Substance use, parenting stress and child maltreatment: Exploring these relationships in a sample of at-risk mothers

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ABSTRACT

In South Africa, there is widespread usage of substances, particularly amongst people of a parenting age. This is concerning, as current research has found that substance use is associated with child abuse and neglect. There exists, however, a gap in the research regarding the link between parenting stress and substance use. The purpose of this research project was therefore to explore the relationships between substance use, child maltreatment and parenting stress. This was assessed in two studies, using quantitative and qualitative research methodologies, respectively. In Study One, survey research was conducted, employing the following inventories: the Alcohol, Smoking and Substance Involvement Screening Test, the Parent-Child Conflict Tactics Scale and the Parenting Stress Index - Short Form. The sample included 199 women who were considered to be "at-risk" mothers on account of their probable history of family violence. Participants were recruited from Non-Governmental Organizations (NGO) centres in the Western Cape. The results provided evidence of an association between parenting stress and substance use. However a significant relationship between substance use and child maltreatment was not found. Study Two involved two focus groups, each consisting of eight women who were recruited from two NGOs that had been involved in Study One. Focus group discussions (in relation to the aforementioned three variables) were analyzed using the thematic analysis technique of template analysis. The group discussions provided evidence for a bi-directional relationship between parenting and substance use. This study has implications for the designing of parenting programmes, suggesting the need to address both substance use and parenting stress in such interventions. Yet, in addition to this, it appears that novel recruitment techniques are necessary in order to locate mothers who are most likely to be at risk for poor parenting behaviours.

Key words: substance use, poor parenting, parenting stress, child maltreatment, thematic analysis, parenting interventions.

INTRODUCTION

More than one-third of individuals living in Cape Town, South Africa, engage in risky drinking behaviours on the weekend (Parry et al., 2002; Wechsberg et al., 2008). In the last decade, methamphetamine (locally known as "tik") usage has also reached devastating levels, with estimates suggesting 7% of the adult population in Cape Town uses this drug (Morris & Parry, 2006; Plüddemann, Myers, & Parry, 2008). As such, substance use in South Africa - and Cape Town in particular - is a pervasive problem. The majority of individuals using substances appear to be of a parenting age. One study put the average age of a substance user in Cape Town at between 37 and 42 years of age, while another study found a high usage of substances amongst young parents between the ages of 18 and 24 years (Plüddemann et al., 2008; Ward et al., 2008). This extensive use of substances by South African parents is a concerning phenomenon warranting further investigation.

A Correlational Link between Substance Use and Poor Parenting

In a review, Magura and Laudet (1996, p. 196) concluded that "there is ample empirical evidence for the link between parental substance abuse and an increased risk for child maltreatment". Indeed, the evidence is largely indisputable: Substance use is associated with parenting problems, as is particularly demonstrated in cases of child maltreatment.

Child maltreatment is defined as the intentional and preventable harm to a child that results from human actions (Pierce & Bozalek, 2008). This general term incorporates both child abuse and child neglect. Child abuse describes any active harm that is inflicted upon a child, including deliberate physical injury (physical abuse), sexual contact between an adult and a child (sexual abuse), and psychological injury inflicted upon a child (verbal or emotional abuse) (Martin & Walters, 1982). Child neglect describes the deliberate failure of a caregiver to engage in the necessary childcare behaviours, including a lack of provision for a child's basic physical, emotional, educational, medical, and hygiene needs (Makoae, Dawes, Loffell, & Ward, 2008).

As early as the 1960s, it was found that alcohol usage was implicated in 62% of reported cases of child abuse and neglect (Young, 1964 as cited in Kameen & Thompson, 1983). Thereafter, much research has been conducted to explore this relationship. Studies investigating this link have typically examined the case histories of children receiving welfare and protective services. Using this method, Famularo, Kinscherff and Fenton (1992) found that 67% of maltreatment cases (including sexual and physical abuse) were linked to substance abuse. Similarly, Murphy et al. (1991) reviewed 206 cases of child abuse, and determined that 43% of these cases involved a parent with a documented alcohol or drug problem. In more recent years, Jones (2004) found this link to be around 68%, and McNichol and Tash (2001) determined that 76% of children in foster care had been affected by substance use in some way. In South Africa, court record research has indicated that substance use is the most important factor underlying child maltreatment (Makoae et al., 2008). This research in particular links substance use to severe child neglect. Thus, legal evidence has led child welfare agency officials to conclude that substance use is the single largest cause of child maltreatment (Walsh, MacMillan, & Jamieson, 2003).

Another method of investigating the link between substance use and parenting is that of retrospective surveys, whereby populations of individuals reporting either child abuse or substance abuse problems are surveyed with regard to the other variable. For example, Black and Mayer (1980) interviewed a sample of opiate addicts and alcoholics, and determined that

nearly half of this sample self-reported maltreating their children at some point. Similarly, studies have surveyed individuals with a reported child abuse or neglect problem, and have found that these individuals are more likely than control group participants to report substance abuse (De Bellis et al., 2001; Kelleher, Chaffin, Hollenberg, & Fischer, 1994). Such retrospective studies, however, are subject to the limitations of self-report methods, including response sets and social desirability bias, particularly on account of the sensitive and potentially incriminating nature of the required responses.

