from participants showed that participants view visiting as important involvement.

"I was involved in his care because the centre will call me when he needs something such as toiletries."

"I try to be involved at least in his life when I go and see him I usually ask the caregivers how he is doing."

“”After two weeks we were involved they said we must come and visit and bring some fruits and there was tuck shop so they want us to leave money but not more than R200.00.”

Theme 3: Any support from family, friends or church

Every individual at some stage needs support from others be it family, friends, church or peers. Just as people influence the social environment; they are also influenced by it in turn. (Lewis, Dana & Blevins 2011:168) alluded to the statement as they stated that when adolescents develop substance abuse problems, the issues are not limited to them alone but affect all their social systems.

The following sub-themes emerged from the above statement as mentioned by the participants:

Sub-theme 3.1: Blamed and judged for spoiling the adolescent

It emerged from the interviews that some family members and friends feel that the parents are too lenient towards the adolescent. The following extracts support this assertion:

“My husband blames me and says I spoil him and that is why he is in drugs.”

Other participants stated the following with sadness in their voices and in their faces:

“My son is not working so when I give him money my family accuses me of supporting his habits, I am his mother what must I do when he needs toiletries? As a results they say I am the cause and do not support me.”

“My daughter has been on drugs for three years now, my family and neighbours believe she will not change I must just leave her.”

“You know there is that judgement in the family oh you are working you have been to school and you know better.”

Sub-theme 3.2: Alienated by friends and family

It emerged from the interviews that friends and family members tend to feel embarrassed by the situation of the adolescent and at the same time they fear that he/she might steal from them as a result they alienate the family of the adolescent.

At times when the addiction is still new or fresh they show support until the adolescent goes in and out of rehabilitation. These statements are supported by the following extracts:

> "Most of my family members were supportive of me and him at the beginning … When he started being readmitted often they lost interest and never supported him."

and

> "Every time when he is home other family members accused him of stealing from them and they decided to alienate him."

> "Some of our family members they feel too embarrassed by the situation so they are tending to withdraw."

> "Once your son or daughter is into drugs they are stigmatised no one wants them or to be associated with them so they keep away and accuse them of stealing so as to support their drug habit."

One participant expressed her frustration as to not knowing who to believe with the accusations of stealing.

> "Now I become frustrated because I do not know who to believe ...Crying; my son or my family, as a result I decided to let him not to go to any of them."

Sub-theme 3.3: The immediate family still believe in the adolescent but the extended family has lost hope

The nuclear family in most cases offers support to the adolescents. However, members of the extended family such as aunts and uncles do not support them. This statement is supported by these extracts:

> "His mother still believe in him and I still believe in him and generally in a close immediate family we support each other and we support him."

> "Most of our extended family members are withdrawing from us because of fear that our son will steal from them to buy drugs or become a bad influence on their own children."

Theme 4: Meaning of support or ideas as to how to support the adolescent after rehabilitation

The researcher wanted to have an idea as to whether the families of adolescents have an idea as to how to provide support to adolescents after rehabilitation for drug abuse. Cleveland et al (2008:157) state that 'family support' was often cited by teens as being the most helpful in quitting drugs and maintaining sobriety (Lewis et al 2011:168) state that family system has the potential to influence the outcome of treatment for the adolescent and the family system itself can be seen as an appropriate target of change.

The sub-themes below emanated from the responses of the participants:

Sub-theme 4.1: Providing finance for personal needs

The responses from the participants indicated that the families preferred to give the adolescent financial support and all that he/she needs so as to prevent him/her from stealing. The participants further stated that they are aware that it is not right to give them money to buy drugs but it is better to do so than to let them steal from others.

The following responses talk to the above statement:

> "With me what I usually give him ZAR30.00 because that's how much nyaope cost. I do this because if I cannot give him, he will be forced to steal to get a day's fix."

> "I always make sure that he has some money to prevent him from stealing from others and risking to go to jail."

> "I provided him with everything that he needed toiletry, clothes, food."

