LIVED EXPERIENCES OF CAREGIVERS OF ADOLESCENTS DIAGNOSED WITH SUBSTANCE USE DISORDER ATTENDING KENYATTA NATIONAL HOSPITAL YOUTH CENTRE

BY

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DECLARATION

I Lydia Njoki Nyaga declare that this thesis is my original work and has not been presented for an award of a degree in any other university.

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DEDICATION

This study is dedicated to my parents and to my lovely children, Charity, Gloria and Shanice who, by their love and encouragement made an extensive contribution to this undertaking. My dedication also goes to my sisters and especially Dr Grace who never left my side. Their enthusiasm and patient enabled me bring this study to conclusion. May almighty God bless us all.

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LIST OF ABBREVIATIONS

ADA : Alcohol and Drug Abuse

DSM-5 **:** Diagnostic and Statistical Manual of mental Disorders fifth edition.

ERC **:** Ethic Review Committee

KNH **:** Kenyatta National Hospital

NACADA : National authority for the campaign against alcohol and drug abuse.

PDM : prescription drug misuse (PDM)

SUD **:** Substance Use Disorder

UN : United Nations

UON **:** University of Nairobi

WHO **:** World Health Organization

YCC **:** Youth Centre Clinic

OPERATIONAL DEFINITIONS OF TERMS

Adolescent: The World Health Organization (WHO) defines an adolescent as any person between ages 10 and 19. Key definition of Adolescent, Youth and Young people falls within WHO / UN and overlap.

Youth: 15 to 24 years

Young people: 10 to 24 years. In this study an adolescent will refer to any person between ages 13 to 18 years and attending youth friendly clinic, KNH. The term adolescent, youth and young person will be used interchangeably.

Caregiver: Any female or male adult of either a biological parents, guardian, a relative or legal guardian and plays the role of first caregiver, shares environment and has best child interest in their hearts and has an adolescent attending youth friendly clinic, KNH.

Drugs: Any substance that enters the human body and can alter the mind, body and behaviour of an individual. This includes illicit and licit drugs like alcohol, tobacco, cannabis, khat and prescribed drugs.

Drug Abuse: This term describes associated problems resulting from repeated use of psychoactive substances. In this study it is use of illicit drugs / substances which results in mood and behaviour change.

Substance Use Disorder: In Accordance to DSM- 5 it is defined as patterns of symptoms resulting from the use of a substance that one continues to take, despite experiencing problems as a result. In this study this is a term used to describe associated behavioural, mental and relationship problems which occurs after use of illicit drugs, alcohol and misuse of prescribed drugs.

Well-being: A feeling or an experience of happiness, comfort or health and that one perceives. It contains all the aspects of a person holistically including physical, emotional, social, spiritual and intellectual. In this study it means feeling well, leaving a satisfactory life and able to manage stress.

Youth Friendly Clinic: According to WHO Youth-friendly health services promotes health-seeking behaviour amongst young people. It has five domains - accessible, acceptable, equitable, appropriate and effective. The focus is on sexual and reproductive health care but integrated mental health care services. In this study youth Centre clinic is incorporated in the health services in KNH and attends adolescent from ages 13 to 23 years. Additionally, it offers HIV Testing and counselling services as well.

ABSTRACT

Introduction: Substance Use Disorder among the adolescent remains a big threat to health and wellbeing of the individual and the family. Substance abuse affects all age groups but adolescent individuals are most at risk because of the negative effects substance abuse has on their physical, psychological, behavioural and social transitions. Caregivers whether a biological parent or a relative of adolescent with SUD often suffer from unintended physical, psychological and social consequences of caring for the child who is using illicit drugs. Indeed, caregivers encounter many untold experiences while parenting an adolescent on substance use. There is limited documentation of such experiences. A remarkable number of researches have focused on adolescent substance use and the experiences of adolescents and little attention has being paid to caregivers. In that respect there is need to explore the experiences these caregivers undergo as they deal with substance habituated issues rising from their adolescent child.

Main Objective: The research study aimed at exploring "Lived experiences of caregivers of adolescents diagnosed with substance use disorder".

Methodology: This was a qualitative study based on in-depth interviews with 18 caregivers of adolescents with SUD conducted at the KNH youth centre focusing on their experiences. Data collected through in-depth interviews were transcribed and thematically coded. Recurrent themes were analyzed and reported.

Results: Caregivers' outcomes encompassed physical, psychological, and social experiences. Physical manifestations were illnesses such as hypertension and ulcers which directly linked to the adolescent's substance abuse. The major psychological strain experience was stress whereas social impact experiences were manifested as social stigma, social isolation and rejection. Coping mechanisms adapted by the caregivers were broadly identified as withdrawing or engaging. Other self-directed coping mechanisms identified were diverse ranging from singing to crying in order to deal with the stress related to the adolescent's substance use disorder.

Conclusion: Caregivers experienced debilitating physical outcomes, lasting psychological effects as well as difficult social outcomes as a result of substance use by their adolescent child. While endeavoring to offer continued support in the midst of seemingly insurmountable obstacles, caregivers adopted coping mechanisms to deal with their situation. Some of which were directed towards the adolescent such as engaging with the adolescent and others directed to self, such as singing, keeping busy, keeping to self and crying. This study revealed the complex landscape of physical, psychological and social turmoil that the caregivers have to navigate while intervening for their adolescent diagnosed with substance use disorder.

CHAPTER ONE: INTRODUCTION

1.0 Background of the Study

The most important aspect in adolescent health is 'behaviour'. Many behaviors that are known to cause non-communicable diseases later in life begin in adolescence, for example, early initiation of substance use in an adolescent can likely develop substance use disorders (SUDs) later in life (World Drug Report, 2018).

The word adolescence was first coined by, G Stanley Hall in the 20th century to denote a developmental transition stage from childhood to adulthood. It is marked by physical, psychological, social and emotional growth and development. (Gray, K. and Squeglia, L. 2018). It is marked by experiences of psychological turmoil as well as intensified experimentation and risk-taking behavior such as substance abuse. Adolescent period varies from 10 to 18 years and also from 18 - 21 years with differences varying in certain societies and cultures until social independence is reached (Hall et al., 2016).

Adolescence period in many communities in the world encompasses mainly transition in education from junior to senior schools, to securing jobs in informal or formal sectors. However, this transition can be hindered by risky behaviour like use of drugs and early unsafe sexual initiation initiated through curiosity and experimentation (Squeglia, 2018).

Substance use is often times initiated during adolescence period. Early initiation and subsequent substance use during this adolescence period has been shown to increase the risk of development of dependence or substance use disorder later in life (United Nations Office on Drugs and Crime, 2018 (UNODC), 2018); Jordan and Andersen, 2017). Studies have shown that the number of adolescents initiated into substance use each day is close to 8000 although

only 5-14% of this number develops SUD (SAMHSA, 2015). In addition, SUDs are among the leading cause of disability among children and youth globally and account for 9 % of disability-adjusted life year (DALYs) worldwide (Degenhardt et al, 2018), with alcohol use disorders, followed by opioid-related disorders and other SUDs accounting for most years lived with a disability or years of life lost due to early death (Erskine et al. 2015).

Substance Use Disorder (SUD) develops after repetitive use of illicit psychoactive substances as well as alcohol causing clinical and functional impairment which is evidenced by impaired control in the consumption of the substance, social impairment where fulfilling major roles in school or work is neglected, risky use in which it is harmful to health, and pharmacological criteria in which side effects occur due to withdrawal or tolerance (American Psychiatric Association, 2013).

SUDs among adolescents is perhaps the most widespread disorder that cuts across borders, tribe, class, faith or ethnicity as evidenced by research conducted both globally and locally. An estimated 3.7% of adolescent between ages 12 to 17 have Substance Use Disorder according to the Substance Abuse and Mental Health Services Administration publication (SAMHSA) 2019), which corresponds to one in every twenty-seven adolescents in 2018 globally.

According to the National Authority for the Campaign against Alcohol and Drug Abuse (NACADA) 2012), 13% of adolescents between ten and fourteen years have used alcohol. In Australia, it's reported that adolescents ages of 12 to 17 have SUD and the same is reported in other first world nations (Crawford et al., 2015). The prevalence of drug and substance abuse globally is at 34% (National Institute on Drug Use (NIDA) 2018.).

Across the globe the rate of drug abuse in men is generally higher than women (UNODC, 2018). Similarly, male adolescents have higher rates of substance use than females (Grüne et al., 2017). These findings are consistent with NACADA Kenya report which shown that 11.7%

school going boys abuse more drugs than their counterparts girls at 5.4% respectively (NACADA, 2016). However, this trend is recently changing with gender gap is narrowing, especially for alcohol use (Hall et al., 2016) for example, binge drinking in 2016 was reported at 5.4% in female and 4.4% in male adolescents respectively.

The drugs which adolescents commonly use worldwide include cannabis, alcohol, and tobacco. These substances share similar patterns of use (Johnston et al., 2017). A publication survey report of Global School Health Surveys (2010 to 2016) demonstrated a rise in widespread presence of cannibal and tobacco use among adolescent between ages 13 to 15 (Miech et al 2017). However, it was noted that youth from Canada use cannabis in great amount than their peers (McKiernan A., 2017). Cannabis has been reported to be the most abused drug in the world due to its perception of low risk of harm and easy availability and this makes it to be the most popular substance initiated in adolescence (UNODC, 2018).

Studies show that adolescents can become poly-drug users easily due to their high tendency to enhance the impact of the different drugs or counteract the side effects (Kelly et al., 2015). This is consistent with research findings that have shown about 57% of adolescents with SUD are abusing two or more substances (Mutter et al., 2015). The National Survey on Drug Use and Health (NSDUH) 2016 revealed that1.3million adolescents or more were engaged in past-year on prescription drug misuse (PDM). Common adolescent PDM source was friends or family, physician sources or purchases only (Schepis et al., 2019).

In Africa cannabis is also widely used among the youth. Studies have shown that youth aged between 14 and 23 in South Africa and in Kenya have used cannabis. In Nigeria and Ghana youth between ages 11-20 years and ages 18-24 years have used cannabis (Maurice et al 2015). In their study, Othieno, C. J., Kathuku, D. M., & Ndetei, D. M. (2000) also found that alcohol,

tobacco, khat and cannabis were the commonest substances used in rural and urban health centres in Kenya.

Report from (SAMHSA, 2019), showed that 3.8% of adolescent aged 12 to 17 required treatment for substance use in 2018. Despite this fact, only 6 to 11% received treatment in 2010 (Ilgen et al., 2011). Lacks of insight for the need of treatment, stigma associated with SUD, and poor health seeking behaviour by adolescents are some of the contributing factors which widen this gap (Ilgen et al., 2011). Among the adolescents, drug abuse is one of the leading causes of preventable mortality and morbidity (NIDA, 2017).

Family members are the ones who usually offer care to patients with substance use disorders and are often the primary caregivers (Orford, Copello, Velleman, & Templeton, 2010; Orford et al., 2001). Following this, family members often suffer from unintended consequences of caring for the member with substance use disorder. Often times, these family members are adolescents.

Substance use during adolescence has health effects seen later in life especially in adulthood, making adolescents not recognize the need for treatment. In turn, caregivers usually play the primary role in initiating the treatment for the adolescent and continued support thereafter. However, this is sometimes challenged by resistance from the adolescent (Kerwin et al., 2015). It is from this point that caregivers start experiencing difficulties arising from addressing SUDs in adolescents. Even though many studies have come up with the role of caregivers in development of adolescent drug abuse, there are limited studies done that focus on caregivers' experiences while caring for an adolescent with SUD (Groenewald and Bhana, 2016).

A study done by Kalam & Mthembu (2018) showed that parenting style is key in managing adolescent substance abuse. Caregivers who were authoritative or authoritarian had high discipline and expectation from their children. This parenting style was effective in managing adolescent substance use. Study by Peña et al., (2016) indicated that maternal demandingness which implies control of the child's behaviour by the caregiver was a protective health risk against use of substances for both male and female adolescents. This involved having standards set up for expected behaviour and hyper-vigilance on the child's activity.

Permissive parenting style, on the other hand, was mostly used in families with adolescents who abused substances. However, these findings contradicted findings from other studies that indicated that parenting styles had no significance in development of adolescent substance use. Other factors like early delinquency, substance use among peers and specific rules concerning substance are also likely contributors to adolescent substance use (Berge et al., 2016). While parenting style may play an important part in the child's life, sometimes the child who is a unique human being with free will might choose to go opposite way.

Most of the problems surrounding adolescent illicit drug use have a negative influence on the family members and particularly caregivers (Slabbert, 2015). There is consistent with the number of family members affected by effects of substance use by a close family member. Research has shown that approximately five individuals in a family suffer the consequence of drug or substance use by an adolescent (The American Journal on Addiction, 2011). Another finding by Velleman, Templeton & Copello (2005) indicated that relatively two more people in the family are affected by effects of substance use by a family member.

In return the affected family members are prone to emotional strains putting them at high risk of developing other health conditions and increasing the use of health care services. Caregivers in particular bear the major brunt of having to care for an adolescent who is actively using drugs and / alcohol and this causes them tremendous psychological strain and physical distress.

A remarkable number of literature have explored effective measures to help persons with substance use problems, however, the interventions to help affected family members is under researched, (Moriarty, et al., 2015).This is well supported by McKeganey, (2014) who indicated that research has mostly studied adolescent substance use comprehensively but the challenges experienced by caregivers, siblings or large family had limited documentation. Additionally, research on experiences of parents of adolescents with addiction problems has not been widely conducted (Groenewald & Bhana, 2017). The acknowledge demand for additional studies implies that more information is needed in order to understand what caregivers experience while caring for adolescents abusing substances.

Caregivers have information about how SUDs develop and how they are maintained and play significant role in defining the outcome of treatment achievement. Caregivers of these vulnerable adolescents require support from trained qualified personnel. Many research studies in Kenya have widely targeted adolescent alcohol and substance use; however, the experiences of caregivers whose adolescents are abusing substances have limited documentation. This is a qualitative study, which used in-depth interview in order to explore the experiences of family members of substance-abusing adolescents.

1.1: Problem Statement

Today, drug abuse among adolescents continues to be a major problem confronting many Kenyan communities and the world at large, increasingly placing caregivers in a difficult situation of having to care for an adolescent with these problems. In many instances, caregivers

fail to recognize symptoms of early substance abuse which is often masked by the acceptance of adolescent changes of behaviour. Therefore, there is caregiver role crisis in the realization of substance use by the adolescent who might have started experimenting use of drug early in age. In KNH Youth Centre clinic, SUD was the leading cause of admission followed by psychosocial cases, (Data from youth friendly clinic, 2018).

The parental responsibility is challenged by the adolescent when they engage in risky behaviour like use of drugs. For many caregivers obtaining treatment for the adolescent with substance abuse initially is a difficult task as a lot of them resist treatment or don't see the importance of the treatment. Many adolescents come to the clinic because they have been suspended from school. They come with referral letters recommending professional psycho-education counseling and are required to report back with a recommendation letter from the reviewing clinician.

Caregivers staying with an adolescent with substance use disorder have added responsibilities over and above the normal responsibilities. These adolescents depend on caregivers for sustained assistance during the treatment period. The caregivers at all times are worried whether or not the adolescent will drop out of school, run away from home get an over dose or land in the hands of law and order officers.

Drug abuse in youths can be chronic requiring proper support, action and care from caregivers. This can be compared to taking care of a child with autism or an adult with Alzheimer where work is tiring , never ending and this can affect one's mental and physical health. Thus, the reality of caring for a youth with substance abuse disorder remains an individual experience which solely impacts the caregivers and threatened their physical, psychological and social wellbeing.

The government of Kenya has been in the frontline in the fight against this scourge which has enslaved many youths. NACADA, religious groups and teachers have all been involved in the mitigation interventions to address drug use related concerns. However, the caregiver concerns have been received very little focus. In providing health and social care to their substance-abusing adolescent, caregivers are often considered as unpaid resource and encounter a lot of challenges since they are usually untrained to tackle the role, yet documentation on their experiences remains limited.

In Kenya, half of the population is made up of young people. Attainment of vision 2030 is pegged on the preparation of the youth for productive engagement in economic activities. Drugs fuels incompletion of schools, unemployment, conflict with the law and engagement in unsafe health practices. Unless decisive action plans are put in place to stem this tide, the ambition to become an industrialized nation pegged on inputs from them will not be attained. Studying the experiences that caregivers encounter in raising an adolescent diagnosed SUD is an initial step in determining ways to strengthen support for them. Evidence based guidance to caregivers would help support caregivers to adopt effective approaches in dealing with SUDs in adolescents. Such focused effort will protect the caregivers from substance use disorder impacts. This study aims to explore challenges caregivers experience while caring for their children with substance use disorder. Particularly, it aimed at exploring the physical, psychological, and social encounters of caregivers while taking care of adolescents with SUDs and how they try to cope with the challenges arising thereof.

1.2 Justification

Despite caregivers having a primary role in raising their children to their full potential, they cannot adequately care for their substance abusing adolescent without assistance and

professional attention. Substance use affects the adolescent health and raises serious problems in care giving role. During childhood, caregivers provide for their children totally for their basic needs. Further they are provided with means of acquiring education that enable them to contribute to their personal and emotional growth. However, when an adolescent has substance use disorder, they engage in unconstructive and unproductive activities. Drug abuse within the adolescent inhibits the achievement of their full potential. The drug use disorder is like a trap set up by an individual becoming an ineffective member of the society as they are consumed by their own addiction, yet caregivers are supposed to support these adolescents unconditionally. Many intervention programmes are for adolescents. Caregivers need to be equipped with skills and knowledge which can come up from the experiences they go through in order to help their children reach their full potential and realize their dreams

The 'Big four 'agenda are programmes aimed at achieving universal healthcare, increasing food and nutrition security, job creation and affordable houses. Achievement of provision of universal health care is through reduction of non-communicable diseases (NCDs) associated with harmful use of alcohol and tobacco which stands at 50% of hospital admission costs. Caregivers of adolescents with substance use problems can benefit from programmes which can equip them with knowledge on how to recognize early signs of substance use in their children. In return caregivers of adolescents with substance use disorders can have reduced burdens while taking care for their children.