In order to address these methodological weaknesses, some prospective studies have been conducted. One such study found a link between a history of substance use and the potential for child maltreatment using the Child Abuse Potential Inventory (CAPI) (Ammerman, Kolko, Kirisci, Blackson, & Dawes, 1999). While this study does add evidence for a link between substance use and child abuse, it must be noted that the CAPI does not directly measure child maltreatment, and therefore these results must still be interpreted with caution.

Finally, several longitudinal studies have been conducted, again finding a strong association between substance use, measured at time one, and child abuse, measured in a subsequent data collection phase (Chaffin, Kelleher, & Hollenberg, 1996; Wolock & Magura, 1996). In summary, despite some methodological weaknesses, there has been a vast array of studies indicating a positive correlation between substance use and poor parenting.

This link between substance use and parenting has, however, tended to focus on cases of extreme child maltreatment, such as abuse and neglect, possibly on account of the ease of access to official records. Yet there has been some research to link substance use to more general parenting malpractices. For example, it has been found that substances interfere with parents' emotional, cognitive, and behavioural functioning (Magura & Laudet, 1996). Substance-using mothers spend less time with their children, and show inconsistency in their emotional support and disciplinary techniques (Bauman & Dougherty, 1983). The ripple effects of the drug-using lifestyle may also impact upon the children of substance users. For example, such children may be exposed to the drug-seeking behaviours of their parents, including crime and prostitution (Johnson, Williams, Dei, & Sanabria, 1990). Thus, while there is a direct link between substance use and child maltreatment, substance use is also implicated in more general deficits in parenting.

It must be noted that the majority of studies finding a correlation between substance use and poor parenting practices have taken place in an American context. This correlational link has therefore not been firmly established in South Africa. As such, research is needed to

provide greater evidence for the relationship between substances and child maltreatment in the South African population.

The Direction of the Relationship

Substance use causes poor parenting?

Despite the establishment of a clear correlational link between substance use and poor parenting in the literature, the exact nature of this relationship requires further exploration. Intuitively, it would seem that substance use causes poor parenting. However, on account of the retrospective nature of the vast majority of research studies, this cannot be stated conclusively. Some evidence, particularly from longitudinal studies, has suggested that the majority of individuals who use drugs began doing so in adolescence (Kelleher et al., 1994). This finding would suggest that drug use precipitated parenting, thereby supporting the assertion that substance use causes poor parenting. However, such an argument does not offer insight as to whether the parent was actually under the influence of a substance at the time of the child maltreatment. One study specifically sought to address this question, and it determined that 65% of children are maltreated *while* their parents are under the influence of alcohol, drugs or both (Westat, 1992 as cited in Donohue, Romero, & Hill, 2006). Hence, there is evidence for a causal link from substance use to poor parenting.

In support of this causal direction, several theories have been proposed to explain why substance use may lead to child maltreatment. Miller, Maguin, and Downs (1997) have advanced three hypotheses to account for the link between substance use and in particular, *child abuse*. Firstly, the *disinhibition hypothesis* posits that there is a direct pharmacological connection, whereby substances suppress the brain areas that control socially appropriate behaviour, thereby leading to parental aggression. Secondly, the *deviance disavowal hypothesis* proposes that child abuse results from substance use, as the drugs or alcohol allow a parent to blame the substances for any ensuing aggressive behaviour. Thirdly, the *cognitive disorganization hypothesis* holds that substance use results in miscommunication in the family, overestimation of threats and an underestimation of the consequences of violence, thereby increasing the likelihood of parental aggression and child abuse.

Furthermore, several theories have been presented to explain the link between substance use and *child neglect*. Firstly, it appears that parents who abuse substances tend to become preoccupied with their drug or alcohol use (Gottwald & Thurman, 1994; Marcenko, Kemp, & Larson, 2000). This preoccupation depletes parents' emotional and energy resources, which in turn leads to a lack of parent supervision, discipline and child protection

(Ammerman et al., 1999). Secondly, frequent usage of substances is a costly endeavour, and this may contribute to child neglect, particularly, in the form of inadequate finances for nutrition, clothing, medical services and schooling (Black & Mayer, 1980).

A bi-directional relationship?

In addition to this directional link between substance use and poor parenting, a relationship may exist in the opposite direction, that is, parenting problems may lead to substance use. A theory that potentially supports this reverse relationship is the stress-coping model of substance use. This model proposes that alcohol and drugs are used as a coping mechanism to escape or avoid unpleasant emotions (Cooper, Russell, & George, 1998). Hence this model suggests that after negative stressors, the likelihood of drug use increases (Kilpatrick et al., 2000). Parenting stress may be an example of such a negative stressor. Parenting stress describes the distress that arises from the demands of being a parent (Deater-Deckard, 1998). This incorporates factors such as a parent's perceived competence, social support, parenting knowledge, and the difficulty of the particular child. Hence, it may be proposed that parenting stress leads to substance usage.

However, while much research has been conducted on the causes of parenting stress, there is minimal research on how parents cope with this stress and whether substances are implicated in their coping mechanisms (McPherson, Lewis, Lynn, Haskett, & Behrend, 2009). This therefore appeared to be a gap in the literature and a niche for further research.

Research Questions

This research project therefore sought to explore the nature of the relationship between three variables: substance use, child maltreatment and parenting stress. These relationships were explored in particular in relation to an 'at-risk' population of parents: women who are likely to have been abused as children or to have experienced intimate partner violence (IPV). For the purposes of this study, the term *family violence* will be used to refer to exposure to childhood abuse or IPV. Research suggests that women who have experienced family violence are more likely to demonstrate poor parenting practices, including aggressive disciplinary actions, neglect and abuse (Zolotor, Theordore, Coyne-Beasley, & Runyan, 2007; Simmons, Lehmann, & Dia, 2009; Kaufman & Zigler, 1989). In addition to this increased risk of poor parenting, women with a history of family violence are also more likely to use substances (Wong, Huang, DiGangi, Thompson, & Smith, 2008). As such, this subset of mothers appears to be a particularly risky group of parents.