> "I will never go out and buy a child a fix but I will make sure that I buy whatever he needs except drugs."

Sub-theme 4.2: Lack of skills to assist

During the interviews participants indicated that the situation of looking after adolescents who are on drugs was overwhelming and they had no skills of supporting the adolescents.

The responses below allude to the situation:

> "It is difficult but I ask him to call me to tell me if he is not coming home."

> "When he sees me on the street he must come to me so that we can talk."

> "I do not know how to help him I do not have the skills even to talk to him."

> "Even the pastors do not help, our pastor told me to pray."

Theme 5: Advice to parents/ families of adolescents' newly entering rehabilitation or who have completed the rehabilitation programme

This theme correlates with theme 4 and its sub-themes which explores whether the participants have any idea or skills of supporting the adolescent. The following sub-themes were formulated out of this theme:

Sub-theme 5.1: Do research about the centre where you will send the adolescent

Participants advised that it helps to have knowledge about the centre where the adolescent will be rehabilitated. One participant responded with emphasis in this regard:

> "Before you take your child to a particular rehab centre you must exactly know what's happening like the programme and is it going to help your child."

> "In this centre they were not been trained on how to avoid drugs or how to cope with peer pressure."

> "They will eat, sleep, and go to church so that when they come out they have nothing to do."

Sub-theme 5.2: This is overwhelming I cannot give advice

Two participants felt overwhelmed by this situation and stated that:

> "I don't know how to support my child. I also need advice as to how I should handle him, I'm still confused."

> "I haven't stayed with him after a rehab programme is complete I cannot' say I will support him because I do not have the skills to support him."

Sub-theme 5.3: Family support is very important

Participants emphasized the importance of family support. In contrast to the participant's statement Sally (2006) claims that it was unclear as to whether family involvement in adolescent treatment programme is more effective than addressing family issues in individual treatment with the youth.

These statements by participants indicate the importance of family support:

> “Make time for your children spend time with your child.”
>
> “Well mam what I can say is the first thing is to not give up hope because everyone deserves a chance this is a challenge like any other challenge.”
>
> “I still believe that family support not only from the mother. Whoever is there in the family must support the adolescents.”.
>
> “Avail yourself in order to talk to a person and try and find a way for them to pass time constructively.”
>
> “Keep on supporting your child irrespective of societal pressure, irrespective of your own problems there is always a chance of recovery.”
>
> “Emotional support is very important telling them that you still love them is very important you know.”
>
> “If you are not there as a parent when your child is going through this addiction it’s not going to help you in anyway therefore I am advising parents to not just support but to fully, fully support.”
>
> “It does not mean that when a child is in rehab you forget about them do go and pay them a visit get involved if the facility wants you to be involved be there avail yourself make time.”

4.3 ANALYSIS OF OBSERVATIONS MADE

Fox and Bayat (2011:74) state that observation is a unique form of data collection as result the researcher has to keep observational notes where she records what she sees and hears. The researcher made the following observations as discussed in sections 4.3.1 and 4.3.2.

4.3.1 Sad faces and slouched shoulders

The researcher observed that the participants showed very sad faces and this was more evident when they were responding to a question on the frequency of rehabilitation. The researcher attributed these body gestures as meaning defeat or loss of hope.

4.3.2 Continuous sobs and crying

Three participants sobbed during the interviews when they were asked about support from the family and friends.

One participant stated the following:

> “My husband does not support us and my family were supportive at first but now they do not support me and they do not support him they say he is stilling from them.”

> ‘’My family is embarrassed and they do not involve us in family activities.’’

4.4 CONCLUSION

The study was aimed at exploring family support for adolescents after rehabilitation for drug abuse. In order to achieve the objectives of the study as described in chapter one and two, five (5) participants who are close families of the adolescents were interviewed. The data collected was analysed until saturation was reached. The data was than divided into categories, themes and sub-themes.