There are several studies in Kenya on adolescent substance abuse and their coping actions, however, there are few on the experiences of caregivers of adolescents who are abusing substances done in other countries and in Kenya alike.

The study sought to quantify and explore the lived experiences of caregivers as they dealt with substance habituated issues arising from their adolescent children. SUD can be chronic illness, understanding the experiences of caregivers of adolescent with drug use problems will offer some insight into this phenomenon.

The anguish experienced by family caregivers, can serve as a preliminary investigation of the experiences and needs of family caregivers of an adolescents with SUD in Kenya. These experiences can be used to document evidence-based intervention strategies that caregivers could use at home when dealing with their drug addicted child.

1.3 Significance of the Study

The findings in this paper contributed to the existing body of knowledge on illustrating lived experiences of caregivers with a substance abusing adolescents.

Knowledge generated from this study may be useful in offering holistic quality care by health workers, especially nurses and psychologists who work in the youth Centre clinics through empowering caregivers with needed information and skills derived from these experiences on how to effectively deal with negative impact of adolescent substance use.

The healthcare team may also use this knowledge to come up with evidence-based approaches, to provide guidelines on the effective strategies necessary to support caregivers in dealing with adolescent substance use. This could involve reformulation of the already existing institutional protocols on family-centered management of adolescent substance use. In turn this will improve adolescent chances of recovery and their quality of life as a whole.

1.4 Research Questions

1. How does adolescent substance use disorder affect caregivers physically?

2. How does adolescent substance use disorder affect caregivers psychologically?
3. How does adolescent substance use disorder affect caregivers socially?
4. How do caregivers cope with adolescent substance use behavior?

1.5 Broad Objective

This study explored the experiences of parenting adolescent diagnosed with substance use disorder at Youth Centre Clinic of Kenyatta National Hospital.

1.5.1 Specific Objectives

The following specific objective guided the study

1. To explore caregivers' physical experiences of parenting an adolescent diagnosed with substance use disorder attending Youth Centre Clinic, KNH
2. To identify caregivers' psychological experiences of parenting an adolescent diagnosed with substance use disorder attending Youth Centre Clinic, KNH
3. To determine the social experiences of caregivers with an adolescent diagnosed with substance use disorders attending Youth centre Clinic, KNH.
4. To determine how caregivers cope with their adolescent diagnosed with substance use disorders attending youth centre Clinic, KNH.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of the relevant literature as guided by the study objectives. This is in relation to the study topic -Lived experience of caregivers of adolescents with SUD.
As noted in Chapter One, research on experiences of parents of adolescents with SUD has not been widely conducted. In fact, literature search in Africa on lived experiences of caregivers whose adolescents are abusing substances have limited documentation in South Africa alone. A literature review of the following databases was conducted: GOOGLE SCHOLAR, PUBMED and OPEN ACCESS. Key words which were utilized included: Caregivers, Parents, Adolescents, Adolescence, Illicit drugs, Substance use, Substance use disorder, Experience, Lived experiences and coping mechanisms.

Substance abuse refers to the use of illicit drugs or other psychoactive substances that produce mood changes and distorted perceptions. These drugs are classified into 10 distinct classes according to criteria in DSM-5. These classes include: caffeine, hallucinogen, cannabis, alcohol, opioids, inhalants, sedatives, hypnotics or anxiolytics, tobacco and stimulants (American Psychiatric Association 2013).

Adolescence is distinct period marked by developmental transition from childhood to adulthood characterized by major physical, cognitive, and psychological changes. (Gray, K. and Squeglia, L. 2018). According to a recent report released by (World drug survey 2018), adolescents can be initiated into substance use in early years of 12–14 or late years of 15–17; a significant period of risk for their physical and physiological development, (Jordan and Andersen, 2017). The report also indicates that substance use may reach the peak among this young group at ages18–25. Similar results also have been reported in Kenya, where by the ages

of 13-15 years marks the age of onset of drug abuse as children transit from primary to secondary school, (NACADA, 2016).

A study by Dougherty et al., (2015) reported that adolescents could develop SUD partly due to the undeveloped part of their brain that is responsible for impulse control and risk-taking behaviours. The risk factors for substance use disorder (SUD) which affect the treatment procedure and improvement, differ due to several factors such as age, gender, education, economic status, culture, health status, race and ethnicity, sexual orientation, (Wisk and Weitzman, 2016; Vaeth et al., 2017). Further to this, substance use has been noted to be common among adolescents in both low- and high-income countries (Nociar, Sieroslawski, & Csemy, 2016).

This explains why Substance abuse among adolescents is a significant public health concern. Review of literature shows that 10% of adolescents in ages 12-17 years in the United States are affected by substance abuse, and about 7% can meet the diagnostic criteria for specific DSM-V SUD at any point (Burrow-Sanchez, Minami, & Hops, 2015). A clinical epidemiology study has shown that 34.4% of admitted patients at a psychiatric hospital in Kenya met the criteria for substance use disorders Ndetei, D. M., et al., 2008).

While most adolescents may not move beyond experimentation, close watch by the South African Community Epidemiology Network on Drug Use (SACENDU) showed that 20 per cent of admissions in health institutions had SUD and were below 20 years. SUD is a self-destroying activity which has high premature fatality. An estimated 70,200 young Americans were victims of drugs overdose in 2017 (Gobel K et al 2016).

Caregivers play an important role in protecting and caring for their adolescent children especially during this phase of their physical and psychosocial development. This is because

the adolescence stage is nested between end of childhood and beginning of adulthood transition period. The majority of adolescents with SUD need family support and often live with their family for a longer period of time.

The family system theory emphasizes that an individual needs to be fully understood on how he/she operates in the family system in order to have successful treatment of SUD. The disturbance of family homeostasis begins when one person changes his/her behaviour due to substance use thereby influencing their social environment which will in turn influence them (Lander et al., 2013). A study on family communication discussed how parents could become campaigners against adolescent drug use by teaching them the preventive measures and particularly emphasizing on norms and discipline. (Choi et al., 2017; Pettigrew et al., 2018). Research has also shown that family members of individuals with substance use problems tend to have higher incidences of mental health problems (Ray et al., 2009).

The complication related to adolescent drug abuse in the family is of concern because it remarkably disrupts the social aspect and psychological wellbeing of the significant others (Groenewald & Bhana 2015). Study findings by Hoeck & van Hal, (2012), indicated that substance and alcohol abuse reduced the physical, mental and financial possessions of each individual and their families.

Generally, it is the caregivers who bear the responsibility of the actions of the adolescent as it is expected of them to come up with solutions to control the adolescent misbehavior. (Smith & Estafan 2014; Author, 2016). Behavioral misconduct, parents' experiences from their adolescents on substance dependence include: theft, violence, aggression, disrupted educational goal, health problems, physical and verbal violence, family relationships breakdown and disrespect (Groenewald & Bhana 2015, Orford et al. 2010, p. 51, O'Brien et al.13)

In this document caregiver strain refers to the tasks or responsibilities, demands, difficulties, and negative psychic consequences of caring for an adolescent child with SUD as a special need. In particular, the researcher is concerned with strain experienced by the caregivers who have primary responsibility for the needs of adolescent child with drug use problems.

2.2.1 Physical Experiences

SUD among the adolescents have been shown to have a significant negative impact not only on the adolescent, but also on the family members and particularly caregivers. Caregivers strain can be the seen as the negative physical manifestations usually related to the extra responsibilities of caring for an adolescent with SUD.

The harm associated with substance use within the family like aggression and violence have been on the increase (Haskell R, Graham K, Bernards S, and Flynn A., 2016). Aggression and violence which are words referring to any form of conduct or action that can cause physical and psychological injuries to another person either verbally, physically or psychologically (McCann et al., 2017).

The findings in this study found that aggression was upsetting, stressful and emotionally exhausting. The shouting, insulting and criticism characterized verbal and emotional aggression. Consistent with these findings were those by Choate (2015) who found that as the substance use problem intensified, the adolescent became noisy with variability in mood changes.

The aggression behaviour was also characterized by manipulation, arguments and telling lies. Violence was seen as pushing, punching and biting. These findings were consistence with research findings by McCann, et al., (2017) which showed that elderly women experienced physical assault from their drug-dependent adolescents in their care.

2.2.2 Psychological Experiences

Parents are generally not aware or well informed about the type of drugs chiefly being abused by their children as well as the risks and resulting problems. As a consequence, this may make them feel that they lack confidence in their ability to guide their children prior to or later after finding out about drug use (Ackard, et al., 2006). A study done by Choate (2015) also found that parents came to know about the adolescent use of substance in three different ways: direct evidence of substance use like overdose which required emergency admission; accidental discovery where a parent would find stuffs in the adolescent room indicating use of substance; failure in fulfill major roles like drop in school performance, having interpersonal problems with other members of the family or giving up important social activities.

Studies have shown that drug use in the family is associated with esteemed stress which can compromise the mental health of parents and their personal wellbeing (Orford, Velleman, Natera, Templeton, & Copello, 2013). Choate (2015) in his study found that caregivers felt helpless and ineffective as they tried to get help. For instance, caregivers felt professionals in the clinic were insensitive to their situation and this made them feel isolated. Caregivers felt disappointed in that professionals often withheld information about their adolescent's condition due to concerns of confidentiality and this made it hard for them to understand the adolescent's drug problem. They desired to be talked to in the presence of their adolescent as is often done in other health-related visits with the clinician. This further revealed how caregivers felt frustrated indicating how substance use disorders can leave families feeling helpless, strained, and disrupted. Usher et al, (2007) in their study reported that caregivers are often conflicted on how to manage and react to behaviors exhibited by their substance-dependent child. Communication breakdown is often experienced between the caregivers and the affected child making it difficult to deal with the issue (Vincent, 2014; Butler & Bauld, 2005). Similar studies

also showed that caregivers often felt confused, helpless, anxious and frustrated with the person's behaviour. (Denton and Kampfe, 1994).

2.2.3: Social Experiences

Violence and aggression affected social communications and family unit function leading to social isolation. The caregivers experienced either public or self-social stigma. The public stigma was evidenced by the secrecy with which they had to engage while seeking care for their child as well as minimizing contact with others because of shame and embarrassment. Self-stigma occurred when caregivers feared being judged by others because of their child's drug use behaviour (McCann et al., 2018).

Adolescent substance abuse has an impact in all areas of family life making. Caregivers are often stressed about the additional burden of taking care of an adolescent with substance use disorder and always feel divided on whether to provide support for their drug affected child or take care of the other children (Jackson, Usher and O'Brien, 2006). Choate (2015) also found that relationship ties between the adolescent and their caregivers as well as the relationship between the adolescent and their siblings was fractured upon discovery of substance use.

In their review, Smith & Estefan (2014) reported that drug dependence affected families largely because of keeping family secrets thus hindering actions towards finding the solution to the problem. This unwillingness to open to anybody or to seek support apart from the immediate household is linked to feelings of being a good parent, and protection from the shame which they might feel if it is known outside of the family (Orford et al., 2010; Choate 2015). Additionally, female caregivers face increased pressure from societal expectations of successful parenting and are more often than not, held liable for their child's behaviour (Smith & Estefan, 2014).

A study done by Wegner, L et al., (2014) showed that occupational performance of a caregiver, and specifically for mothers, was not achieved satisfactorily due to adolescent substance use. Mothers had to adapt new ways within their routines, roles, habits and rituals in order to accommodate the child with SUD as a large proportion of the mother's time, energy, attention and focus were directed to the one child with SUD than to the other siblings. The role of a wife or worker as well as the social life of the mother was not spared either. Findings by Wilson, et al., (2018) also showed that the unpredictable and undesirable nature of the behaviour of the child with SUD made the caregivers avoid interactions with others.

2.2.4: Caregivers' coping mechanisms

Different studies have researched many models of how caregivers respond to family member's aggression and violence (Orford et al., 2013; Choate, 2015). An example is "Stress-Strain-Coping-Support Model", which show how family members act in response to a member's violence and aggression. The model has three approaches: withdrawing from the person or environment, tolerating the behaviour by accepting the child's behaviour and engaging the problem either by seeking alternative help from the police or a health professional.

Caregivers have come up with different approaches to manage the child's misconduct. Study results by McCann et al. (2017) indicated that caregivers would be cautious to observe anything that would provoke aggression, avoiding social activities, seeking for alternative enforcement and sharing the drug problem with other family member. Choate (2015) found that some caregivers would impound all the drugs from their drug abusing child; others would keenly observe the child's movement and track all their social media communication.

Involving family members in the treatment of adolescent substance use is necessary in order to be successful. Research by Cook, (2001) concluded by saying management of adolescent drug use without paying attention to caregivers "limits our vision and decreases the potential for the recovery of a young life".

2.2.5 Theoretical Framework: Neuman's Systems Model

Many researchers have come up with different theories that support the understanding of how substance use among the adolescent can lead to SUD. One of the nursing theories that can be applied in this study is Betty Neuman's Systems Model (Alligood & Tomey, 2006). Neuman's Systems Model function as a theory for understanding how Substance Abuse can change various aspects of an individual's life, families members life's and vice versa.

The Neuman Systems Model is a suitable model for guiding the nursing practices and providing a holistic viewpoint. Lived experiences research deals with people who are willing to be engaged with the interviewer and express their opinions and experiences. Each and every individual has a unique experience with life and their perceptions, beliefs, and values are influenced by these experiences. Lived experience of health can be considered as the quality of life experienced by the person. Lived experiences of health basically involve one's interrelationships with others in the world (Fawcett, 2000).

Neuman's model is based on the individual's relationship to stress, reaction to it, and protective interventions. Neuman's theory describes a human being as a basic structure surrounded by concentric rings referred as a system. The theory views client as an open system who may be an individual, a family, a group or a community.

In this model, concentric rings are made up of lines of defense. The lines of defense are outlined as line of resistance, normal lines of defense and flexible lines of defense and each consists of five variables: physiological, psychological, socio-cultural, developmental, and spiritual. The lines of resistance represent internal factors that help the client defend against a stressor. The inner/normal line of defense represents the person's state of wellness. The flexible line of defense is dynamic, prevents stressors from affecting the client system and maintains an individual's normal balance (Neuman and Fawcett, 2002).

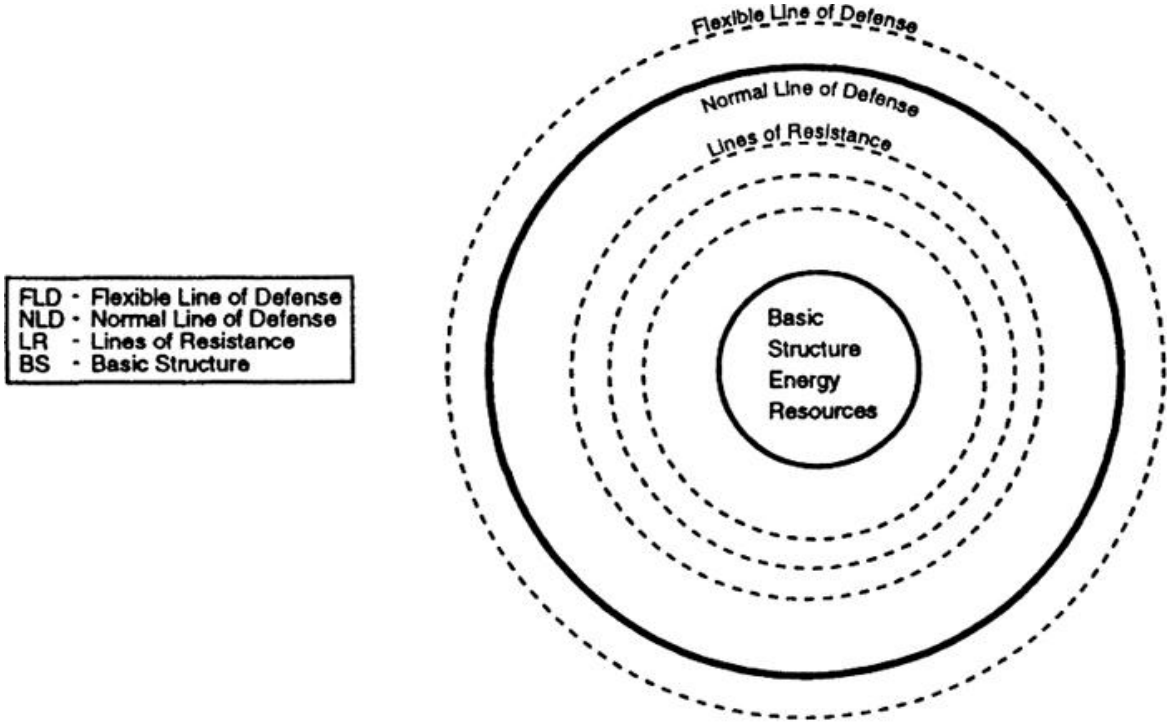
Neuman defines stressors as environmental forces that disrupt the system's balance. These Stressors in the model are Extra-personal which occur outside the person, Interpersonal which occur between individual and Intrapersonal and occur within an individual. According to Alligood & Tomey (2006) these stressors are universal and can have negative impacts physically, emotionally or socially when individual's system is disrupted.