The questions of this research project were, therefore as follows:

1. Is substance use associated with poor parenting practices, such as child maltreatment, amongst ‘at-risk’ mothers in South Africa?
2. Do mothers use substances to cope with parenting stress?

In the spirit of methodological pluralism, these questions were explored in two separate studies, using quantitative and qualitative methodologies, respectively.

STUDY 1

Method

Sample

The sample included 199 mothers or grandmothers, provided they were the primary caregiver of a child. These women were recruited from Non-Governmental Organizations and community centres in the Cape Town region. Two sampling techniques, namely snowball and purposeful sampling, were used in order to access the sample. Organizations were approached to request their participation in this study and responsive organizations were asked if they could in turn recommend any further organizations for participation (snowball sampling). The actual women at the organizations were then asked to sign up for the study if they were above 17 years of age and had children between the ages of 3 and 8 years (purposive sampling).[1] While this sampling procedure was not randomized and does not therefore present a generalizable sample, this was the only means of accessing this population of women for whom there was no pre-existing sampling frame.

Most of women participating in this study were Coloured[2] or isiXhosa-speaking Black Africans, generally of a low socio-economic status. Many of the participants had limited schooling and therefore may not have been functionally literate. Some of the women had experiences of family violence, particularly if they were recruited from shelters for abused and battered women.

Design

This study employed a quantitative design, whereby participants were surveyed using three structured inventories. This research was therefore cross-sectional and correlational in nature, with the aim of exploring the links between three variables, namely substance use, child maltreatment and parenting stress.

Materials

All participants were required to respond to a questionnaire consisting of four sections. Participants initially responded to a set of demographic questions, which gathered information regarding race, language, level of education, age, sources of income, and

[1] This age group of children (3 to 8 years) was used to coincide with the majority of the research examining parenting programmes, and particularly the Positive Parenting Program (Triple P) (for example, Bodenman, Cina, Lendenmann, & Sanders, 2007; Connell, Sanders, & Markie-Daads, 1997)

[2] 'Coloured' is an apartheid classification term referring to a person of a mixed European and African ancestry. This is a demographic marker and does not refer to any inherent characteristics.

employment and marital status (see Appendix A). Thereafter, three inventories were used to measure the specific variables under study.

Substance abuse: Firstly, the World Health Organization's (2002) Alcohol, Smoking and Substance Involvement Screening Test 3.0 (ASSIST) test was used as a measure of drinking and substance-using behaviours (see Appendix B). The ASSIST is a brief test consisting of eight questions, which screen for the use of a variety of drugs, including cannabis, cocaine, amphetamines, inhalants, sedatives, hallucinogens, opiates, miscellaneous drugs, alcohol and tobacco. This test also measures for the frequency of drug use and the impact of this usage on a respondent's life. Most of the questions in the ASSIST employ a 5-point likert-scale ranging from *never* (in the past three months) to *daily or almost daily*. This scale produces two scores for each respondent: a total substance involvement score (the sum of all responses for all the classes of drugs), and a specific substance involvement score (the sum of responses within each particular drug class.) The ASSIST user manual then provides cut-off points in order to classify participants into three categories based on their specific substance use: low, moderate or high risk (Henry-Edwards, Humeniuk, & Ali, 2003). The ASSIST has been tested in several sites around the world, where it has been found to be a reliable and valid screening test (Newcombe, Humeniuk, & Ali, 2004.)

Child abuse: Secondly, the Parent-Child Conflict Tactics Scale (CTS-PC) was used (see Appendix C). This version of the Conflict Tactics Scale (CTS) is a 35-item questionnaire, which measures parents' disciplinary actions towards their children (Straus, 1979). Participants are required to respond with regard to the number of times they have used a particular form of discipline in the past year. There are six subscales of the CTS-PC: non-violent discipline, psychological aggression, minor physical assault, physical maltreatment and severe physical maltreatment. This scale was therefore used as a measure of child abuse. The CTS-PC has been found to have good test-retest reliability (Amato, 1991 as cited in Straus & Hamby, 1997). Furthermore, the briefness and simplicity of this test make it accessible to a sample of participants with minimal education.

Parenting Stress: Thirdly, Abidin's (1995) Parenting Stress Index, Short Form Scale (PSI/SF) was used as a measure of parenting stress. The PSI/SF contains three scales, assessing parental distress, parent-child dysfunctional interactions and the difficult behaviours of the child. There are 36 items, which are answered on a 5-point likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). This PSI/SF has been found to be have high test-retest reliability and validity, both when considering typically developing children and children that are HIV positive in South Africa (Abidin, 1995; Potterton, Stewart, & Cooper,

2007). The PSI/SF can provide a total parenting stress score, in addition to scores for each of the three sub-scales. This PSI/SF also has a built-in 'Defensive Responding' scale which can be used to locate participants who are biased to present themselves in a favourable light.

Procedure

Participating NGOs and organizations received an advertisement poster to place in their receptions in order to recruit potential participants (see Appendix D). Women (both day visitors, women living on-site and staff members) were then able to sign up for the study with the centre receptionists.