The data were placed in 5 categories and main themes and sub-theories namely:

Categories

1 Frequency of admission to rehab
2 Parental / Family involvement
3 Support system

4 Knowledge of support after rehabilitation

5 Parental/family advice

Themes

1 Number of times the adolescent was admitted in a rehabilitation institution

2 Centre involving the family in the rehabilitation process/programme

3 Any support from family, friends or church

4 Meaning of support or ideas as to how to support the adolescent after rehabilitation

5 Advice to parents/ families of adolescents newly entering rehabilitation or completed the rehabilitation programme

Chapter 5 will conclude the study and will focus on conclusions and recommendations.

CHAPTER 5

SUMMARY, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

This study was about exploring family support for adolescents after rehabilitation for drug abuse, and to make some recommendations to the rehabilitation centre regarding involving the family throughout the rehabilitation process.

Chapter 1 was an introduction of this study, and highlighted the extent of drug abuse among the adolescents, and that adolescents need their families to support them. It also included motivation for the research, the objectives and the proposed methodology to be used in order to complete the study. Chapter 2 discussed the literature that supports the study and that which is in contrast with the study, while Chapter 3 described how the qualitative approach was employed. Chapter 4 analysed data under themes and sub-themes. The data that were obtained through structured and semi-structured interviews with the participants were supported with previous research studies and relevant literature. Chapter 5 will begin with a brief description of the previous chapters.

Recommendations will subsequently form a platform for future research and provide the rehabilitation centre with information as to how to improve rehabilitation by including families. This chapter will also discuss the findings of the study in relation in relation to the objectives of the study as presented in chapter one namely:

- To identify the involvement of families in supporting their adolescent children after drug rehabilitation.
- To describe factors involved in the support of families for adolescents after drug rehabilitation.

The researcher was able to explore family support for adolescents after rehabilitation for drug abuse and to subsequently answer the research questions mentioned below

through the chosen methodology as discussed in chapter three. The research questions were as follows:

- What is the extent of family involvement in supporting adolescents after drug rehabilitation?
- What are the factors involved in the support of families for adolescents after drug rehabilitation?

Also through data obtained, analysed and discussed in Chapter 4. Chapter 5 will include recommendations as to how to involve or include families during rehabilitation of the adolescents with a problem of drug abuse.

5.2 LIMITATIONS OF THE STUDY

The limitation to the study was that the researcher's study is limited to only one rehabilitation institution and therefore it will limit the findings and understanding. The researcher did not experience any limiting factors regarding the implementation of the research methodology that was chosen for this study. The researcher identified other limitations during data analysis as follows:

- The inclusion criteria limited the study to adolescents living in Mamelodi, the researcher is of the opinion that if the inclusion criteria were opens to other townships the results would have yielded a different picture.
- The majority of the participants were guardians of male adolescents, thus limiting the reflection of the two different genders.

5.3 RECOMMENDATIONS

Recommendations that emanated from the findings of this study are threefold. Recommendations to the rehabilitation centre which may be applicable to all rehabilitation centres; recommendations for families of adolescents going through drug rehabilitation and lastly recommendations for further research.

5.3.1 Rehabilitation centre

The following recommendations are made to the rehabilitation centre for improvement of care rendered:

- The researcher suggests that the rehabilitation centre needs to have a clear and proper programme of rehabilitation/treatment.
- Families of adolescents on treatment should be made part of the rehabilitation process so that it becomes easy for them to support the adolescents fully after they are discharged from the centre. Hogue and Liddle (2009:132) alluded to this statement as they state that family based therapy was found to have superior outcome effect for drug use compared to client based therapy. In support of this Ramirez et al (2012:37) states that les supportive and less structured family were associated with greater problem severity for adolescents.

5.3.2 Family

The findings of the study have shown that support for adolescents after drug rehabilitation is done haphazardly and that families are unsure what to do in order to support the adolescents.