The Systems Model family describes family as an open system made up of subsystems of family members. The family system strives to defend its state of balance against the effects of internal and external environmental stressors that threaten the state of wellness (Neuman & Fawcett, 2002). Neuman's Systems Model allows the researcher to understand how adolescent's SUD alters their family system which symbolizes wellness.

Family's stability is threatened when an adolescent engages in drug abuse through adapting new role demands in the management of the illness. The main purpose of a family is to maintain its integrity and wellness. Therefore, difficulties experienced by the caregivers of an adolescent with SUD in the process of care-giving create disruption in the system's balance. Caregiver responsibilities can be regarded as a source of stress in the care-giving practice. Alarmingly, adolescents do not recognize potential health issues associated with illicit drug use as the effects can only be seen later in adulthood (Kerwin et al.,2015).

Using the Neuman Model helped the researcher to understand the environmental forces that impact the client system as stressors. These stressors are their experiences which occur daily as they live with an adolescent abusing drug. This model also provided the researcher with a comprehensive assessment in terms of care-givers experiences and practice. It guided the researcher in recommending effective problem-solving techniques during the primary, secondary and tertiary prevention interventions strategies. In this regard, the Neuman Systems

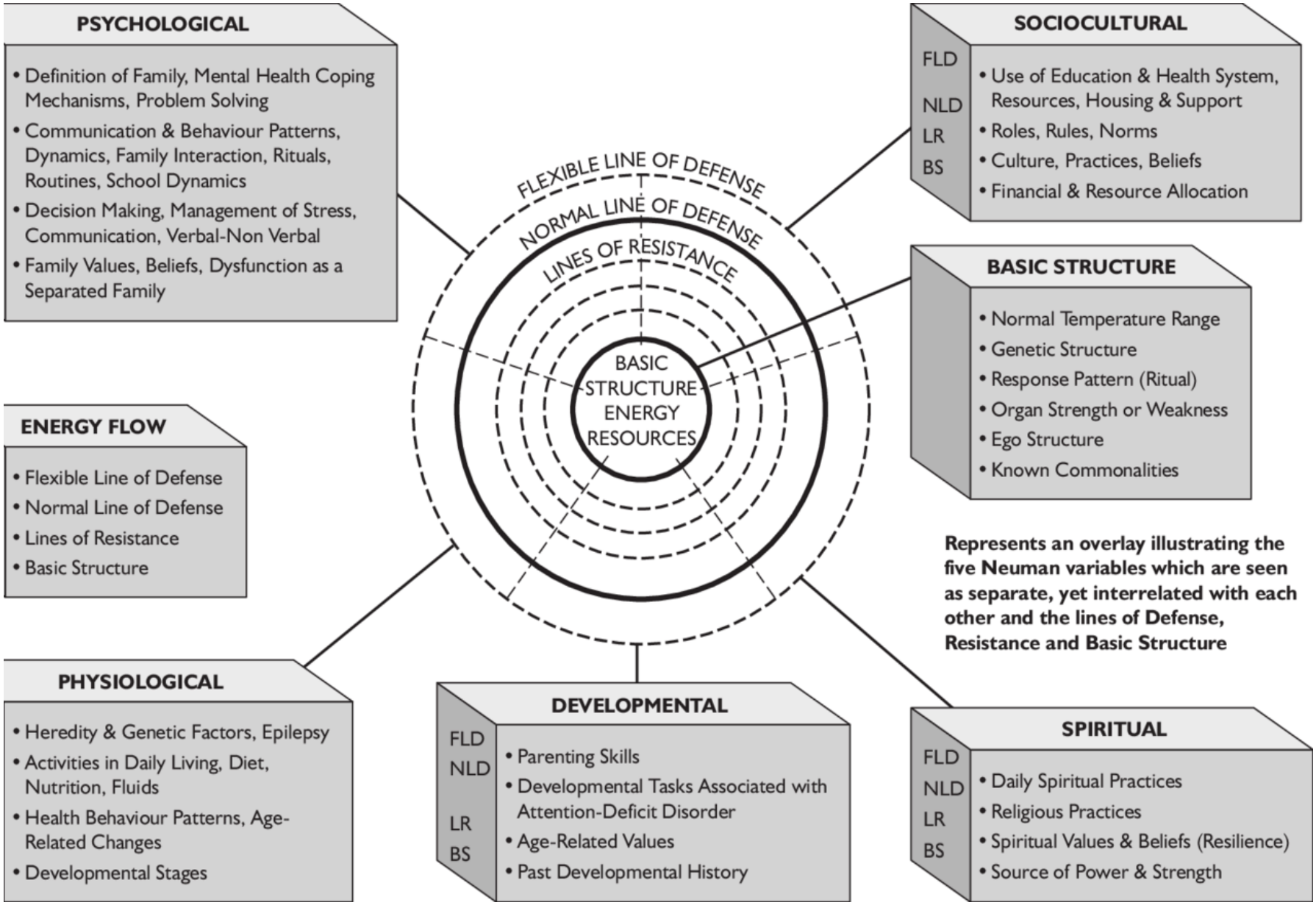
Model provided the researcher with a broad viewpoint regarding how adolescent's SUD affects caregivers.



SOURCE: Adapted from the Neuman systems model diagram, by permission of Betty Neuman.

2.2.5 Criticism of the model

1) Neuman has presented a view of the client that is equally applicable to an individual, a family, a group, a community, or any other aggregate.
2) The Neuman Systems Model, particularly presented in the model diagram, is logically consistent.
3) The emphasis on primary prevention, including health promotion, is specific to this model.
4) The major weakness of the model is the need for further clarification of terms used.
5) Interpersonal and extra personal stressors need to be more clearly differentiated.



Source: Adapted from the Neuman systems model diagram, by permission of Betty Neuman.

CHAPTER THREE: RESEARCH METHODOLOGY

3.0 Introduction

The following chapter includes a detailed description of the methodological proponents of the study. It discusses the research design, study area, the target population, sample size, sampling technique, inclusion and exclusion criteria, data collection instruments and procedures. Also discussed are the validity and reliability of research instruments, data analysis procedures, data storage, ethical considerations and data dissemination plan.

3.1 Study Design

The study adopted a descriptive cross-section research design which was used to establish the physical, psychological and social outcomes of caregivers of adolescents diagnosed with SUD. It utilized interpretative phenomenological approach.

The qualitative method was intended to show the variation in opinions, feelings, and experiences within a target population (Sandelows, 1994). Phenomenological design, allowed the investigator to learn of the real meaning of the participant's experiences (Creswell et al., 2007). This design suited the study well as its objective was to gain an understanding of how caregivers experience living with an adolescent child who is addicted to a substance and how they cope with the situation. This research design has been used in studies by McCann, et al. (2017); Groenewald & Arvin 2017; Jackson et al. (2007), and Usher et al. (2005) which were all aimed at investigating caregivers' lived experiences of their adolescent's substance abuse.

By asking probing questions to the participants, it allowed participants to deeply reflect on their experience at the same time allowing them to express their narrative in their own style (Suddaby, 2006) hence giving the researcher an understanding of the development of the experience. (Charmaz, 2014).

3.2 Study Area

This study was carried out at the Youth Centre Clinic in Kenyatta National Teaching and Referral Hospital (KNH) located in Upper Hill, Nairobi County. KNH is a public tertiary, referral hospital with a 2500 bed capacity. It's also a teaching hospital for the University of Nairobi's School of Medicine. It's one of the largest hospitals in Central and East Africa. The hospital has a well-organized and efficient referral system. KNH is the hospital is popular and option for many Kenyan people because it is low cost charges and good quality of health services. It serves a wide catchment of approximately 3 million citizens, making it appropriate for the purpose of fulfilling the requirements of this study. The hospital offers various in and out-patient health care services in its several specialized clinics. Besides, the hospital promotes medical teaching and engages in formulation of health policies.

The youth centre is located on the ground floor just next to the exits entrance. The youth centre receives clients from ages 13 years to 23 years. The Youth Centre was founded in the hospital though the funding of Pathfinder International in 1990 and later surrendered to Kenyatta National Hospital in 2000. The clinic offers promotive health services, preventive and curative services as their core objective hence to reducing mortality and morbidity related with risk behaviours. Specifically, services offered include counselling services and youth reproductive health including post abortal care, family planning services, STD (Sexually Transmitted Diseases) management, care of gender based violence survivors (GBV) and HIV Testing and counselling (HTS).

The mental health services include psychiatric review and treatment and psychosocial counselling services. The conditions seen include substance use disorder, Conduct disorders, gender dysphoria disorders, personality disorder, Anxiety disorder, neuro- developmental disorder. The clinic sees approximately 290 adolescent per month and around 3400 per year.

There are 90 adolescent seen with substance abuse disorder per month. The YCC sees an average of 8 new patients per week.

The clinic operates from Monday to Friday for 8 hours daily. The YCC has six nurses/counsellors, one data clerk staff and one support staff. This was per the time of data collection. Two psychiatrists and one psychologist are available in the clinic. Gynecological services are offered in the wards.

Because the youth centre operates daily there were high chances of recruiting many participants. Also since the hospital is a referral centre there was the probability of getting caregivers from all over the country. Hence different caregivers had equal chances of participating in the study.

3.3 Study Population

The populations studied were 32 caregivers of adolescents diagnosed with substance use disorder and attending Youth Centre Clinic, KNH.

3.4 Sample Size determination

Sample size adhered to the principle of data saturation (Saunders et al., 2018). Saturation occurred around the 18th interview. Many studies in descriptive phenomenological research demonstrate that data saturation is typically achieved with a sample size of 7 to 15 participants (Aguinis & Solarino, 2019).

3.5 Inclusion and Exclusion Criteria

3.5.1 Inclusion criteria

The study participants met the following characteristics:

1. Consenting caregivers who had an adolescent attending the KNH youth centre with ages between 13 to 18 years with a diagnosis of substance use disorder.
2. Consenting caregivers with an adolescent child in age of 13 to 18 years and diagnosed with substance use disorder and in the role for at least six months and attending Youth Centre Clinic.
3. Consenting caregivers over 25 years of age.

All adolescent diagnosed with SUD as documented in case records were assessed to satisfy the criteria for SUD as outlined in the DSM V criteria (American Psychiatric Association, 2013).

3.5.2 Exclusion criteria

Participants were not being included in the study if they had any of the following characteristics:

1. None consenting caregivers with an adolescent child aged 13 to 18 years and diagnosed with substance use disorder and attending Youth Centre Clinic.
2. Caregivers with an adolescent child aged 13 to 18 years and diagnosed with substance use disorder and in the role for less than six months and attending Youth Centre Clinic.
3. Participants with an adolescent child aged 13 to 18 years with a recent history of mental illness.
4. Participants/caregivers below 25 years of age.

3.6 Sampling procedures

The study used purposive sampling (Parahoo, 2014) to select participants. This method was helpful in selecting participants who possessed the required characteristics (Parahoo, K., 2014). Besides, this sampling method was suitable as the researcher felt that it captured the full understanding of caregivers' lived experiences of their adolescent's substance abuse (Rubin & Babbie, 2008). This sampling technique was employed as the purpose of this paper was to

obtain an in-depth perception of the participants' lived experiences (Babbie & Mouton, 2010). Both male and female participants from Nairobi and its environs were selected for the study.

3.7 Data Collection Methods

In this study, the researcher used individual semi-structured interview guide to collect information. Other data collection tools used to support the collection of data in this study comprised field notes and tape recorders.

3.7.1 Interview Guide

An interview guide was prepared in line with the objectives of the study. All interviews were face to face and were audio-recorded. It allowed interviewees to express their experiences and to make sense of their responses through interaction with the researcher. A Counselor was available in the YCC to attend to any emotional reactions aroused during the interview. None of the participants had an on-going therapeutic relationship with the counsellor.

Different interview skills were used, for instance, listening, encouraging, probing, reflecting and linking while also summarizing the questions consecutively enhanced the integrity of the study. Triangulation of data sources was achieved by interviewing various caregivers raising adolescents who were abusing drugs.

The center of attention in this study was not to expand generalizations across to the whole population, but to demonstrate the complication of the lived experiences of caregivers of adolescents with SUDs.

3.7.2 Validity of the research instrument

Validity means the degree to which an instrument measures what it is supposed to measure and gives accurate results (Kurian, 2010). The research instrument was submitted to the supervising lecturers and experts in the field who helped ascertain that its content items were represented

satisfactorily i.e. face validity and content validity. Internal validity in qualitative research scores highly because it records the real experience of the participants in their natural setting and the meaning they assign to these experiences.

The internal validity of the study was achieved through a pre-test. Pre-testing was done at Center for Substance Abuse Treatment (CSAT) clinic in Mathari National Teaching and referral hospital. The interview guide was pre-tested with caregivers of adolescents with SUD. Only caregivers of adolescents with SUD who gave a written consent were recruited for the pretesting. Necessary adjustment to the tool was done thereafter. The pre-test process gave feedback on the relevance and scope of the questions. In addition, it helped check terminology used by the researcher.

3.7. 3 Reliability of the Research Instrument

Reliability is the measure of the degree to which a research instrument yields consistent results or data after repeated trails, Thyer et al, (.2019). A tool is considered reliable when it produces the same results for different participants. In this study the researcher achieved reliability by presenting a thorough explanation of the essential theories and viewpoints of the study, as well as details about the participant's selection.

3.7.4 Training of Research Assistants

One research assistant was recruited and trained on the use of the interview guide. The research assistant was a male. He was purposively selected. He was a qualified clinical psychologist at bachelor’s degree level. He was trained on how to assist the researcher in audio taping and recording.

3.8 Data Collection Procedure

Study participants were enrolled daily at the start of clinic every day. This was done at the registration desk where all patients reported before being reviewed. The researcher went through the patients' files and with help from researcher assistant purposively recruited a specific number of study participants each day depending on patient turn out.

Participants were informed about the need to participate in the study before being involved in the study. It should be noted that caregivers of substance-dependent adolescents are a difficult population to reach. Study by Neale, Allen & Coombs (2005) revealed that building a trusting relationship with substance-dependent populations is a challenge. The counsellor who works at YCC, Kenyatta helped by referring the participants to the researcher as most of the caregivers and adolescents knew him. Involving a known counsellor helped overcome resistance. None of the participants had ongoing therapeutic relationship with the counsellor.

The interviews were done after participants were reviewed by the clinicians. All participants required to provide informed consent for the study before participating in the study. Participants were given a written cope of the consent form which was read clearly by the interviewer. The reading of the consent form and the participants' verbal consent were recorded on audiotape.

Filled consent forms were kept safely to maintain confidentiality. Interviews were conducted by the principal investigator in a private room at the YCC KNH using a semi- structured interview guide. The field notes documented the behavior, facial expressions and responses of the participants during the interviews. The field notes were compiled to describe the responses of the participants. The field notes were written during the interviews and coupled with the transcripts.

The interviews lasted between 30 to 70 minutes each. The interviews were conducted in either English or Kiswahili based on the preference of the participant. All audio recordings were tape recorded and transcriptions done verbatim with direct translations into English for interviews conducted in Kiswahili

3.9 COVID 19 Prevention/Safety Measures

Before the participants were ushered into the room set aside for the in-depth interviews, they were assessed for any symptoms of acute respiratory illness such as fever, nasal congestion, rhinorrhea, sore throat or cough on order to safeguard the participants from corona virus disease (COVID-19). The researcher also ensured all the participants were wearing disposable surgeon's face masks at all times and were provided a place with soap and running water for washing hands or alcohol hand-rubs with at least 70% alcohol, and encouraged frequent hand hygiene to limit or prevent person to person transmission. A health talk was also given to all patients on respiratory hygiene/cough etiquette, restricting movement within the institution and restricting visitors to the hospital as well as the proper way to wear face masks to prevent cross infection. The researcher also ensured that the space where the interviews were held was well ventilated and spacious enough for participants to be able to keep the recommended social/physical distance of one and half metres. Environmental cleaning and disinfection were ensured by regularly cleaning of the surfaces and floors within the ward with a disinfectant solution. Proper personal protective equipment was worn as per the situation.

3.10: Data Management

After completion of data collection, the demographic data were checked for completeness. Missing values, extremes values and inconsistency were identified and corrected.

The recorded audio responses were transcribed verbatim and translated directly into English for those interviews not conducted in English.

3.10.1: Data entry and cleaning

The demographic data was entered into a Microsoft Excel program where data cleaning was done. After cleaning, the data was transferred to statistical package for social sciences (SPSS) version 25.0 software for analysis.

3.10.2 Data analysis

The socio-demographic data and clinical characteristics of the study population were summarized and presented using measures of central tendency and dispersion

The transcribed data was reviewed severally in order to make sense of what they contained. Key highlights were noted down. Elimination of unnecessary or repeated words such as "I know, I mean, etc." were done at this stage. Any recurring or similar categories were then combined and coded together. All codes were reviewed and examined merging codes showing similarities in their content. Transcript contents were examined for major themes. This was done by checking the relationship between these categories and analyzing them and then linked them into themes. The themes were identified from the phrases or words mostly used by the participants. The final step involved linking the findings of the theme to the study objectives in order to find meaning and interpret the study results.

3.10.3 Data storage

All typed field notes and all audio recordings were encrypted and saved on my laptop with a password which was only accessible to the investigator. Data was backed up in password protected external hard drives. This data will be stored for a period of 10 years in line with the relevant research policy before it is deleted.