The surveys were conducted in face-to-face interviews by researchers, interpreters and research assistants. The face-to-face format was used in order to ensure that illiterate women were not excluded from the study (Kitzinger, 1995). Verbal interviews have the additional advantage of enabling the researcher to clarify participants' uncertainties and therefore ensure that fewer items are left incomplete (Babbie & Mouton, 2007).

The actual survey was translated and back-translated from English to Afrikaans. Depending on the participant's preference, the interviews took place either in English, Afrikaans or isiXhosa (the latter language requiring an interpreter). All the interviewers and interpreters were adequately trained in order to ensure that they were familiar with the questionnaire and could therefore conduct the interview in a similarly standardized manner.

The interviews took place at the organization or NGO in a private room. Interviews typically lasted one hour[3], and began with an initial discussion of informed consent issues (see Appendix E). Upon completion of the interview, participants received a brochure containing useful parenting advice (see Appendix F), some refreshments and a small sum of money for travelling costs.

Ethical Considerations

Ethical approval for this study was granted from the Research Ethics Committee of the University of Cape Town (UCT) Department of Psychology. In line with ethical considerations, participants' responses were kept anonymous, and the informed consent forms of participants were kept in a locked filing cabinet, accessible only to the researchers.

Results

Description of Participants

Sociodemographics

[3] The interviews included several additional inventories, in line with a larger research project being conducted for a Master's degree in Clinical Psychology.

A total of 202 mothers were interviewed in this study. Three participants were, however, excluded from the analysis on account of their presumed social desirability bias, as determined by the Defensive Responding scale of the PSI/SF. As presented in Table 1, participants' ages ranged from 17 to 87 years, with an average age of 32.5 years. Nearly one-half of the participants were single mothers (46.7%) with approximately one-third of the sample (35.8%) having a partner or marriage spouse. The sample was roughly divided into half Coloured and half Black women (48.0% and 47.0% respectively), with isiXhosa and Afrikaans being the most spoken languages. The average number of children of participants was 2.14. Most participants had not completed high school (76.2%) and the majority of these women were not working (81.7%). The leading source of income for participants was the Child Support Grant, with 79.7% of women receiving this funding. Yet many participants still struggled to afford basic necessities: over half of the participants (61.7%) stated that they had run out of money to buy food in the last month.

Parenting Stress

Participants' parenting stress scores were divided into the three subscales. The Parental Distress subscale had the highest mean (*M*=37.01, *SD*=8.36). This was followed by the Difficult Child subscale (*M*=33.23, *SD*=8.57) and the Parent-Child Dysfunctional Interaction subscale (*M*=30.12. *SD*=8.37).

Substance Use

Forty-six participants (23.12%) had never before used any substances. The remaining participants were then classified into two categories relating to their specific substance involvement scores: low risk, or moderate to high risk (a category created by merging the moderate and high risk categories outlined in the ASSIST user manual) (Henry-Edwards et al., 2003). As can be seen in Table 2, 40.2% of participants fell into the moderate to high risk category for tobacco use, and 16.08% of participants were in this risk category for alcohol use. Just over 9% of the participants were risky users of amphetamines, and 6.03% and 5.53 % of participants fell into the risk categories for cannabis and sedatives respectively. Virtually no women were classified in the risk category for inhalants and cocaine (both 0.5%), and no women were risky users of hallucinogens or opiates.

Child Maltreatment

The CTS-PC provided an overview of the prevalence of certain disciplinary actions performed by participants towards their children (see Table 3) (Straus, 2000a; Straus, Hamby, Finkelhor, Moore, & Runyan, 1998). The non-violent disciplinary method of 'explaining to a child why something was wrong' was the most prevalent action in this sample, with 85.93%

of participants having done this in the past year. This was followed by a form of psychological aggression: 'shouting, yelling or screaming at a child' (80.90%). Other prevalent forms of discipline in the past year included 'spanking a child on the bottom with a bare hand' (77.89%), and 'threatening to spank a child but not actually doing it' (75.88%). In terms of "ever prevalence" (the scale showing the prevalence of a particular act without the referent period of one year), 'explaining why something was wrong', and 'shouting, yelling or screaming at a child', remained the most prevalent actions (86.93% and 83.92% respectively).

Finally, the number of sample members who performed a certain disciplinary act three or more times in the past year was calculated. 'Shouting, yelling or screaming' was the most frequently used tactic, with 54.77% of the sample using this form of discipline three or more times in the past year. This was followed by 'explaining why something was wrong' to a child (53.27%) and 'threatening to hit or spank a child but not actually doing it' (52.26%).

Table 1
Demographic Characteristics of the Sample

	n (N=199)	%		n (N=199)	%
Age			Number of Children		
17-20	16	7.92	1	71	35.15
21-30	91	45.05	2	68	33.66
31-40	53	26.24	3	34	16.83
41-50	25	12.38	4	16	7.92
51-60	8	3.96	5+	11	5.45
61-70	5	2.48	Education		
71-80	0	0.00	Some primary	17	8.42
81-90	1	0.50	Complete primary	12	5.94
Marital Status (N=198)			Some high	125	61.88
Single	94	46.77	Complete high	37	18.32
Partnered	34	16.92	Post-matric	6	2.97
Married	38	18.91	Post-graduate	2	0.99
Separated	11	5.47	Employment Status		
Divorced	8	3.98	Working	34	16.83
Widowed	13	6.47	Not working	165	81.68
Language			Sources of Income		
English	28	13.86	Work	33	16.34
Afrikaans	75	37.13	Pension	9	4.46
isiXhosa	85	42.08	Partner	65	32.18
English & Afrikaans	2	0.99	Child grant	161	79.70
Afrikaans & isiXhosa	2	0.99	Disability grant	9	4.46
isiXhosa & English	2	0.99	Family	66	32.67
Eng, Afrikaans & isiXhosa	2	0.99	No income	5	2.48
Other	3	1.49	Other	10	4.95
Race			Hunger Scale		
			Run out of food in past 30		
Coloured	97	48.02	days	123	61.69
Indian	2	0.99	Previously run out of food	145	72.28
Black	95	47.03			
White	3	1.49			
Asian	0	0.00			