The following are therefore the researchers' recommendations:

- The researcher suggests that families should be more involved in the rehabilitation centre activities by enquiring about the treatment/rehabilitation process and how they can be involved and not wait for the centre to call them.
- The families must use the initial rehabilitation centre if the adolescent relapses as the centre had already developed a strong bond with the adolescent thus making cooperation easy.
- Families should do proper research about the rehabilitations institutions before placing their adolescent so that the adolescent can receive proper treatment that include family as a support system.

5.3.3 Recommendations for future research

The study recommends that a similar research be done in South Africa at a larger scale than this one. The sensitivity of the topic and the apparent stigma associated with this type of study in most cases limits the number of participants one researcher can recruit.

5.4 CONCLUSION

The study explored family support for adolescents after rehabilitation of drug abuse. The findings were supported by relevant literature and previous research articles. The literature relevant to this topic is minimal therefore that posed a challenge to the researcher. From the interviews with the participants the researcher gained insight that drug abuse by adolescents is a sensitive and hurtful situation therefore even the families do need some kind of debriefing and involvement during rehabilitation.

The problem statement was that although there is a high rate of relapse of adolescents after rehabilitation there is a need to research whether families do support the adolescent after rehabilitation. The researcher gained insight during interviews that families are not clear as to how to support the adolescent; mainly because the rehabilitation centres do not involve families as they rehabilitate the adolescent. The findings of this study as well as recommendations make this study relevant to the current situation in South Africa regarding adolescent drug abuse, high relapse rate and family support after rehabilitation.

With this study, the researcher hopes that rehabilitated drug abusing adolescents will be supported by their families' in order to become valuable members of families and society.

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Annexure A

Ethical Clearance from the Department of Health Studies,
Higher Degrees Committee, Unisa

Annexure B

Request to conduct a study at Second Chance Recovery Centre

Permission granted by the Second Chance Recovery Centre to conduct a study

Annexure C

Informed consent form

Annexure D

Semi-structured interview questions

Annexure E

Demographic information form

ANNEXURE A

ETHICAL CLEARANCE FROM THE DEPARTMENT OF HEALTH STUDIES, HIGHER DEGREES COMMITTEE, UNISA

UNISA university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

REC-012714-039

HSHDC/227/2013

Date:	6 November 2013	Student No:	806-344-3
Project Title:	Exploring family support for adolescents after rehabilitation for drug abuse.		
Researcher:	MP Mzolo		
Degree:	MA in Nursing Science	Code:	MPCHS94
Supervisor:	Prof GB Thupayagale-Tshweneagae		
Qualification:	D Tech		
Joint Supervisor:	-		

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE B

REQUEST TO CONDUCT A STUDY AT SECOND CHANCE RECOVERY CENTRE

21 October 2014

The Manager/Director
Second Chance Rehabilitation Centre
3955 Section M
Mamelodi West
Pretoria 0001
Telephone: 012-805 6999

PERMISSION TO CONDUCT RESEARCH STUDY

Dear Madam/Sir

I am writing to request permission to conduct a study at your institution. I am currently enrolled with the University of South Africa and am in the process of writing my Master's Thesis. The title of my study is: **Exploring family support for adolescents after rehabilitation for drug abuse.**

The study will be conducted through an interview session by the researcher after the participants have received an informed consent.

Findings of the study will be presented to the institution and the participants on completion of the study. I will not commence with the study until I have received ethical approval and I will also provide you with the copy of the letter of ethics approval.

Your approval to conduct the study will be greatly appreciated. I will be happy to answer any questions or concerns that you may have. You may contact me at 082 503 5111 and work telephone number 012 319 5672. My email address: makhosazana.mzolo@gmail.com

Supervisor: Professor G. Thupayagale-Tshweneagae
University of South Africa
Tel: 012 429 2195
E-mail:tshweg@unisa.ac.za

Sincerely
Mrs Makhosazana Patricia Mzolo (Researcher)
Master in Nursing Science student, University of South Africa
Student Number: 08063443

ANNEXURE B

PERMISSION GRANTED BY THE SECOND CHANCE RECOVERY CENTRE TO CONDUCT A STUDY

Second Chance Recovery Center
<secondchance.recoverycenter@gmail.com>

10:40 AM (1 hour ago)

Dear Sir/madam

With reference to your letter dated 06/11/13, the management hereby allow Ms MP Mzolo to run her research program in our facility at any time.