3.11 Ethical Considerations

Approval to conduct the study was sought from the University Of Nairobi School Of Nursing Sciences. Ethical approval was sought from the KNH/UON ERC in order to carry out this

study. After approval, the researcher further sought permission from the hospital management to conduct the study. Permission to access and enroll study participants was obtained from unity in charge of obstetric and gynecology unit. These three steps guaranteed that no harm was done to the participants in fulfillment of the principle of beneficence.

The informed consent form was administered by the principal investigator after explaining the purpose of the study. No inducements or rewards were offered to the participants to join the study. The participants were free to withdraw from the study at will. This fulfilled the principle of respect for persons. The persons who declined to provide informed consent did not participate in the study. There were no potential risks to the participants for taking part in the study as no invasive procedures were performed on them. In cases where emotional distress arose during the interview process the participants were directed to a counsellor for help. The principle of Non-maleficence was observed. Confidentiality was also maintained by excluding the identification details on the study tool and also by storage of all research materials in locked cabinets only accessed by the researcher.

CHAPTER FOUR

4.0 RESULTS

4.1 Introduction

In this chapter, findings from the study are presented. The results are presented according to themes deducted from the interviews, accompanied by exemplar statements from interviewees' narrations of their lived experiences with reference to the objectives of the study. The main themes identified were: caregivers' physical experiences, caregivers' psychological experiences, caregivers' social experiences, caregivers' coping mechanisms as well as other emergent themes. Caregiver is a word used all through this paper to mean a biological parent, adoptive parents or relative (such as a grandparents) or other adult who fulfills a parental role for the child and taking care of an adolescent with substance use disorder.

4.2 Socio-demographic characteristics of caregivers and their adolescents

4.2.1 Caregiver's socio-demographic data

Findings from the study revealed that most (72.2%, n=13) of the caregivers were the adolescent's biological parent. The caregivers' ages ranged from 26 to 68 years with a mean age of 45.1 years and a standard deviation of 9.4. The most common age group was 41-50 years with exactly half (50.0%, n=9) to the respondents falling within this age group. Slightly more than half (61.1%, n=11) of the respondents were female while 38.9% (n=7) were male, additionally, a large percentage, 72.2% (n=13), were married, 16.7% (n=3) single and 11.1% (=2) separated. All the respondents indicated that they were Christians as was the case with the adolescents. The findings further indicated that a majority of the participants 38.9 %(n=7) were business owners. Table 4.1 and Table 4.2 shows the demographics of the caregivers and adolescents.

Table 4.1: Caregiver participants and their relationship to the adolescent in treatment

N=18		Proportion (%)
Biological Mother	**9**	**50**
Biological Father	**4**	**22.2**
Brother	**2**	**11.1**
Aunt	**2**	**11.1**
Uncle	**1**	**5.6**

Table 4.2: Socio-demographic profile of the respondents.

Demographic Factor	**Categories**	**N**	**Proportion (%)**
Age of the caregiver	21 to 30 years	2	11.1
	31 to 40 years	3	16.7
	41 to 50 years	9	50.0
	Over 50 years	4	22.2
Gender of the caregiver	Female	11	61.1
	Male	7	38.9
Marital Status of the caregiver	Married	13	72.2
	Single	3	16.7
	Separated	2	11.1

4.2.2 Caregivers Occupations

The findings further indicate that a majority of the participants 38.9% (n=7) were business owners. More distribution on the occupation is indicated in figure 4.1 below:

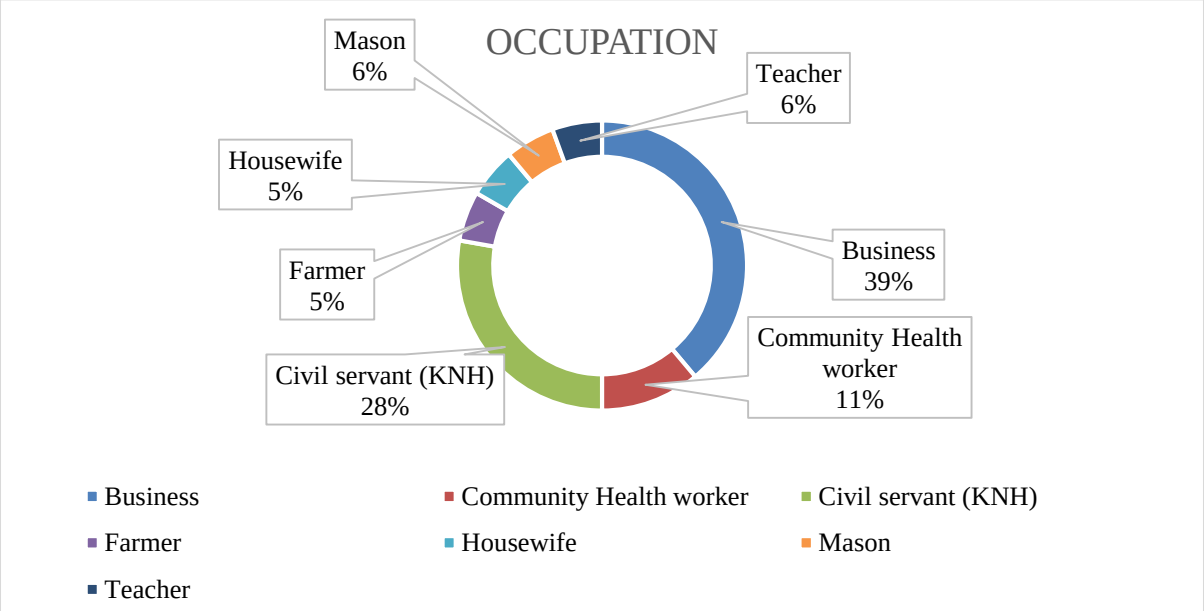
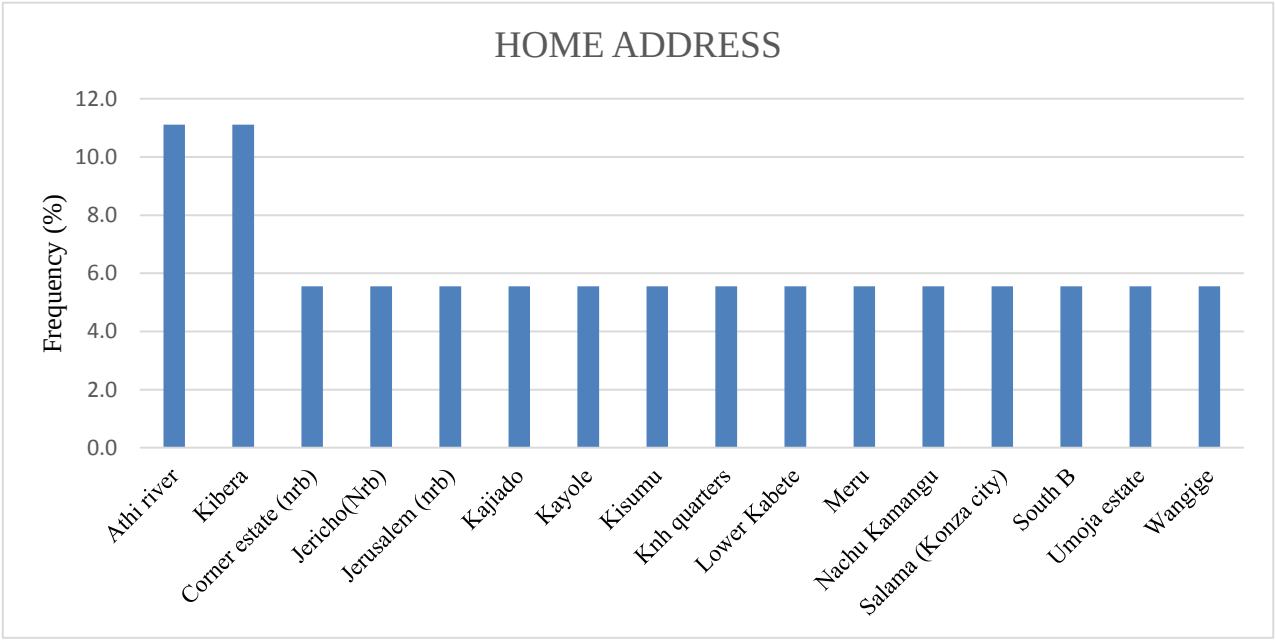


Figure 4.1: Caregiver's Occupation

4.2.3 Residence.

The findings indicated that all caregivers lived with the parents. 11.1%(n=2) of the respondents lived in Athi-river and 11.1%(n=2) lived in Kibera as well Further distributions are indicated in figure 4. 2 below.

Figure 4.2: Residence



4.2.4 Adolescent's socio-demographic data

Exactly half of the adolescents 50.0 % (n=9) were aged 18 years, 22.2 %(n=4) were 17 years, 16.7 %(n=3) were 16 years and only 11.1 %(n=2) were 15 years old. Out of the 18 adolescents, only 1 was female while the others (94.4%, n=17) were male. All of the adolescents in this study lived with their parents. Most of the respondents lived within Nairobi and slightly more than half (55.6%, n=10) of the adolescents were in form 4. Table 4.3 ages distribution of the adolescent.

Table 4.3 Socio-demographic characteristics of adolescents.

Demographic Factors	**Categories**	**N**	**%**
Adolescent's age	15 years	2	11.1
	16 years	3	16.7
	17 years	4	22.2
	18 years	9	50.0
Adolescent's gender	Female	1	5.6

	Male	17	94.4
Adolescent's education level	Form 1	1	5.6
	Form 2	2	11.1
	Form 3	5	27.8
	Form 4	10	55.6

4.2.5 Birth Order

In terms of birth order, most (61.1%, n=11) of the adolescents were first-borns

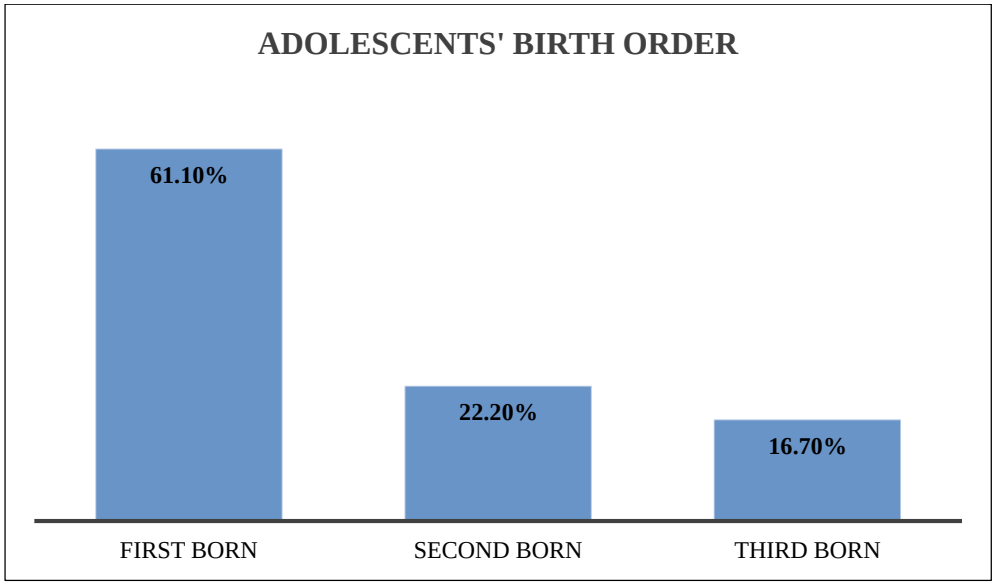


Figure 4.3: Adolescents birth order

4.2.6. Drug abused

In this current study, all adolescents had extensively used Marijuana. Additionally, 22.2% (n=4) had used Nicotiana Tabacum (Kuber), 44.4%(n=8) were addicted to Ethanol (alcohol), 11.1% (n=2) catha edulis (khat), 11.1%(n=2) Hookah (Shisha) and 5.6%(n=1) Nicotiana tabacum (cigarettes). Only 33.3% (n=6) of the respondents abused marijuana only, while 44.4 %(n=8) of the adolescents abused a combination of drugs two drugs. Marijuana and alcohol were the drugs most commonly abused together with 27.5% (n=5) of the adolescents recorded

to have used the two. Three (16.7%) of the adolescents in this study had each used a combination of three different drugs; Bhang, kuber & shisha, Bhang, alcohol & shisha, Bhang, alcohol and Khat (miraa). Only one respondent reported abusing four drugs namely Bhang, khat (miraa), alcohol and Kuber. Figure 4.4 shows the drugs abused by the adolescents. The substances commonly used in descending order of frequency were alcohol, tobacco, khat and cannabis. Only alcohol and tobacco were extensively used.

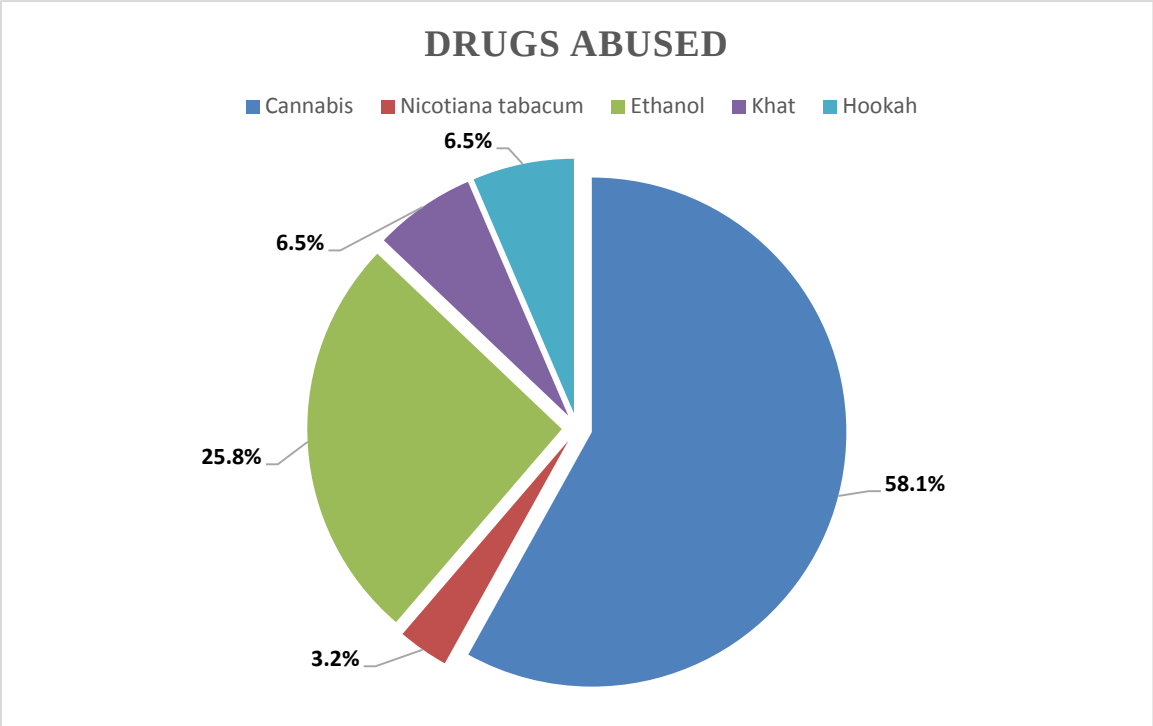


Figure 4.4: Drugs abused by the adolescents

4.3: Caregivers' physical experiences

Drug use affects the caregivers physically, with manifestations of physical morbidities related to the extra responsibilities of caring for an adolescent diagnosed with SUD. This was assessed by asking the caregivers whether they felt physically ill or unwell as a result of their adolescent's substance use. The theme is identified as "Illness" which was related to

caregiver statements and which manifested in physical ailments. In the first theme, two different subtypes related to physical experiences were identified as Violence/ Aggression and Financial loss.

The following findings were obtained concerning physical experiences of caregivers of adolescents with substance use disorders.

Sub-Theme 1: Illness

As a direct consequence of the adolescent's substance use, caregivers narrated how their physical well-being had been invaded by illness. The physical ailments included hypertension, ulcers, insomnia, migraines, headaches and hypertension, sleep disturbance and weight loss. Most caregivers had a medical intervention for their ailments.

High blood pressure

Stress related to the adolescent's substance use disorder led to manifestations of illness physically in form of hypertension. When asked whether they felt physically ill or unwell as a result of their adolescent's substance use, one participant recalled:

> *"There was a time my pressure used to be high and I used to assume, but now I think its okay. I just decided to let go." [Participant 14]*

Another participant narrated how her son being expelled from school caused her a lot of pain which eventually led to her developing high blood pressure.

> *"It reached a point where the school expelled him, the teacher called me to take my son and found they have put his suitcase outside. I had a lot of pain "doctor", I had pain because I remember my blood pressure was 185" [Participant 3]*

Another participant stated that as a result of crying because of the pain and anguish caused by her adolescent abusing drugs, she developed high blood pressure.

> *"…that's what I have been doing just crying until I developed hypertension' [Participant 8]*

Ulcers

A number of respondents also reported that they developed stomach ulcers as a result of their adolescent using drugs. One participant said:

> *"My ulcers started, I was doing badly, I didn't want food, I didn't want anyone talking to me, I wanted to be left alone and I was thinking about when the child will be normal again." [Participant 5]*

Often times, when caregivers got stressed, they would consequently develop ulcers, one caregiver said:

> *"…these things have stressed me, in fact I've had stomach ulcers, I'm unable to eat and I was always tired." [Participant 6]*

Migraines

Headaches were also reported by one of the caregivers as a physical outcome directly attributable to the adolescent's use of drugs:

> *"I would have headaches, headaches to the extent that I could not open my eyes." [Participant 14]*

Another participant had to be prescribed stronger pain killers because of the constant headaches she would get from worrying about her adolescent child.