Other	2	0.99

Table 2.
Number of Participants Classified in Moderate/High Risk Category for a Specific Substance

Substance Type	n (N=199)	%
Tobacco	80	40.20
Alcohol	32	16.08
Cannabis	12	6.03
Amphetamine	18	9.05
Inhalants	1	0.50
Sedatives	11	5.53
Cocaine	1	0.50
Hallucinogens	0	0.00
Opiates	0	0.00
Other	1	0.50

Table 3.
Prevalence of Parent-Child Conflict acts in the Sample (N=199)

Disciplinary Action	Prevalence in past year		Ever Prevalence		Used 3 or more times in past year	
	Number	%	Number	%	Number	%
Non-Violent Discipline						
A. Explained why something was wrong	171	85.93	173	86.93	106	53.27
B. Put him/her in "time-out"	120	60.30	127	63.82	75	37.69
Q. Took away privileges or grounded him/her	95	47.74	98	49.25	48	24.12
E. Gave him/her something else to do instead of what he/she was doing wrong	112	56.28	113	56.78	71	35.68
Psychological Aggression						
N. Threatened to spank or hit him/her but did not actually do it	151	75.88	153	76.88	104	52.26
F. Shouted, yelled or screamed at him/her	161	80.90	167	83.92	109	54.77
J. Swore or cursed at him/her	76	38.19	80	40.20	37	18.59
U. Called him/her dumb or lazy or some other name like that	61	30.65	61	30.65	19	9.55
L. Said you would send him/her away or kick him/her out of the house	40	20.10	47	23.62	17	8.54
Minor Physical Assault (Corporal Punishment)						
H. Spanked him/her on the bottom with your bare hand	155	77.89	156	78.39	85	42.71
D. Hit him/her on the bottom with something like a belt, hairbrush, a stick or some other hard object	77	38.69	80	40.20	37	18.59
P. Slapped him/her on the hand, arm, or leg	104	52.26	104	52.26	47	23.62
R. Pinched him/her	56	28.14	58	29.15	23	11.56
C. Shook him/her	77	38.69	81	40.70	32	16.08
V. Slapped him/her on the face or head or ears	37	18.59	37	18.59	8	4.02
Physical Maltreatment						
O. Hit him/her on some other part of the body besides the bottom with something like a belt, hairbrush, a stick or some other hard object	39	19.60	41	20.60	18	9.05
T. Threw or knocked him/her down	9	4.52	9	4.52	2	1.01
G. Hit him/her with a fist or kicked him/her hard	30	15.08	31	15.58	10	5.03
Severe Physical Maltreatment						
K. Beat him/her up, that is you hit him/her over and over as hard as you could	17	8.54	18	9.05	7	3.52
I. Grabbed him/her around the neck and chocked him/her	11	5.53	11	5.53	3	1.51

M. Burned or scalded him/her on purpose	4	2.01	4	2.01	1	0.50
S. Threatened him/her with a knife or gun	4	2.01	9	4.52	0	0.00

Analyses

SPSS Version 18.0 was used for the following statistical analyses. All the scales used in this study had good to excellent internal reliabilities: Cronbach's α for the PSI/SF, ASSIST and CTS-PC were .90, .85 and .70 respectively. A single composite score was created for participants on each of the three scales. For the PSI/SF, participant's responses were summed to create a total value. These total scores ranged from 46 to 163, out of a potential range of 36 to 180. The mean score was 100.35 (*SD*=20.55). Participants' responses on the eight questions of the ASSIST were also summated to create a total substance use score. ASSIST total scores ranged from 0 to 74, with a mean of 9.48 (*SD*=10.79). Finally, a total value for child maltreatment on the CTC-PC was calculated. In order to compute this maltreatment score, the items relating to non-violent discipline were removed. The remaining items were then weighted using the recommendations of Straus (2000a) for the Revised Conflict Tactics Scale (CTS2). Psychological aggression and corporal punishment items received a weighting of one; physical maltreatment a weighting of five; and severe physical maltreatment items were weighted with an eight. Participants' scores were then summed to form a single score. These scores ranged from 0 to 51 with a mean of 20.22 (*SD*=9.76).

Pearson's correlations were conducted for the variables *parenting stress* and *child maltreatment*; while Spearman's correlation coefficient was utilized with the correlations of *substance use* (the assumption of normality was violated). All correlations were run as one-tailed tests. Inspection of the intercorrelation matrix (see Table 4) shows two statistically significant but low correlations: *substance use* was positively correlated with *parenting stress*, $r_s = .194$, $p<.01$, and *parenting stress* was positively correlated with *child maltreatment*, $r = .201$, $p<.01$. There was no significant correlation between *substance use* and *child maltreatment*.