Nomonde Mnguni (Managing Director)

ANNEXURE C

Informed consent for families participating: IN A STUDY EXPLORING FAMILY SUPPORT FOR ADOLESCENTS AFTER REHABILITATION FOR DRUG ABUSE

What kind of a study is this?

This study is to look at family support for the adolescents after drug rehabilitation. Much research has been done about the factors and consequences of drug abuse by adolescents but little if no information about whether families does support their adolescents after rehabilitation. We are interested in learning about how do you support your adolescents after they have been rehabilitated.

What will I have to do?

After filling in a consent form, participate in 45 minutes interview in which notes will be taken by the researcher while the interview is being tape recorded.

Later the researcher will meet with you so that you can read or listen to transcript of the interview so as to make sure that the information is correct.

What are the benefits?

Your help will assist the researcher as well as those who conduct rehabilitation. It will tell how it is like not to know how to support the adolescents after rehabilitation. From what you and others share, therapists can learn how to involve families during rehabilitation of the adolescent.

You and other families will get a summary of the findings when the study is complete.

What are the risks?

You may at some point find it uncomfortable to talk about certain things. You have the right to control what is talked about. If the interview is too uncomfortable, you can end it at any time.

Is it private?

The researcher will ask you about the support that you will give your adolescent after rehabilitation. She will not be sharing your specific responses with anyone else except her supervisor.

Your information will be completely confidential. False names will replace yours on the information form and in the typed copy of the interview. Only the researcher and her supervisor will have access to the data.

Once the completed study is accepted any material containing identifying information will be destroyed, including audiotapes (if applicable), notes and transcripts with identifying information in them. None of your personal information will ever be available to anyone.

Can I quit if I want to?

Yes, as participation is voluntary. You may quit at any time. There is no penalty now or in the future for you and your child.

Is there any compensation?

There is no compensation but when the research is completed, participants will be provided with a summary of the study's findings.

- You will have the satisfaction of sharing your story.
- You will know that your contribution may help others.
- Beyond the above, you will receive no additional compensation.

Participants' Permission and Responsibilities

I the undersigned agree to participate in the study. I have read the consent form and had all my questions answered. By signing below, I give my consent freely to participate in this study. I am aware that my privacy will be maintained and that I have the right to withdraw at any time without being penalised. I agree to follow the guidelines of the study.

If I have any questions about this research I will contact the person mentioned below:

Makhosazana Mzolo

Researcher

082-503-5111

Makhosazana.mzolo@gmail.com

_____

Participant's Name (please print)

_____ _____

Participant's signature Date

ANNEXURE D

SEMI-STRUCTURED INTERVIEW QUESTIONS FOR PARTICIPANTS

The researcher will start with a brief introduction explaining the purpose of the study and informing the participants about their rights no to answer any questions or to stop the interview without penalty. The following questions were asked during the interview:

1. Would you please tell me if this is the first time that your child is in a rehabilitation centre?
2. Are you part of this rehabilitation or does this centre involve you in this rehabilitation process?
3. Do you have any sources like family, friends or church etc., which can help you to support your child during and after rehabilitation?
4. Do you have any idea of how to support your or what does it mean to support you child when he/she comes out of rehabilitation?
5. What advice if any, would have for the parents/ families of adolescents newly entering rehabilitation or recently completed the rehabilitation programme?

ANNEXURE E

DEMOGRAPHIC INFORMATION FORM

Name and Surname:_____

Residential address: _____

_____

Telephone Number: _____

Name and Age of your adolescent in the rehabilitation centre: _____

What is your relationship to the adolescent on rehabilitation? _____

How long has your adolescent been in the rehabilitation centre? _____

Is this the first time in the rehabilitation centre: _____

If no how many times has he/she been to rehabilitation centre: _____