> *"For me, when I have headaches, even when I take Panadol, I still cannot sleep... it reached a point where they had to prescribe a more powerful drug than the normal paracetamol such as extra Panadol. With those ones is when I could finally get some sleep." [Participant 6]*

Sleep Disturbance.

Caregivers reported experiencing lack of sleep as a result of their adolescent using drugs. One participant narrated that they were not able to sleep due to having nightmares because of thinking about all the bad things that might happen to their child:

> *"I've had nightmares ever since I realized my son was doing bhang. In fact, I used not to sleep, I used not to sleep, I could dream of him being arrested, I could dream of him on a truck dead, I simply had nightmares because I knew where this was taking him." [Participant 14]*

Another participant reported:

> *"I did not get sleep and I don't know why I did not sleep. Sometimes you know I listen to this radio programs until" [Participant 13]*

A participant also reported that the behaviour of their adolescent who was abusing drugs made her unable to sleep:

> *"You can't sleep because he would come and wake me up, saying let us pray, and he prays and prays seriously...." [Participant 8]*

Another participant reported that she could not get deep sleep

> *Even when I was sleeping, I still could hear footsteps outside or movement of people outside so it was not deep relaxing sleep. [Participant 5]*

Weight loss

Weight loss was another physical outcome identified. One participant narrated how her son's use of drugs affected her weight; she said that she lost a lot of weight because she was stressed by her son's behaviour and was not able to eat for a month. This further showed how adolescents' substance abuse can negative physical impacts on one's health.

> *I lost a lot of weight, I was psychologically affected, I was not able to eat for a month because I was in a dilemma that what if the child doesn't change, how will my life be? How will I live with this child? Will he continue stressing us this way? [Participant 6]*

Another participant explained how she lost weight due to loss of appetite.

> *"I buy snacks I don't eat, by buying them I assume that I have consumed them. So I did not have appetite, I did not have moods ....my weight is gone... " [Participant 9]*

Sub-type 1: Violence/aggression

When under the influence of whatever substance, they were using, an adolescent would sometimes become violent. Those who more prone to experiencing violence were caregivers of advanced age such as grandparents. One participant reported that his nephew would often show acts of violence and aggression to the grandmother:

> *"He requested money and the grandmother had none, when she didn't get the money, the child beat her up…. Until the neighbours intervened and asked why he is hurting*

his grandmother? He turned violent claiming he will hit them all and that they should all leave. So, the men who came they threatened to beat him up." [Participant 11]

Aggression was also made manifest by throwing things around after becoming moody and temperamental.

"Sometimes he was moody and temperamental. He would throw things around. When you tell him to wash the dishes, he would start throwing the dishes around. It is as if he has this uncontrollable anger." [Participant 16]

"When he is back, he demands food aggressively, and when he is denied he then hit the grandmother with a stick and another time he hit her with a jerrican of water." [Participant 11]

Aggression was also directed not only to the caregiver but also to others. One participant said that her son beat up her house help's child:

"… there was a time he beat up a child who belonged to my house help… and injured the child's ear. It incurred an expense of 5000 Kenya shillings for treatment at KNH" [Participant 13]

Sub-type 2: Financial loss

Caregivers experienced financial loss in different ways. For example, one participant, who was a small business owner said that she would have to close her business in order to make time to come bring her son to the clinic, she would also have to cater for transport and medication costs, thus incurring financial losses.

"I am struggling with my small business because I have to close when I am bringing him to the clinic. This has affected me my businesses. It has also affected me

financially because of the money I have to use on transport to and from the clinic and sometimes we find a long queue at the clinic." [Participant 1]

Financial loss was also experienced through theft of money or other valuable items by the adolescent who was abusing drugs:

"At that period, I had lost about 10,000 shillings in the house. I looked for it all over and could not find it. My son apparently was the one who found the 10,000 shillings and took it." [Participant 12]

Loss of property through damage by the adolescent was also another way caregivers incurred financial losses as a result of the adolescent's substance use. Two participants reported this:

"He broke all the window panes, I replaced and he broke them all again," [Participant 6]

"When comes home and he has smoked his stuff he hit three goats by the head and they died…So when it comes to the chicken, he hits them when they cross his paths with a stick killing them instantly" [Participant 11]

4.4 Caregivers' psychological experiences

The study findings revealed that caregiver's suspicions and first realizations of the adolescent's substance abuse problems proved to be very overwhelming. This left caregivers feeling psychologically strained. In this study, caregivers' were asked to narrate how their psychological health was affected in the event of the adolescent substance use. The following four themes were obtained.

Theme 1: Stress

A large proportion of the participants reported stress as a psychological outcome due to their adolescent abusing drugs. Stress was further deciphered into several sub-themes according to the subject or context of narration.

General Stress/depression

Several participants mentioned stress/depression as a major psychological outcome. One participant was particularly concerned about how his peers viewed him because of the fact that his adolescent was abusing drugs.

> *"It affected my health a lot. In fact, I had a depression. I felt very sad and I wondered how my friends would view me knowing my son was abusing drugs at this tender age..... I even wondered who had taught him to abuse drugs, many things were going through my mind." [Participant 13]*

Often times, depression or stress can manifest itself with feelings of hopelessness or lack of motivation and energy to accomplish daily routine tasks. Another participant narrated how depression left them hopeless and unable to complete usual household tasks such as washing clothes.

> *"I was very very depressed, I was very very depressed I was depressed, I think I was depressed beyond my capability because I could just sleep the whole day, I didn't even take care of my home ... I remember pilling clothes for even over a week I couldn't wash them, I was always tired. I had no energy." [Participant 6]*

Psychological pain

Psychological pain was as a result of frustration, denial, regrets or shock when they discovered about drug use by the adolescent child. Caregivers expressed being hurt by the adolescent drug use behavior in relation to care given, managing the adolescent with substance use problems and generally parenting.

> *"I felt my heart is aching for almost two hours in the counselling room, I could not even move. This was due the flashback of the trying moments… and I thought to myself this is not normal." [Participant 12]*

Caregivers felt pain because they could not reason with their child regarding drug use.

> *"I was shocked, as a parent you must be shocked. When I tried to reason with the child that smoking bhang is not good, he says that it's good" [Participant 5]*

Another participant felt a lot of pain losing his son into drugs.

> *"I was in shock that I had lost my son and he is the firstborn. Use of bhang is becoming part of him.... It pains even to think about it...." [Participant 1]*

One participant felt pain due to regrets.

> *I did not believe with my eyes and also, the father did not believe it... I regretted taking him to that school. Because the teacher had told me how the school has such cases. I regretted taking him to that school. [Participant 14]*

One participant said that she was in denial when she learnt about her son's substance abuse. The denial caused her a lot of psychological pain later.

"At first, I denied about the drug use.... I did not believe at first. I wondered who had introduced my son to these vices… I was shocked and I did not believe at first." [Participant 1]

Some participants said that they felt frustrated upon discovering that their children were using drugs.

One participant said.

"When he confessed to me, I felt a bit frustrated. I just looked at myself as being unfortunate. At that point I felt frustrated…I knew at least I had a boy who would take my position, the moment I knew he was into drugs, I felt very frustrated… [Participant 5]

One participant felt like shouting to his son due to the pains he was experiencing after he learnt about drug use.

"I feel frustrated, I wanted to scream at him…. …. I told him ….when you get into drugs and behave this way, it is the parents who feel the pinch not you." [Participant 4]

Work-related stress

Caregivers reported that their work was affected as a result of the adolescent's abuse of drugs. One participant reported that she would often be moody and while at work, if she would meet customers who also had moods then she would behave in an unfriendly way thereby affecting her business.

"There comes a time, you know a customer comes with his own moods and maybe he has found you with your own. So, you find you do not want to talk to him or you talk to

him in an unfriendly way and I wonder it is this stresses that I place on myself." [Patient 18]

Having to set aside time to bring the adolescent for treatment to the clinic was also a source of stress and affected the caregivers work life. One participant said:

"Very much like today I was going to work I had to come so if I am told to come along for counselling, I can come but it will affect my work" [Participant 16]

Another participant narrated that she was unable to concentrate at work as a direct consequence of her child abusing drugs:

"I told the clients i serve that I am not in a position to serve because the family problems are quite overwhelming and I am unable to concentrate.... So lack of concentration, your body is there but your mind is just...," [Participant 10]

Theme 2: Lack of spousal support

Spousal support or family support is key in ensuring that an adolescent receives care that will ensure that they recover from substance use disorder (Orford et al., 2010; Choate 2015), however, a number of participants reported that they did not receive the much-needed spousal or family support while caring for the adolescent with substance use disorder. One participant felt like she was left to carry the burden of caring for their daughter:

" It is like he also fears his daughter, I don't understand him, he does not want to talk to her and I ask him you want me to carry this burden alone? ....he has left me with the burden, he does not want to counsel his daughter…. " [Participant 18]

Other participants echoed the same sentiments. They were also left alone by their spouses to deal with their adolescents who were abusing drugs.

> *"…the dad always pretending like to be very busy not wanting to deal with this issues mmh, now I'm in this alone and it went like that it just went like that. Now I'm the only one who has been struggling with this issue." [Participant 16]*

Another participant felt like she was being set-up for failure. She narrated that her spouse would do nothing even after witnessing changes in behaviour in their son, he was often quiet. The spouse felt that if it got worse, then her husband would blame her for the undesirable outcome of their daughter

> *"I see he is waiting for my child to be very spoilt then he says it is the mother that has not raised the child well. You know there is a way you see he is quiet; he is waiting for something to happen and say it is the mother." [Participant 2]*

Another participant also shared having had a similar experience where her spouse would have nothing to do with trying to help their son with substance abuse disorder. She said:

> *"Now the biggest problem, this boy isn't accepting that this thing is bad, my partner isn't party to this issue ….now he just decided to keep quiet and let me deal with this boy alone ….And it was overwhelming because I was expecting him to react as a man and he's doing nothing and the boy feels like the dad is okay...." [Participant 14]*

Theme 3: Effects of substance abuse on other family members.

Family cohesion is usually negatively affected as a result of an adolescent's abuse of drugs. The lives and routines of other family members living with the adolescent with substance abuse disorder is usually disrupted by their behaviour. Other siblings may feel stressed or neglected.

One participant noted that her adolescent who was abusing drugs was stressing the younger brother: *"He (the younger brother) was stressed. Everyone was stressed*. Another caregiver was also constantly worried about her other son who was taking care of the one with substance abuse and kept checking on him to make sure he was not causing the brother much trouble:

> *Yes, she fears every time. She calls me and asks me if he is giving me problems.... I don't want him to give you any. If he is preventing you from doing your work...send him back home i will watch over him..." [Participant 15]*

Theme 4: Strained family relationships

Family relationships suffer due to the experiences that the caregivers and their families go through as a direct consequence of an adolescent's abuse of drugs. Family members become distant, blames are apportioned and feelings of hatred set in. Family homeostasis suffers and members experience lack of peace. One participant narrated:

> *"Yes, it has been affected because we are not at peace like before where in the evening we could sit down and enjoy our meals. We are currently living in fear on what he would do when he comes home and starts throwing things around or become violent towards us. There is always conflict in the house and we are not at peace as we were before." [Participant 12]*

The gap between the family members also often widens, especially that between the caregiver, who is usually the parent, and the adolescent. Another participant shared her experience:

> *"It is not like before. He is distant himself these days ...not like before where he was free with me. He comes home and he does his own things and we cannot talk freely as*

before. I cannot ask him how was your day or tell him do this or do that like before, today he decides if he is going to do it or not." [Participant 6]

Substance use disorders literally break families apart. Two participant describes how hopeless they felt with the first family and was contemplating leaving their current family, remarrying and starting another family. He said:

"In fact, at one point, I was looking forward to having another family because I have a feeling that this family will not take me anywhere. I was looking forward to having a young family again, where probably I can sire some sons, because I feel frustrated the first family was not taking me anywhere." [Participant 4]

"The child feels the mother loves him more than I do. ...I have avoided them because the mother supports him….Because if there is hatred towards me, it is better I shift because there is danger….I have money… ….I will leave them the house and look for another. What can you do really? Do you want to hear that the son killed his father or the father killed his son?" [Participant 5]

4.5: Caregivers' social experiences

Social impact experiences of caregivers with adolescents diagnosed with substance use disorder emerged in different forms. The most common form was social isolation. Additionally, the caregivers narrated instances where they felt stigmatized and rejected. Five sub-themes emerged from this main theme.

Sub-Theme 1: Social isolation

It is a natural human reaction to distance oneself from something undesirable. Participants felt that because of their child's substance use, people would often try to avoid them and their child or even their entire family. When the neighbours noticed that their son was behaving in

a different way, one participant narrated how the neighbours distanced themselves from them and were blind to the fact that they had a problem.

> *"…they have distanced themselves from us there is one of the neighbours who told me that my children have a lot of noise. Others don't see that we have a problem" [Participant 10]*

Some participants had to forego their social life since they had to make time to take care of the adolescent with substance use disorder. Talking on behalf of his spouse, one participant narrated:

> *"But she had to cut it down to look after him, she had to cut also her social life like she couldn't go out freely, she couldn't sleep, she had to keep watch over him" [Participant 15]*

In other instances, participants would shy away from the general public because of what they were going through, one participant reported:

> *"… I didn't want anyone talking to me, I wanted to be left alone and I was thinking about when the child would be normal again." [Participant 1]*

Sub-Theme 2: Social integration

As a result of strong social support systems and lasting bonds, instances when the adolescent's drug abuse did not have any effect on the caregiver's social life and that of the family as a whole were discovered. One participant shared that her social life and that of her mother was unaffected by the adolescent's situation.

"Personally, my friends are receptive I hang with them, they come to my house, we story tell, we have fun, we eat together. My mum's friends call her, we have good friends I can say. Socially I can say we are in a good place." [Participant 2]

Another participant disclosed:

"I have this friend of mine who supports me a lot. So, when my son comes home and acts up, I confide in her and she offers me encouragement. She is the one who often supports me through this." [Participant 14]

Sub-Theme 3: Restricted movements

Due to the unpredictable nature of the adolescent's behaviour when they are under the influence of a drug, caregivers often find themselves on the lookout most if not all of the time. This then means they are not able to move freely and go to such places as the market. One participant reported how his mother's movements had to be restricted because she was the one taking care of the adolescent who was abusing drugs.

"Previously, when that situation happened… she was not moving around freely she could not go the market…. The activities she used to do had to stop so that she can concentrate on the child?" [Participant 17]

Another participant said:

"My mother can't farm when he is around maybe she makes sure the child has left so that she goes farming and when the child comes back the grandmother hides herself and gets in the house and locks herself up". [Participant 11]

Sub-Theme 4: Social rejection

A number of participants reported that they or their family faced rejection as a result of their

adolescent abusing drugs or as a result of how they handled the adolescent's use of drugs. One participant narrated how a neighbour rejected her other children when they sought shelter at the neighbour's house. The neighbour purported that the children would bring demons into her house:

> *"But there was a day we had gone to church to pray for the child, my children were scared to sleep at home alone the elder child asked if they could spend the night in the neighbour's place. I told them it is okay. That mother got scared of the kids. She thought the children were bringing demons into her house. My children from that day hated that mother." [Participant 8]*

Another participant also shared that the rest of his family showed hatred towards him because of how he handled the adolescent who was under the influence of drugs:

> *"My family hates me at the moment because they see I have broken the child's leg instead of taking him for counselling." [Participant 11]*

Sub-Theme 5: Social stigma

Participants also reported that they noticed that they were being treated differently by the neighbours because of their son's situation. One participant said:

> *"Even up to today there are some people who look at me different when I pass by them." [Participant 12]*

Another participant also noted the attitude the neighbours had towards her and her son. She reported that the neighbours would say unpleasant things about her son.

"The neighbours talk badly about my son. They say he takes drugs; he is not disciplined" [Participant 4]

4.6: Caregivers' coping mechanisms

In response to the question on how they cope with all the challenges arising from their adolescent use and abuse of drugs, the participants mentioned several ways of coping all of which are presented below as sub-themes.

Theme 1: Withdrawing, engaging, Tolerating or Keeping to self

Majority of the participants said that they dealt with issues by keeping to themselves as they preferred not to talk to anyone about them. One participant narrated how the co-workers noticed that he was acting differently but he could not open up to them.

"I kept quiet at work and they could ask me, what happened to you? You are so quiet; you have been silent for too long. Why are you silent? I could say I am okay." [Participant 6]

Another participant reported that he kept quiet mainly to protect the image of her son and feared that if she talked to anyone then it would have had negative consequences, especially for her son.

"[I was stressed] and I kept quiet. I never talked to anyone about it… I didn't want people to see my child as a bad boy…, I didn't want to expose my child even to the relatives [Participant 10]

Other participants also echoed the same comments:

"I would stay in the house while I praying. When I feel overwhelmed, I relax because I don't like sharing." [Participant 2]

"I usually keep quiet; I don't talk to people I carry the burden alone" [Participant 7]

Some participants recalled how they engaged, withdrew or tolerated the child drug use behaviour.

"When he became very violent…..I called the police…he was arrested for 3 days" [Participant 11]

The mother wants me to handle everything… being that he is a boy…. She has distanced herself…… [Participant 4]

When I started noticing change in behaviour ...I thought it was adolescence catching up with him....I talked with him and promised to change...I have caught him twice with bhang...I had hope that he would stop using ...he is a good boy[Participant 14]

Theme 2: Keeping busy

One other way participants reported that they dealt with stress and other issues related to their adolescent's use of drugs was keeping themselves busy with other things. One participant reported that she continued with her chicken business even after they moved from where they previously resided.