A mediation analysis was then conducted in order to determine if *substance use* mediated the relationship between *parenting stress* and *child maltreatment*. The Sobel test of mediation was not significant ($p= .30$), suggesting that no mediation occurred, and therefore parenting stress did not impact on child maltreatment indirectly through substance use (Preacher & Leonardelli, 2001).

Table 4.
Intercorrelations between Parenting Stress, Child Maltreatment and Substance Use

Variable	Parenting Stress	Child Maltreatment	Substance Use
Parenting Stress	-		
Child Maltreatment	.201**	-	
Substance Use	.194**	.087	-

**p<.01(1-tailed)

STUDY 2

Method

Sample

Sixteen women were recruited for this second study from two organizations that had been involved in the previous study. The first organization was a community centre with an attached children's crèche, and the second was a shelter for abused women. The women were recruited using a convenience and purposeful technique, whereby any available women with children between the ages of 3 and 8 years were asked to participate in the study. Eight participants were selected from the community centre, and these participants were all Coloured women. A further eight participants were recruited from the shelter, and this sample group included three Coloured women, two Black women, one Indian, one White and one North African woman. All participants were of a low socio-economic status. Seven of the women had experienced intimate partner violence. Some of the participants had participated in the quantitative component of this research project.

Design

This study employed a qualitative design in order to explore and explain the relationships between substance use, parenting stress and child maltreatment in richer detail (Willig, 2001). As there is minimal existing research on the links between parenting stress and substance use, qualitative research provided a means of generating data that may not have been visible in the structured research with predetermined operational definitions (Babbie & Mouton). Hence, both a quantitative and qualitative study was conducted in order to obtain more meaningful data (Rosenthal & Rosnow, 2008).

Procedure

This study employed two focus groups in order to generate qualitative data. A focus group is a research technique whereby data is collected through a group interaction on a topic that is determined by the researcher (Kitzinger, 1995). Focus groups are useful in that they allow a researcher to tap into many everyday forms of communication. Focus groups also allow participants to respond and comment on each other's contributions, thereby giving the researcher access to data that would not be available in an individual interview (Willig, 2001). Hence, the focus groups were used to gain more naturalistic and rich data.

The focus groups were scheduled at the community centre and shelter respectively, in a private room. The focus groups took place over a period of an hour and a half. The groups began with a discussion of informed consent (see Appendix G). Thereafter, a series of probe questions were used to structure and spur the discussion (see Appendix H). At the end of the interview, participants were provided with refreshments and a small monetary compensation for their time.

Analysis

The focus group discussions were transcribed, and the data was subsequently analysed using a particular thematic analysis technique known as template analysis (Crabtree & Miller, 1992; King, 2008). A hierarchical template was initially constructed using categories that had emerged in the literature. This template was then applied to the data. The template was subsequently revised and refined until it was considered to adequately capture the complexity of the data, with both exhaustive and mutually exclusive categories.

Ethical considerations

Ethical approval for this study was granted from the Research Ethics Committee of the UCT Department of Psychology. This approval was based on the assumption that participants' names would not be linked to their responses and the audio-recording of the focus group would be destroyed subsequent to transcription. In addition, only the researchers would have access to the tape and transcriptions.

Results

Firstly, much data suggested that substance use results in poor parenting, with one participant explicitly stating "it [substances] makes them bad parents" (Participant 3, Community focus group). In particular, it emerged that substances can be linked to an increased prevalence of child abuse, child neglect and more general parenting malpractices.

Child abuse

In the discussion of the effects of substances on parenting, participants mentioned several different forms of child abuse. Firstly, substance use was linked to physical abuse:

> Like my sister. Her son is about twelve years old. When he was still a baby she beat him very hard, she beat him every day. That time was just the mandrax. And she was on mandrax, that was twelve years ago. And she was very abusive with the child. (Participant 3, Community focus group).

> It's the drugs and alcohol. A sober person won't hit the child. (Participant 2, Community focus group).

Secondly, the sexual abuse of children emerged in this discussion with one participant noting that substances result in "our children get[ting] raped, abused" (Participant 3, Community focus group).

Thirdly, verbal abuse of children was linked to parental substance use:

> They [substance-abusing mothers] use those big Italian words. (Participant 1, Shelter focus group).

> And the way they talk to the children. Very ugly. Not necessary. Swear, "jou ma se 'mm'", "jy het 'mm mm' in jou ore". It's ugly swearing words. Ugly swearing words And the children must still grow up. In that. (Participant 3, Community focus group).

Fourthly, substance use was linked to the economic or financial abuse of children, particularly in relation to the misuse of the Child Support Grant to pay for substances. One participant even suggested that "the mother just make children so they can get a all-pay grant to go and buy drugs" (Participant 5, Shelter focus group). Participants spoke of the drug dealers actually waiting near the pay-stations on the designated pay-day of the grants:

> Some of the merchants wait for you while you busy. My child's father, he's a drug lord, he waits for the money-lenders, he waits for them. (Participant 5, Shelter focus group).

This exploitation of the Child Support Grant to finance substance cravings rather than the children's needs was an issue of concern for many of the participants:

> I asked myself, that's the child's money. Is she gonna go and abuse all the money? What about the child's needs? It's for the child, not for them to go do other bad stuff. (Participant 8, Community focus group).