> *"That chicken business I moved with it to…, so now I simply keep myself busy but still no single day passes without the thought of my son going through my mind, but because I don't want that stress" [Participant 6]*

Another participant reported:

> *"I try putting on projects like if I was waking up late, I try waking up early. I look for other projects like I put this and that …like now I had a new project, I had like seven and I used to run myself" [Participant 9]*

Theme 3: Sharing with others

One participant mentioned that his mother (the adolescent's grandmother), who would be left with the adolescent most of the time, often shared her troubles with other people.

> *"She has friends who talk to her most of the time. My mum is very communicative when she has a problem, she calls her friends and they talk. That is how she handles her stress best." [Participant 15]*

Theme 4: Singing

Some participants reported that after singing, they felt better and that singing helped them deal with the stress brought upon them as a result of their child using drugs.

"Right now, when I feel things are tough, I try singing and it makes me feel better." [Participant 3]

"I normally resolve to singing gospel music, and when the music doesn't seem to sooth, I normally go to the washrooms and cry." [Patient 13]

Theme 5: Crying

Other participants resorted to crying as a way of dealing with the issues brought about by the drug abusing adolescent. One participant said:

"When I wake up from that point of crying you can't tell that I had a problem…., I cry the way a toddler cries after he has been pinched. That's how I cry" [Patient 9]

5.0: Emerging Themes

5.1: Adolescent Substance abuse and caregiver's experiences

Sub-theme 1: Discovery of substance abuse

Adolescents can possess the prowess of concealing, for unbelievably long periods of time, their use of drugs especially when caregivers spend most of the time away from their adolescents. Caregivers usually discover the scourge often when the effects have worsened. In this study, there were different ways caregivers through which caregivers learnt of their adolescent's substance abuse.

Adolescent Self-confession.

Often, caregivers are oblivious to their adolescent's use of drugs. One participant said:

"...you know what made me realize it was a drug, is self-confession. I never realized out of the effects, he had to open up to me and tell me this is. It is very hard to notice. This is a polite boy, quiet. So, you can't tell the difference." [Participant 4]

Another participant said that when he confronted his son, he confessed that he had been using drugs:

"I got the courage and asked him, apart from food, what else are you taking outside there? He said he smokes weed, weed is his food, it is his medicine and it is his everything, it is even his god." [Participant 8]

Informed by school

Adolescent's substance use was also revealed to the caregivers by the school, often through a phone call since most of the adolescents were still in high school. One participant said that she got a call in the middle of the night from the school's administration informing her of her son's conduct and use of drugs.

"When this child was in form two, is when I noticed something amiss...., one night I was called by the school. When I went and met his form two class teacher who told me from other people's observations and interactions with your son, he is becoming aggressive. He's using a substance..," [Participant 12]

Another participant shared a similar experience

"This is a boarding school. Now being a Sunday, it was not easy for teachers to notice that the children had taken the substance and were drunk.., they were trying to protect each other by hiding. This was around 12 midnight. This is the time I received the phone call from the school…. He called also other parents." [Participant 3]

Change in behaviour

Other caregivers discovered that their adolescent was using drugs when they noticed change in behaviour. One participant noticed that her son would isolate himself a lot, and then they suspected that something could be wrong:

> *He liked isolating himself… he could spend most of the time away. Like from morning till evening you will not be able to see him until late at night. Then when he comes, he isolates himself by going to the bedroom and chills and if you go to the bedroom, he could leave for the sitting room where there is minimum attention. [Participant 2]*

Another participant also noticed the changes in movement of her son and immediately sensed something was amiss:

> *"Sometimes I sleep late at night and he is left watching the television and at night his friend calls him and he leaves the house, my instincts told me that this child is not okay" [Participant 4]*

> *"…he could leave the homestead without permission and come back very late or fail to come back. He can go missing for like a week without giving us any idea where he is" [Participant 8]*

Another participant also shared that he noticed that his son was sleeping a lot:

> *"…. he could start at 7pm in the evening and by 9pm he is still asleep. So, we wake him up for supper, because now both of us are late, we get to the house at 9pm..., so by the time we are done preparing supper it is 10 o'clock and this boy has slept for about 4 hours. ..Initially it does not come to my mind, you only think this is out of normal activities." [Participant 13]*

Informed by friends

Other participants came to discover their adolescent's drug use through other friends who informed them about it. One participant narrated:

> *"It's another guy who is a caretaker who told me that by the look of things it seems these children are smoking marijuana and that is when we started investigating…. Later another caretaker came and told me that my son is usually found in a place where they do these deeds and that is when I knew that my son smokes Marijuana." [Participant 7]*

Caregiver's self-discovery

Some caregivers discovered their adolescent's drug use by themselves, either through catching the adolescent in the act or finding evidence of the drugs in the adolescent's possessions. One participant said:

> *"I woke up in the morning and I decided to go to his bedroom after praying. I found him with a container. Then, I asked him what he was taking and he was shocked. I took it to the dad, and the dad told him that it was bhang." [Participant 11]*

Two other participants described how they caught their adolescent using the substance after they had long suspected.

> *"It was even the father the first time, he caught him smoking in the house…: He went back to the house, it was in the afternoon… Yeah..., unexpected. So that time it was him who caught him smoking in the house". [Participant 8]*
>
> *There was a night I was resting in the seat waiting to sleep. He was watching the television. I heard a paper sound. I immediately woke up and I told him harshly to*

give me the paper, I then took the paper and checked what was wrapped in. It looked like crushed tea leaves…. "[Participant 12]

Another client explained how found the drug in his son's bag:

"Now because the dad was always against my opinion and any suspicion i was having i just went and sat next to him, to the dad. I told him just go and check his bag now... I've sent him to the supermarket, go and check that bag now. He went, he got the bhang and he took it". [Participant 9]

CHAPTER FIVE: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 DISCUSSION

5.1.1 Introduction

This section presents a discussion of the findings gained from the study and relating them to previous research findings. To begin, socio-demographic characteristics of the caregivers and of the adolescents are discussed, followed by caregivers' physical, psychological, and social experiences. Finally, the conclusion and recommendations are presented.

5.2 Socio-demographic characteristics of caregivers and their adolescents

5.2.1 Caregivers' age

Half of the caregivers were aged between 41-50 years which represents a stage of middle adulthood that according to Dacey, Travers and Fiore (2009) usually ranges from 35 years to 64 years and is marked by a focus on career, work and family. During this stage, responsibilities increase and parents or caregivers often find themselves balancing career, family and other social relationships and often find it difficult to take a keen interest in their teenagers' lives. This leaves a gap where guidance and direction from parents lacks and teenagers veer off into undesired behaviours such as experimenting with drugs and other substances (Gramet, Jacobs & Sopczyk, 2010)

5.2.2 Caregivers' gender

Slightly more than half (n=11) were female. This showed that care giving responsibility often fell on the female caregiver. These findings resonated with findings from other studies that showed that social responsibility of bringing up the adolescent was largely placed on the mother with high social expectations (Smith & Estefan, 2014). Even though their spouses were there, parents of the female gender took the responsibility of ensuring that their adolescent

attended clinics and was taking their medication as prescribed. The mothers would also often miss work and other duties just to take care of their adolescent. This further elucidates the challenges mothers or caregivers of the female gender face in trying to balance parental duties and other demanding duties as well. These findings were similar to those by Cavanaugh (2007) and Ceballo & Borquez (2008) who explicated the challenges facing mothers with adolescents diagnosed with substance use disorder. Mabusela (2014) further observed that the absent father phenomenon is on the rise as more fathers are less involved in the lives of their children thus increasing the chances their teenagers being involved in risky behaviour such as abusing substances. These findings are also supported by a study done by Newman, Harrison, Dashiff & Davies (2008)

5.2.3 Caregivers' marital status

In this study, thirteen of the eighteen participants interviewed were married. Family ties play an important role in the development of substance use in adolescents. Circumstances such as inconsistent parenting, single parenting and other environmental factors make adolescents vulnerable to substance use addiction (Lander, Howsare & Byre 2013. However, despite the marital status of the participants in the study, which is meant to embody a stable family with consistent parenting roles, all caregivers were affected by adolescent substance use. Berge et al., (2016) also concurred that family-related factors that are associated with an increased risk of adolescent substance abuse include inconsistencies in disciplining the adolescent, poor parental supervision and monitoring of behaviors, family conflict and unclear expectations for behavior.

5.2.4 Caregivers' employment status

The findings further indicated that a majority of the participants 38.9% were business owners. According to Marais (2012) the responsibility of parents working, especially away from home, can lead to strained parent-adolescent relationship consequently leading to substance

abuse as adolescent are mostly left unmonitored. Due to long working hours and parents being away from their adolescents for extended periods of time, adolescents are often left unsupervised leaving them vulnerable to engage in substance use or depending on their peers for guidance. Employment takes a lot of parents' time and energy and the tendency is for them to focus more on their careers and less on the children, especially the adolescents, (Masombuka, 2013).

5.2.5 Adolescents' age

Half to the adolescents in this study were aged 18 years with ages ranging from 15 to 18 years. This age range has been shown to be critical risk periods of initiation into drug and substance abuse, which is an early adolescent age of 12-14 years or late adolescent ages of 15-17 years, (Crawford et al., 2015; Jordan and Andersen, 2017). Similar results have shown that this transition marked with risky behaviour like use of drugs and early unsafe sexual initiation through curiosity and experimentation (Squeglia, 2018). Findings from this study were similar to that reported in Kenya, where by the ages of 13-15 years children had already started using drugs as they transition from primary to secondary school, (NACADA, 2016). Whereas most substance use initiation is usually when adolescents are away from their parents, this study found that substance use was discovered while parents stayed with their adolescents due to the lockdown measures by the government to curb the spread of COVID-19 when all children were at home and idol. Some were introduced by peers during this period of prolonged school break and others took advantage of the laxed parental watch to engage in substance use and other activities that predisposed them to substance use.

5.2.6 Adolescents' gender

In this study, nearly all of the adolescents diagnosed with SUD were males. These findings were similar to those of Grüne et al., (2017) who found that male adolescents had higher rates of substance use than females. Another explanation could be that male adolescents are not as

closely watched and guarded as their female counterparts. Similarly, a recent Swedish survey of alcohol and drug use among students found that boys in their second year of upper secondary school showed a higher degree of risky alcohol consumption than girls with higher proportions of boys than girls reporting substance use (Anderberg, & Dahlberg, 2018)). Having a little more freedom as a male adolescent could increase the risk of experimenting and thus developing substance use and dependence.

5.2.7 Adolescents' residence

All of the adolescents in this study lived with their parents or caregivers. About 11% of the adolescents lived in Kibera and Athi River. Environmental factors have been shown to increase the risk of substance use development in adolescents (Chaote, 2006). In this study, the two areas where most of the adolescents lived in are markedly different, one is a suburb, high income neighborhood whereas one is a slum area (low income neighborhood), both of which are risk factors for development of substance abuse. This indicates that SUDs among adolescents is irrespective of social or financial status, tribe, class, faith or ethnicity according to the Substance Abuse and Mental Health Services Administration publication (SAMHSA, 2019). In this study, high, middle, and low-income status was evidenced by place of residence of both the teenagers and their parents, further adding evidence to the fact that substance use disorder among adolescents cuts across all social classes.

5.2.8 Drugs abused by the adolescent

A slew of drugs were abused by adolescents according to findings from this study. Marijuana was abused by all of the adolescents in this study. A similar study by Maurice et al., (2015) revealed that youth between ages 11-20 years and ages 18-24 years had used marijuana. This study also showed that adolescents had used more than one drug at a time, these findings were similar to findings by Kelly et al., (2015). Mutter et al., (2015) also found that 57% of adolescents with SUD are abusing two or more substances. This predisposition to abuse more

than one drug is evidence of the increased risk-taking behaviour of adolescents always wanting to experiment with multiple substances. Peer pressure also plays a role in adolescents becoming poly-users of substances. Hamilton, Danielson, Mann & Paglia-Boak (2012) showed that family detachments may expose the adolescent to experimenting with drugs as well as leading to changes in behaviour as was explicated by Valois & Drane (2007). However, their findings were contrary to the findings in this study as most of the adolescents came from intact families but still developed substance use. This showed that other factors, aside from just stating that one is married, play a role in family cohesion that ensures that adolescents are kept in check. For example, couples could be married but the family is highly dysfunctional or adolescent could be having both parents but the parenting style is highly permissive.

5.3 Caregivers' physical experiences while parenting an adolescent diagnosed with substance use disorder

Substance abuse is a looming and growing worldwide scourge that affects individuals and families in many different contexts. Manifestations of adolescent substance use are increasingly becoming a pervasive and persistent problem with the potential for serious health and safety consequences not only for today's adolescent but also their caregivers (National Institutes of Health, 2010). In this study, mental and physical health effects as a result of taking care of an adolescent with SUD were inextricably linked.

5.3.1 Physical illness

The participants reported varied conditions that affected them physically and manifested in form of illness or physical symptoms of illness. Such conditions as hypertension, ulcers, insomnia, lack of appetite and weight loss were linked to psychological factors such as daily

stressor that the participants experienced. Given the exposure to constant stressors, caregivers' physical health come under immense pressure and is often undermined (Orford,et al, 2013). These daily stressors were directly linked to the adolescent's use and abuse of drugs. Furthermore, Teater (2014) postulated that substance abuse affects different levels including the biological, psychosocial, health and the social factors of an individual and their families. From this study, the researcher felt, through and through, that the participants considered less their physical experiences and were concerned more about the well-being of their adolescent. The participants somewhat believed that if the effects substance use of their adolescent could be fully resolved, then their physical outcomes would be resolved as well. Most of the caregivers in the study mentioned that they had developed health conditions as a direct result of living with their adolescent's addiction problem.

Hypertension

Caregivers commonly described physical ill-health and a number of them mentioned having hypertension which was directly attributable to the adolescents use of drugs. This was so as they caregivers developed signs and symptoms of hypertension while dealing with the adolescent's use of drugs. For example, a mother of an adolescent in high school said: "*I had a lot of pain doctor, I had pain because I remember my blood pressure was 185".* She had been highly stressed as a result of her son's substance use until she developed high blood pressure. Another mother stated that as a result of crying because of the pain and anguish caused by her adolescent abusing drugs, she developed high blood pressure. *"…that's what I have been doing just crying until I developed hypertension'.* These experiences are similar to those found by Orford,et al, (2013) that indicated that constant stressors that the caregivers were exposed to often led to physical ill-health such as hypertension.

Ulcers

Caregivers, as a direct consequence of the strains and stressors caused by their adolescent substance abuse, developed ulcers that affected them physically. One woman shared: *"My ulcers started, I was doing badly, I didn't want food..."* Her experience was similar to that of another mother who said: *"...these things have stressed me, in fact I've had stomach ulcers, I'm unable to eat and I was always tired."* These experiences further indicated that adolescent drug use had far reaching consequences to the caregiver as a result of the continued daily stressors on the caregiver. This is in line with findings by Orford et al (2013) that attributed a number of physical outcomes to daily stressors that the caregivers experience as a result of substance use by their adolescents.

Migraines

Daily stressors that the caregivers are exposed to also lead to development of migraines that physically affected the caregivers and was directly attributable to the adolescent's use of drugs, one caregiver said: *"I would have headaches, headaches to the extent that I could not open my eyes."* Another respondent corroborated her experience: *"For me, when I have headaches, even when I take Panadol, I still cannot sleep."* The stress-related health problems have been reported to be very common among parents that are living with children who are abusing chemical substances as they are constantly worried about the behaviour and life style of their children. Findings from this study echoed findings from a study done by Smith & Estefan (2014) who also attributed most of the physical outcomes to daily stressors that caregivers experience. According to Orford et al, (2010), caring for a person with SUD, gives rise to a stressful life that creates strain to the family members leading to physical and psychological sicknesses, these findings held true in this study as well.

5.3.2 Physical assault

Although minimal, physical assault, especially towards elderly caregivers, as a result of aggression by the adolescent abusing drugs was also identified as another physical outcome of parenting an adolescent with substance use disorder. These findings were consistent with research findings by McCann, et al., (2017) which showed that elderly women experienced physical assault from their drug-dependent adolescents in their care. Other times caregivers received unkind treatment from their children, where the children threw things aimlessly shouted at them or destroyed some items when their demands were not satisfied. This ultimately led to physical exhaustion to caregivers. This could be attributed to the fact that the adolescents felt that their elderly caregivers did not possess the physical acumen to contend with them and thus took advantage of such situations. One respondent said: *"When he is back, he demands food aggressively, and when he is denied he then hit the grandmother with a stick and another time he hit her with a jerrican"* another participant reported *"… there was a time he beat up a child who belonged to my house help… and injured the child's ear"*. In these instances, aggressive behaviour was manifested towards an elderly caregiver further validating findings by McCann et al, (2017); Orford *et al.* (2010).

5.3.3: Financial loss

According to (Copello et al., 2009b) there are different dimensions to take into account when considering the cost of substance use by an individual in the family. Areas impacted by drug use /alcohol use include loss of income, cost to the individual e.g. buying drugs, cost of the treatment, cost of theft , loss of employment and property loss, (Parliament of the Commonwealth of Australia, 2007). In summary the economic cost to a family member/caregiver may be a direct financial expenditure, time spent supporting the adolescent child with SUD, for example through taking them to appointments, or providing child care.

Additionally, other indirect and intangible costs, which can occur includes loss of working hours. This has an economic value attached to them, Copello et al., 2009b)

In the study, Caregivers experienced financial loss in different ways. For example, one participant, who was a small business owner said that she would have to close her business in order to make time to come bring her son to the clinic, she would also have to cater for transport and medication costs, thus incurring financial losses. *"I am struggling with my small business because I have to close when I am bringing him to the clinic.." [Participant 1]* Financial loss was also experienced through theft of money or other valuable items by the adolescent who was abusing drugs: *"At that period, I had lost about 10,000 shillings in the house. My son apparently was the one who found the 10,000 shillings and took it." [Participant 12]*

Loss of property through damage by the adolescent was also another way caregivers incurred financial losses as a result of the adolescent's substance use. Two participants reported this: *"He broke all the window panes, I replaced and he broke them all again," [Participant 6]*

"So when it comes to the chicken, he hits them when they cross his paths with a stick killing them instantly" [Participant 11]

5.4 Caregivers' psychological outcomes while parenting an adolescent diagnosed with substance use disorder

The study findings revealed that caregiver's suspicions and first realizations of the adolescent's substance abuse problems were compounded by doubts until a behavior change in the adolescent's life became more evident to confirm a substance abuse problem. Discovery of substance use was mainly through being informed by the school, through change of behaviour, self confession, informed by friends or caregiver's self discovery. Caregivers attempt to confront this situation is met by resistance and lies (Usher et al., 2007). This proved to be difficult as caregivers reported feeling frustrated, shocked or in denial. The study by Usher et

al., (2007) also found that parents reported feelings of guilt and desperation in early attempts to confront child drug use behaviour.

In this study, caregivers' commonest psychological distress was stress under different environments and contexts. For example, participants experienced family related stress, work-related stress, stress resulting from lack of spousal support, and stress related to care seeking among others.

5.4.1 Stress

Studies show that the stress and strain of having a family member with a substance use problem can exhibit in psychological symptoms such as anxiety, depression, guilt and panic attacks (Orford et al. 2010; Orford et al. 2013). Additionally, misunderstandings, judgements, blame games and shaming from schools, the authorities, neighbours, and relatives can arise within families as a result of an adolescent's substance abuse resulting in a complex web of negative psychological outcomes (Chaote, 2011).

As a result, families suffered loss, grief, constrain and sometimes even violence. These results echoed findings by Estefan (2014) who explicated the widespread negative effects of substance use disorders on families. Families can be left feeling hopeless and constrained as a direct consequence of substance use disorder by a member in the family, be it an adolescent or an adult (Vincent, 2014). *"The child feels the mother loves him more than I do… Because if there is hatred towards me, it is better I shift because there is danger…. Do you want to hear that the son killed his father or the father killed his son?" [Participant 5]*

Stress related to lack of spousal support in dealing with substance abuse in the adolescent was commonly reported, especially by female caregivers who were often the mother of the adolescent. They often felt left on their own to deal with the adolescent, somewhat implicitly suggesting that it is the sole responsibility of the mother to take care of the adolescent all

through, even in such circumstances as substance use disorders. Indeed, this assumption is congruent to findings by Smith & Estefan,2014) who stated that the mother is often held responsible when things don't go as expected, such as the development of substance abuse in an adolescent as they are regarded as the fabric that keeps the family together. When such happens, the mother's parental abilities are brought into question and blame apportioning commences. This clearly indicates the gender bias that exists in evaluating parental roles and responsibilities as mothers and fathers are judged differently (Thurer, 1994). This study revealed that if the both parents worked together, positive changes in caregiver-adolescent relationships could be easily initiated and maintained.

5.5 Social experiences of caregivers of adolescent with SUD

Caregivers together with other family members are vital in supporting other members of the family with substance use disorders. While endeavouring to offer support, family members often face insurmountable obstacles such as stigma and social isolation (Copello et al. 2009). The caregivers shared their frustrations as they felt rejected by their communities, unwanted and got a sense that the neighbours judged them by the actions of their adolescent children as unfair to them. Additionally, they felt as if the neighbours treated them as if they were allowing the behaviour of their adolescent children while in reality they were also experiencing great challenge. Of the social outcome experienced by the caregivers, social isolation and stigma were the commonest.

5.5.1 Social stigma

According to Corrigan et al. (2011), stigma can be experienced in two different ways. One can experience public stigma which usually involves negative attitudes of the general public towards individuals with unwanted qualities or characteristics, in this case, substance abuse. Stigma can also be self-instigated through internalization of public stigma thereby resulting in

reduced self-worth and lowered self-esteem (Corrigan & Watson 2002). In this study, findings of public stigma were evident, however self-stigma was not clearly described by the participants but insinuations of the same could be felt in participant's narrations. Experiences of stigma can be complex and can be projected not only to the caregiver or parent of the adolescent with substance use disorder but also to the rest of the family. In this study, one of the social outcomes was rejection of the other family members by a neighbour because of the existence of an adolescent abusing drug in that family. Similarly, Corrigan et al (2006b) also found that families also experienced blame and shame as a direct consequence of their family member's substance use.

5.5.2 Social isolation

The other common social experiences was social isolation which was manifested through neighbours, friends and even other family members and relatives distancing themselves from caregivers of adolescents with substance use disorders and their families. Caregivers in turn felt ashamed and embarrassed. These experiences drove them to feel isolated and become less vocal about their circumstances and thus preventing any attempt to seek informal or even formal support for themselves and their substance-abusing adolescent. These findings were similar to those by Wilson, et al., (2018) that showed social isolation can be a deterrent to sharing and seeking help, especially for those taking care of adolescents with substance use disorders. This could have also been made worse by the fact that most of the caregivers were from an urban setting where there exists laxed social norms and a loose sense of community and collective responsibility where everybody minds their own business.

5.5.3 Social rejection

Caregivers shared that the felt rejected by the community they were living in. They shared their concerns that the community perceived them as irresponsible parents because their teenagers

were abusing chemical substances. This finding was similar to that by Usher et al., (2007) who found that the community blamed the caregivers for their adolescent's development of SUD. However, the parents needed the community to treat them with respect and stop judging them. It was evident that respondents were struggling to keep up with the way the community members were treating them. They verbalized that they felt unwanted in their own community. One respondent shared how her kids were rejected by her neighbour because the neighbour thought that the kids would bring demons to her house and influence her kids: "*I told them (the children) it is okay if they are scared, they can go and sleep with that mother (the neighbour). That mother got scared of the kids. She (the neighbour) thought the children were bringing demons into her house. My children from that day hated that mother."* this is an explicit example of how caregivers felt victimized by the community because of their adolescent's substance use disorder.

5.6 Caregivers' coping mechanisms

Global literature has identified different coping mechanisms to adolescent substance abuse amongst caregivers. Notable examples included Usher et al. (2007) who found that caregivers adopted different coping mechanisms broadly categorised as Tolerating, Engaging or Withdrawing. In this study, some caregivers decided to engage their children while others resorted to withdrawing as a form of coping with the adolescent's substance use disorder. Coping mechanisms that emerged explicitly from this study were those that were self-directed towards the caregivers' themselves. The coping mechanisms identified were adopted by the caregivers to deal with stress as a result of the adolescent's substance use. Singing, sharing with others, keeping busy, keeping to self and crying was commonly mentioned as coping mechanisms adopted as a result of substance abuse by the adolescent. This was rather divergent from literature that discussed, in detail, how caregivers adopted coping mechanisms that were considered external to the caregiver and directed to the adolescent, such coping mechanisms

could involve engaging with the adolescent through dialogue, punishment and being vigilant of the adolescent's movements and behaviours (Jackson et al., 2007).

5.6.1 Engaging as a coping mechanism

By taking the time to talk to the adolescents and help them seek care, caregivers showed willingness and effort to engage with their adolescents in order to resolve the substance use disorder. In this study, most caregivers took the time to help their adolescent with treatment and recovery efforts showing a great deal of engagement. Further, when the said adolescents would become violent, the caregivers reached out to the authorities or other neighbours so as to solicit for help in dealing with the violent behaviour.

5.6.2 Withdrawing as a coping mechanism

Withdrawing occurred when one caregiver (spouse) felt unsafe or showed signs of unwillingness to handle the adolescent behaviour and left the issue to the other spouse to deal with it alone. These findings echoed those by Jackson et al. (2007) who showed that caregivers would disengage from their adolescent as a last resort. There were also instances where caregivers exhibited forms of denial that their adolescent was engaging in substance use and abuse, this was consistent with findings from Butler and Bauld (2005) who also found that some caregivers denied their child's substance use.

5.6.3 Tolerating as a coping mechanism

Tolerance appeared to be most evident with all caregiver when they noticed change in behaviour in the child and who thought the behaviors as normal adolescent development changes. These findings were similar with past research that shows that families reached a point where they would tolerate, engage or withdraw (Choate, 2015; Orford et al., 2006) due to adolescent substance use behaviour. In addition, as part of tolerance, majority of the participants preferred to keep their troubles to themselves and deal with them on their own,

this could be due to findings by McCann et al. (2011a) that stated that openness may not always elicit support but rather result in direct criticism or exclusion.

5.6.4 Sharing experiences as a coping mechanism

That notwithstanding, disclosure and being open to discussions concerning substance use and abuse by others might elicit support from close family members and friends thus reducing stigma and stress related to taking care of adolescents with substance use disorders. Indications by this study that none of respondents sought professional help to deal with their psychological experiences could mean that they felt that their psychological experiences were part of a new normal and did not need any therapeutic intervention. This study supports this notion since the caregivers who experienced physical morbidities sought care from professionals for their ailments but psychological care was rather ignored and dealt with in ways that the caregivers saw fit.

5.7 Conclusion

The study provided an insight into caregivers' experiences of parenting adolescents diagnosed with substances use disorder. Generally, the researcher draws the following conclusions based on the findings of this study.

- In this study, mental and physical health outcomes as a result of taking care of an adolescent with SUD were inextricably linked. Adolescent drug abuse starts early in life, affecting the health and well-being of both adolescents and caregiver. Drug use affects the caregivers physically, with manifestations of physical morbidities such as hypertension, ulcers, lack of appetite and weight loss that have been worsen by their daily concern and worry over their adolescent's substance abuse. This study found that caregivers who experienced physical morbidities sought care from professionals for their ailments.

- Psychological experiences consequent to the adolescents' drug use was mainly stress that affected different facets of the caregiver's life such as their work life and the relationship with their families. Most caregiver with psychological stress did not seek for professional help. Most caregivers had developed various DSM-V conditions including Sleep disorders, panic disorder, Generalized Anxiety Disorder and depressive disorders and were not aware.
- Caregiver's social experiences were mostly negative and included rejection, isolation and stigma. Caregivers expressed their concerns that some neighbours judged them by the actions of their adolescent children as unfair to them.
- The study also noted that it was very difficult for caregivers to say that they were coping. Caregivers adopted different coping mechanisms to deal with the negative consequences of parenting an adolescent with SUD. Some of the coping mechanisms included confiding in others concerning their experiences, distracting themselves with work, singing or even crying. Others preferred to keep to themselves.

5.8 Recommendations

Based on the study findings, the following recommendations have been put forward for consideration by the relevant parties and stakeholders involved in the care of adolescents with substance used disorders.

1) Youth centre clinic to come up with ways of screenings all caregivers in order to identify any other underlying symptoms the caregivers might be having. Caregivers should also be sensitized on the importance of taking care for themselves as they care for their substance abusing adolescent. Support groups for caregivers of adolescent with SUD can also help caregivers share their experiences, empower caregivers with knowledge on substance abuse, its prevention, early detection and available treatments.

2) The hospital should form a multidisciplinary committee team responsible for community outreaches. The outreaches should identify a comprehensive holistic program for helping families with drug-using children and improving their quality of life. The hospital should involve the Community health workers in the mental health campaigns.
3) The county governments to establishing well staffed Community Psychiatric Mental Health Clinics in the rural and urban areas. The clinics would be run by psychiatrist nurses and other team members. The clinics should organize school health talks; campaigning for collective responsibility of guiding adolescents through such a vulnerable period. Dispelling myths around specific substances by educating the communities about all illicit drugs.

Further research

- Since this was limited in scope and reach, further research should be conducted at a wider scale, preferably longitudinal studies in order to further explore the experiences of caregivers beyond the clinic setting.
- Caregivers' rights are violated by adolescents abusing substances. Caregivers need protection from such harms. For future research, a model designed to address the needs of the caregivers who are parenting adolescents abusing illicit drugs should be considered.

5.11 Dissemination Plan

The findings of the study will be shared with health professionals in the department where data was collected. This will enable them identify information that could help in improving care provision at the clinic. The study results will also be presented during the annual scientific

conference. There is intention to publish the findings in order to increase access of the results to health care professionals and the public at large. The study results will also be available in the UON Repository.

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APPENDIX 1: Project timeline from Oct 2019 to Nov 2020

Activity	**OCT 2019**	**NOV 2019**	**DEC 2019**	**JAN 2020**	**FEB 2020**	**MAR 2020**	**APRIL 2020**	**MAY 2020**	**JUN 2020**	**JUL 2020**	**AUG 2020**	**SEP 2020**	**OCT 2020**	**NOV 2020**
Development of the concept														
Proposal writing and presentation														
Pretesting the instrument														
Submission of proposal to Ethics Board														
Data collection and analysis														
Report writing and corrections														
Presentation of the project														
Project results dissemination														

APPENDICES

APPENDIX I: LETTER TO KNH/UON ETHICS AND RESEARCH COMMITTEE

Lydia Nyaga
University of Nairobi
School of Nursing
Sciences

The Chairperson
KNH/UON Ethics and Research Committee
P. O. Box 20723-00202
Nairobi.

Dear Sir / Madam,

RE: ETHICAL REVIEW AND APPROVAL

I am a second year post graduate nursing student, pursuing Master of Science in Nursing (Mental Health and Psychiatric Nursing). I am writing to request permission to carry out research on **"LIVED EXPERIENCES OF CAREGIVERS OF ADOLESCENT DIAGNOSED WITH SUBSTANCE USE DISORDER ATTENDING KENYATTA NATIONAL HOSPITAL YOUTH CENTRE".**

Your kind consideration to allow me carry out this research will be highly appreciated; it will go a long way in facilitating completion of my studies. The research findings will be utilized both locally and internationally in improving provision of quality patient care.

Your consideration will be highly appreciated and it will go a long way in facilitating my study completion and also research findings will be utilized both locally and internationally in provision of optimal patient care.

Thank you.

Yours sincerely,
Lydia Nyaga
Reg No: H56/11646/2018

APPENDIX II: LETTER TO KNH CHIEF EXECUTIVE OFFICER (CEO)

Lydia Nyaga
University of Nairobi
School of Nursing Science

The CEO
Kenyatta National Hospital
Nairobi.

Through,
Head of Department,
Youth Friendly Clinic
Kenyatta National Hospital.

Dear Sir / Madam,

RE: PERMISSION TO UNDERTAKE A RESEARCH STUDY.

I am a second year post graduate nursing student, pursuing Master of Science in Nursing (Mental Health and Psychiatric Nursing). I am writing to request permission to carry out research **on "LIVED EXPERIENCES OF CAREGIVERS OF ADOLESCENT DIAGNOSED WITH SUBSTANCE USE DISORDER ATTENDING KENYATTA NATIONAL HOSPITAL YOUTH CENTRE".** I am planning to carry out the research at Youth friendly clinic.

Your consideration will be highly appreciated and it will go a long way in facilitating my study completion and also research findings will be utilized both locally and internationally in provision of optimal patient care

Thank you

Yours sincerely,

Lydia Njoki;

Reg No: H56/11646/2018

APPENDIX III: CONSENT EXPLANATION FORM

This is a form designed to seek the informed consent of the caregivers of adolescent diagnosed with substance use disorder who expressly provide their consent to participate in the study.

Researcher: Lydia Nyaga

Institution: School of Nursing Sciences, University of Nairobi

Invitation to Participate in the Study

Dear Respondent,

My name is Lydia Nyaga, a postgraduate student at the School of Nursing, University of Nairobi. I am conducting a research study titled **''LIVED EXPERIENCES OF CAREGIVERS OF ADOLESCENT DIAGNOSED WITH SUBSTANCE USE DISORDER ATTENDING KENYATTA NATIONAL HOSPITAL YOUTH CENTRE.** As professionals working with adolescents diagnosed with substance abuse, we would like to know more about how your adolescent's experimenting with drugs and/or alcohol has been like for you. We believe that by learning this information, we can help professionals provide better services to families. I am inviting you to participate in this research study. Participation is voluntary and you may choose to withdraw from the study at any stage, and such a decision and action will not affect how you access treatment for the dependent and other healthcare services in this hospital or institution.

Once you agree to participate in the study, you will be asked to sign or use your thumb finger to put a mark (thumb print) on the consent form.

The information you will provide will be handled with utmost confidentiality. Personal information and other relevant information will be sort and collected for research purposes only. The information will only be accessed by the researcher and researcher assistant. All personal identifiable information will be coded to protect your identity. All notes, interview transcriptions, and any other information will be kept in a locked file cabinet, and any electronically collected PIN will be stored in a password protected personal computer and external storage devices. The interview will take approximately 45-75 minutes.

Benefit(s)

There will be no direct benefit to you for your participation in this study. However, as a participant in this study, you will make immense contributions towards the development of the knowledge and understanding of the experiences that will benefit healthcare practitioners locally, regionally, and globally, particularly in understanding your experience. Such an understanding will foster the achievement of evidence-based care parents' management objectives. There will be no remuneration or financial benefits to you for participating in this study.