Participants also noted that substances may be used as a means of excusing abusive behaviour directed towards children:

> Children, they, uh, people murder them. Ja, and then they blame it on the tik. Maybe they not on tik and they say it's the tik. (Participant 3, Community focus group).

Child neglect

Parental substance use was not only linked to child abuse, but child neglect as well. A key form of neglect that was discussed was that of a lack of child care and supervision by drug-using parents. One participant spoke of a mother who had not taught her child adequate toilet training on account of her preoccupation with drugs:

> She's four years old. She still pees in haar broek [her pants]. And she still pees in her pants, man. And that is not necessary because you do have a mother. Just to see the children grow up in this community, it's very tearful for the mothers that is on drugs. (Participant 2, Community focus group).

Another participant described how a substance abusing mother provided inadequate child care with regard to her child's attire:

> And the child plays the whole day in the school clothes... And comes to school with the same clothes again on. (Participant 2, Community focus group).

A lack of supervision again emerged when a participant described how the children of substance-using mothers "are just left the whole day to do whatever they want to do. The mother just want to get the money for tik." (Participant 3, Community focus group).

A second form of child neglect that emerged from discussions was a lack of parent protection of children on account of substance use. One participant spoke of the accidents that may occur in the homes of alcohol abusing parents:

> Parenting, the way I see it, the mothers are mostly, she's drunk, she's always drunk, she's cooking but the wine is next to the stove, and that's how accidents, houses burning down, stuff like that. (Participant 5, Shelter focus group).

Thirdly, the physical neglect of children was described, especially on account of the fact that substance-using mothers may expend the family income on substances, thereby depleting the finances needed to meet the children's physical needs:

> And she [a mother abusing tik] doesn't buy anything – milk – and she has still a baby. And when the money's up, she comes to us, "don't you have a tea bag, or don't you have milk, or I just want boiling water for my child". (Participant 8, Community focus group).

Fourthly, educational neglect of children was described as a result of substance use:

> The child doesn't attend the crèche anymore. She [the mother] used the money for tik. (Participant 8, Community focus group).

A fifth example of neglect that arose in discussions was that of a lack of medical provision. One participant spoke of mothers who avoided going to medical centres on account of their drug use:

> And you know the other thing, the parents who use drugs, like the women who use drugs, they don't take the children to the clinic 'cause they breastfeed the children, and they're scared they find drugs in the children. Or their behaviour or whatever is going to lead to that. So they neglect the injection or anything of the child. (Participant 1, Shelter focus group).

Finally, some participants provided examples of how substance use can lead mothers to completely abandon their children:

> The mother gave birth to the child and left the child in the dirt bin because she was a drug addict, she was a prostitute, she couldn't have that child because she's scared she

won't be able to go and do her work to feed her addiction. (Participant 5, Shelter focus group).

Parenting malpractices

Still other more general parenting problems emerged from the discussions regarding the impact of substance use on parenting. One prominent theme that arose was that of substance-abusing mothers showing inconsistent emotional support to their children:

> Extreme ups and downs. Extreme ups and downs. Go though depression, go though anger, go through happy, go through meek and mild. Ja. Double symptoms. (Participant 8, Shelter focus group).

> These are the children 'cause your feelings are not the same, today you're like, "oh, I love you children", and tomorrow, "oh, stay away from me". (Participant1, Shelter focus group).

Another impact of parental substance use was that of children being exposed to substances from an early age, and even being forced to assist parents in acquiring substances:

> My best friend, she and her husband, they smoke buttons together. They don't care whether their child is sitting there. (Participant 5, Shelter focus group).

> [When you need your fix] Then it's like the children must go look for money. (Participant 1, Shelter focus group).

Substances were therefore implicated in poor parenting in the form of child abuse, neglect and general parenting malpractices. However, some contradictory evidence also emerged, with some participants suggesting that substances may actually improve parenting by giving mothers the energy they need to accomplish all the tasks demanded of a parent.

> [With drugs, I can] wash, clean and all that. And then now I will go now and wash them. And if I don't use it, it's like I can do nothing. Like I'm just lazy.... I use the drugs to be on my feet, to be on my toes. Do what my child wants me to. They bathed; they fed. (Participant 5, Shelter focus group).

> Like when you do drugs, when you're under the influence, then you have lots of time. (Participant 1, Shelter focus group).
>
> No, they say they are tiking today in order to make the house clean. They tik so as to stay awake. (Participant 7, Community focus group).

In addition to this idea that drugs assist mothers in accomplishing the many tasks of parenting, data emerged from the focus group discussions to suggest that substances may also be used as a means of coping with parenting stress.

Parenting stress

Some general discussion regarding the difficulties of parenthood showed that many participants found parenting to be "very hard work" (Participant 7, Shelter focus group). One of the most frequently cited stressors of being a parent was that of trying to cope with the difficult behaviours of one's children. An often quoted example of a difficult behaviour was that of children complaining, "Yes, always complaining." (Participant 3, Community focus group). Some participants also found the "constant bickering between children" (Participant 1, Shelter focus group) to be stressful. Other mothers spoke of the continuous stress of attempting to get their children to act in accordance with instructions:

> They don't want to listen. They will do what they want or just don't do what they don't like. And that makes you stress 'cause you must keep on talking to them, keep on shouting at them and they don't listen at all. (Participant 2, Community focus group).

Further behaviours that caused parenting stress included swearing and name-calling:

> He is like so rude; he swears at me, the big words – yesterday, he said 'p' word to me. (Participant 4, Shelter focus group).
>
> And the names he's calling you [as a mother] – so you're a fat man, you're a ugly face and all that. (Participant 8, Community focus group).