This study proposal has been reviewed and approved by the KNH/UON ERC which is a body that ensures the protection of persons like you that take part in research studies. This approval has been granted after the submission of the study proposal to the committee by the Director of the School of Nursing of the University of Nairobi with the approval of my University supervisors.

In the very event that you require any additional information or for any other purpose regarding this study, relevant contact details are listed below:

1. **Principal Investigator**
   Name: Lydia Nyaga
   Phone No. +254 723712063
   Email: nyagalydia@yahoo.com
   Physical Address: School of Nursing Sciences
   University of Nairobi, College of Health Sciences
   Kenyatta National Hospital Campus

   Supervisors
2. **Dr: Irene Mageto**
   Phone No. +254205419
   Email igmageto@uonbi.ac.ke
   Physical Address: School of Nursing Sciences
   University of Nairobi, College of Health Sciences
   Kenyatta National Hospital Campus

3. **Dr. Lucy Kivuti**

   Phone No. +254710499700

   Email: lukibitok@uonbi.ac.ke

4. **Ethics Committee**

   Prof. M.L. Chindia,

   The Secretary,

   KNH/UON Ethics and Research Committee

   Tel No. +254 726300-9

   Email: uonknh_erc@uonbi.ac.ke

   Physical Address: School of Pharmacy Grounds

   University of Nairobi, College of Health Sciences

   Kenyatta National Hospital Campus

APPENDIX IV: CONSENT CERTIFICATE

I……..., out of my own free will, give consent of myself to take part in this research study carried out by Lydia Nyaga, the nature of which has explained to me. I also understand and acknowledge that my participation in the study is purely voluntary. I understand that I am free to withdraw this study consent, and subsequently, from the study, at any time. I also understand that withdrawing my consent, and subsequently, from the study, will not affect the quality of care given to my dependent at the Kenyatta National Hospital.

Signature of participant (or thumbprint)……

Date……

I certify that the above consent has been freely given in my presence

Investigator…….

Witness Signature……..

Date…….

APPENDIX VI: SEMI-STRUCTURED INTERVIEW GUIDE

This interview schedule served as a guide during the actual interview.

Pre interview_____ ____Consent to interview____Consent to audio recording___

Opening prompt: "I am interested in knowing about your experience of having an adolescent diagnosed with SUD. Before I start to record, I will ask some general questions about you.

Demographics

Type of caregiver_____Relationship: ____ Age: _____ Gender__

Marital status: _____Occupation_____Residence_____Religion__

Adolescent Age: ___Adolescent Gender: _____Birth Order ____

Adolescent level of education_____ where the adolescent reside/stays____

Religion_____Adolescent DX _____

1) **These questions looks at how the adolescent started using substance of abuse**
    a) Name the drug (s) of choice your child takes……
    b) Please tell me what brought your son/daughter to YFC,KNH
    c) Can you describe the moment that you learnt your child has addictive problem?
    d) What thoughts and/or concerns ran through your mind as you learned about your adolescent's substance abuse?
    e) What made you think your child had a problem
    f) Who initiated treatment for your child?

2. These questions find out caregivers experiences (physical outcome).

i. Have you felt physically ill as a result of your adolescent's addiction?

ii. Can you describe in detail with a specific moment when your child was violent or aggressive due to substance use.

iii. What could have provoked the behaviour or which drug had the child used in this occasion

iv. In reference to the person behaviour how did you feel or what happened thereafter?

3. These questions find out caregivers experiences (psychological outcome).

i. What was it like for you after discovery of this behaviour?

ii. What was your initial reaction?

iii. With this behaviour, how do you see the future of this child?

iv. What has been the effect of the substance use on you as the caregiver personally and the family functioning

4. These questions find out caregivers' experiences (Social outcome).

i. Have you had feelings of isolation because other parents/caregivers do not have their adolescent in treatment or experimenting with drugs and/or alcohol?

ii. How has your relationship with your adolescent changed since he/she began experimenting with drugs and/or alcohol?

iii. Can you tell me how has been your experience in the support of your child?

iv. What effect have your experience had for you

Prompt: employment, Relationship, Sibling,

v. How has your child's behavior affected your occupational performance?

vi. What effect if any, does the person's behaviour have your family structure and functions?

5. These questions focus on how caregivers dealt with adolescent substance abuse.

i. When you feel stressed, depressed and/or hopeless how do you deal with the situation?

ii. What interventions did you try before seeking for help at this Youth Centre?

iii. How was the response from your child after introducing the above measures?

iv. What led you to determine that treatment and follow up at youth centre clinic was needed?

v. What advice would you give to professionals, such as nurses, counselors, psychologists psychiatrists who work with adolescent and his/her family?

6. These questions focus on ending the interview

i. Do you have any questions or clarifications for me?

ii. Do you have any other information you would like to add which I might have not asked during the interview?

YALIYOMO: SEHEMU YA II:

RATIBA ILIYOANDALIWA YA MAHOJIANO.

Ratiba hii ya mahojiano ilitumika kama kielelezo wakati wa mahojiano halisi.

Mahojiano ya awali… … … …. … … .. Idhini ya Mahojiano… … …… …

Idhini ya Kurekodi sauti… … …

Ufunguzi: ”Nimevutiwa kujua kuhusu uzoefu ulio nao na vijana waliobaleghe na kutambuliwa kuwa na SUD. ”

Maelezo ya Kimsingi.

Aina ya Mlezi… …… … …… … … . Uhusiano… … … … … … …… Umri… … … … … .. Jinsia… …… ……

Hali ya Ndoa… … … … …… … … .. Kazi…… … ……..... Makazi…… …… .. Dini…….

Umri wa Kijana aliyebaleghe…… … .. Jinsia ya Kijana… …… … … … Orodha katika kuzaliwa…… ……

Kisomo cha Kijana… … ……..... ..... Makazi ya Kijana… …… … …… . … . ... Dini… … … … ……..

DX ya Kijana… … … … … … … … ..

1)**Maswali haya yanaangazia jinsi Kijana alianza kutumia mihadarati.**

a. Taja dawa ya/za kulevya anazotumia mtoto wako… …… …… … …… ..
b. Je, waweza kueleza wakati mahususi ulipogundua kuwa mtoto wako ana shida ya uraibu wa mihadarati?

c. Ni fikra zipi na/au wasiwasi upi uliojaa mawazoni mwako ulipogundua kuhusu uraibu alio nao mtoto wako?

d. Ni nini kilichokufanya ufikiri kuwa mtoto wako ana shida?

e. Ni nani aliyeanzisha matibabu ya mtoto wako?

2)**Maswali haya yananuia kupata matokeo kutoka kwa mlezi, (Matokeo ya Kimwili)**

a. Umewahi kuhisi kuwa mgonjwa kimwili kutokana na uraibu wa mtoto wako?

b. Unaweza kueleza kwa mapana , kwa kutolea mfano mahususi wa wakati mtoto wako alikuwa katili au mkali kutokana na matumizi ya mihadarati?

c. Ni nini kilichosababisha hulka hii au, ni dawa ipi aliyokuwa ametumia mtoto wako wakati huo?

d. Kwa kuzingatia tabia yako binafsi, ulihisi vipi ama ni nini kilifanyika baadaye?

3)**Maswali haya yananuia kupata matokeo kutoka kwa mlezi, (Matokeo ya Kisaikolojia)**

a. Ilikuwaje kwako baada ya kutambua tabia hii?

b. Ni nini ulichofanya cha kwanza?

c. Kwa kuzidi kuwepo kwa hulka hii, wayaonaje maisha ya baadaye ya mtoto huyu?

d. Ni nini matokeo ya matumizi ya mihadarati kwako kama mlezi na kwa utendakazi wa familia?

4)**Maswali haya yananuia kupata matokeo kutoka kwa mlezi, (Matokeo ya Kijamii)**

a. Je, umekuwa na hisia za kujitenga kwa sababu wazazi/walezi wengine hawana watoto katika matibabu au wanaotumia mihadarati/pombe?

b. Uhusiano wenu umebadilika vipi tangu aanze kutumia dawa za kulevya/pombe?

c. Je, unaweza kunieleza jinsi kumekuwa katika kujaribu kumsaidia mtoto wako?

d. Hali hii imeleta matokeo gani kwako?

Katika: kazi, uhusiano, undugu

e, Tabia ya mtoto wako imeathiri vipi utendakazi wako kazini?

f, Ni athari gani (kama kuna yoyote) ambayo imeletwa na tabia hii kwa muundo wa familia na utendakazi wake?

5. **Maswali haya yanalenga jinsi walezi walivyoshughulikia watoto wao wanaotumia mihadarati.**

a. Ulipohisi msongo wa mawazo, huzuni na kukosa matumaini, uliishughulikia vipi hali hii?

b. Ni nini ulichojaribu kufanya kabla ya kutafuta msaada katika Kituo hiki cha Vijana?

c. Je, alijibu vipi mtoto wako baada ya kuanzisha hatua zilizo hapo juu?

d. Ni nini kilichokuelekeza kuamua kuwa matibabu na kufuatilia hapa katika Kituo cha Kliniki ya Vijana kulihitajika?

e, Ni wosia gani unaweza kuwapa wataalam kama vile wauguzi, washauri na wanasaikolojia wanaofanya kazi na vijana na familia zao?

6)Maswali haya yanalenga kukamilisha mahojiano.

a. Je, una maswali au ufafanuzi wowote kwangu?

b. Una habari yoyote ungependa kuongezea ambayo pengine sikuuliza wakati wa mahojiano?

APPPROVAL FROM KNH

KNH/R&P/FORM/01

KENYATTA NATIONAL HOSPITAL
P.O. Box 20723-00202 Nairobi

Tel.: 2726300/2726450/2726565
Research & Programs: Ext. 44705
Fax: 2725272
Email: knhresearch@gmail.com

Study Registration Certificate

1. Name of the Principal Investigator/Researcher
   LYDIA RACHEL NJOKI MYAGA
2. Email address: shanicenyagen@gmail.com Tel No. 0723712063
3. Contact person (if different from PI).....
4. Email address: ..... Tel No. .....
5. Study Title
   Lived Experiences of Caregivers of Adolescents Diagnosed with Substance use Disorder Attending KNH Youth Friendly clinic, KNH
6. Department where the study will be conducted (Youth Friendly Centre) OBS/GYN
   (Please attach copy of Abstract)
7. Endorsed by Research Coordinator of the KNH Department where the study will be conducted.
   Name: DR. IKOU KOUNGO Signature ..... Date 04/09/2020
8. Endorsed by KNH Head of Department where study will be conducted.
   Name: DR MAUREEN OUKO Signature ..... Date 07/09/2020
9. KNH UoN Ethics Research Committee approved study number P127/02/2020
   (Please attach copy of ERC approval)
10. I Lydia R. Njoki commit to submit a report of my study findings to the Department where the study will be conducted and to the Department of Medical Research.
    Signature ..... Date 03/09/2020
11. Study Registration number (Dept/Number/Year) Obs/940 399/2020
    (To be completed by Medical Research Department)
12. Research and Program Stamp 09 SEP 2020

All studies conducted at Kenyatta National Hospital **must** be registered with the Department of Medical Research and investigators **must commit** to share results with the hospital.

APPPROVAL FROM ETHICS

UNIVERSITY OF NAIROBI
COLLEGE OF HEALTH SCIENCES
P O BOX 19676 Code 00202
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Tel:(254-020) 2726300 Ext 44355

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Facebook: https://www.facebook.com/uonknh.erc
Twitter: @UONKNH_ERC https://twitter.com/UONKNH_ERC

KENYATTA NATIONAL HOSPITAL
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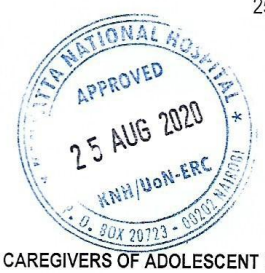
Tel: 726300-9
Fax: 725272
Telegrams: MEDSUP, Nairobi

Ref: KNH-ERC/A/274

25th August 2020



Lydia Nyaga
Reg. No. H56/11646/2018
School of Nursing Sciences
College of Health Sciences
University of Nairobi

Dear Lydia

RESEARCH PROPOSAL – LIVED EXPERIENCES OF CAREGIVERS OF ADOLESCENT DIAGNOSED WITH SUBSTANCE USE DISORDER ATTENDING KENYATTA NATIONAL HOSPITAL YOUTH CENTRE (P127/02/2020)

This is to inform you that the KNH- UoN Ethics & Research Committee (KNH- UoN ERC) has reviewed and **approved** your above research proposal. The approval period is 25th August 2020 – 24th August 2021.

This approval is subject to compliance with the following requirements:

a. Only approved documents (informed consents, study instruments, advertising materials etc) will be used.
b. All changes (amendments, deviations, violations etc.) are submitted for review and approval by KNH-UoN ERC before implementation.
c. Death and life threatening problems and serious adverse events (SAEs) or unexpected adverse events whether related or unrelated to the study must be reported to the KNH-UoN ERC within 72 hours of notification.
d. Any changes, anticipated or otherwise that may increase the risks or affect safety or welfare of study participants and others or affect the integrity of the research must be reported to KNH- UoN ERC within 72 hours.
e. Clearance for export of biological specimens must be obtained from KNH- UoN ERC for each batch of shipment.
f. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. (*Attach a comprehensive progress report to support the renewal*).
g. Submission of an *executive summary* report within 90 days upon completion of the study. This information will form part of the data base that will be consulted in future when processing related research studies so as to minimize chances of study duplication and/ or plagiarism.

Turnitin Originality Report

LIVED EXPERIENCES OF CAREGIVERS OF ADOLESCENTS DIAGNOSED WITH SUBSTANCE USE DISORDER ATTENDING KENYATTA NATIONAL HOSPITAL YOUTH CENTRE by Lydia Njoki Nyaga

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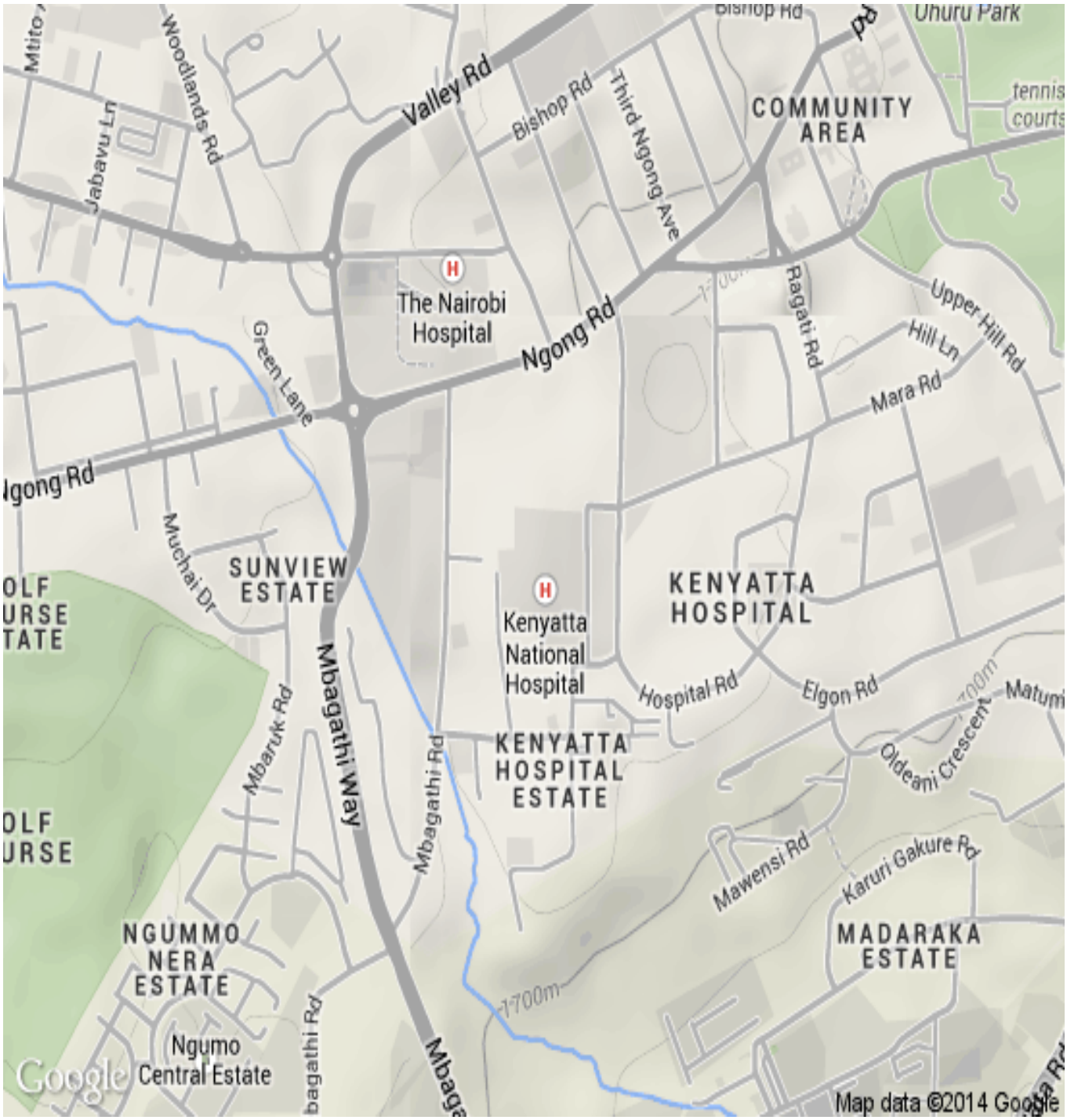
Directional Map of KNH



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