Children's aggressive behaviours and hyperactivity were also frequently mentioned in the discussions of parenting stress:

> When he gets angry, you wonder if it's the same child, the sweet boy. If he screams, you run away, you think it's a lion – RRR! He scares me, my heart beats. (Participant 7, Shelter focus group).
> My children is very hyperactive, and is also aggressive sometimes. (Participant 8, Community focus group).

Yet it was not only child misbehaviour that resulted in parenting stress, but participants often stated that the burden of being the primary caregiver - particularly in the case of being a single mother - was extremely stressful.

> They are in the mothers. It's always the mothers that took care of the children. It's always the mother they must come to. Always the mother. If they complain, the mother must do something. It's not the father. (Participant 8, Community focus group).

> Especially when there's no dad. Ah, it's difficult. It's difficult when there's no mom and dad. (Participant 3, Community focus group).

Being a single mother also meant that many participants found the economic burden of their children to be particularly stressful:

> You know I find a lot of, especially single moms' stress, would come from financial burden. Normally when it the mother and the father, there's two incomes, it's easier to cope with. (Participant 8, Shelter focus group).

Finally, a frequently cited source of stress for participants was that of community stress with regard to unsafe living circumstances, inadequate police support, and a lack of social support from other mothers.

> 'Cause I don't want my children to do drugs, I don't want my kids to be violent and gangsters. And I think the pressure of all that is giving me stress cause of um, I mean the community we live in. And the lifestyle is scary. 'Cause your child is growing up – what is going to happen to that child? (Participant 1, Community focus group).

Where's the police? They do nothing at all. (Participant 2, Community focus group).

> You don't get a chance of coming to talk as parents. And speak out. And all the problems at home, you need to talk to somebody. It's scary because you can't talk to anyone here. Can't trust people. They don't listen to your problems, they think of it's going to be a gossiping story. (Participant 1, Community focus group).

In summary, participants described parenting stress as resulting from the difficult behaviours of children, the burden of being a primary caregiver and community stress.

Coping with parenting stress

During the discussions regarding how mothers cope with the stress of parenting, drugs and alcohol were frequently mentioned as coping mechanisms. One woman stated that "it is sometimes easier to cope with the drug than what it is to cope with reality." (Participant 8, Shelter focus group). Other women also spoke about turning to substances to cope:

> And I think that's why some drink also. Can't handle what's going on in your life. And everyone can't handle the stress in the same way, so some go to drinking and some to drugs. (Participant1, Community focus group).

> I used tik and cocaine and I was on the needle, and I used to mix it with the tik, and I smoke it and I used it to do rock. I started doing drugs after I gave birth to my eldest son. I didn't want him and my mommy's pestering me on the one side, no matter what he is, look after him. So, my sister told me, so why don't you start this with me, it will calm you down. (Participant 5, Shelter focus group).

> [Smoking] It helps, ja. It helps. (Participant 2, Community focus group).

However, not all the discussion supported this notion of substances being used as a coping mechanism for parenting stress. Some participants spoke of other coping techniques, including drinking tea, talking to other mothers, women's groups, learning parenting skills and prayer. For example:

> I chose to run – whenever I have stress, when I feel like I can't make it anymore, I run to the church. I run to God, 'cause I know he's the solution to all problems. I take my

> kids with me, and every time I want to pray, I put them in front, 'cause I just leave them in God's hands. (Participant 7, Shelter focus group).

Furthermore, some participants argued that while substances may be used to cope with parenting stress, this was not the original reason that the majority of women began to use substances. One participant stated that most women start using drugs when they are "young young. Twelve. Yes. Twelve years old" (Participant 2, Community focus group). Another participant spoke of peer pressure as being the main motivating factor behind substance use:

> Because their friends is doing it. They can't beat them, so they join them. (Participant 3, Community focus group).

Still other participants attributed substance use to histories of family violence, and in particular, childhood abuse:

> I was on crack cocaine and I was on mandrax. Also running from abuse in my childhood. (Participant 8, Shelter focus group).

Thus, contradictory evidence emerged to suggest that while some parents may use substances to cope with parenting stress, women often began using drugs at a young age when faced with peer pressure or abusive home situations. Moreover, other coping techniques were frequently linked to parenting stress.

GENERAL DISCUSSION

Substance use and poor parenting

When considering the use of substances in this sample, participants reported relatively low levels of substance use, aside from that of tobacco. Concerning this latter drug, nearly half of the sample fell in the moderate to high risk category, suggesting that they were dependent on tobacco, using it hazardously and probably experiencing social, financial, legal, or relationship problems as a consequence of their use (Henry-Edwards et al., 2003). However, when tobacco is ignored due to its limited implications for parenting, the substances for which the greatest number of women engaged in risky use were alcohol, amphetamines and cannabis, respectively. This is similar to the findings of a study which determined that alcohol, cannabis and amphetamines are the drugs used most frequently in black townships and coloured communities (Wechsberg et al., 2008). However, in this present study, alcohol was found to be used hazardously by 16% of the sample, which is less than

research estimates that at least one-third of the Cape Town population engage in risky drinking behaviours (Parry et al., 2002).

Physical maltreatment of children was found to have a high prevalence in this sample of mothers. When considering corporal punishment, 77.89% of the sample said that they smacked their children, in comparison to a recent Western Cape survey which found that only 57% of mothers reported that they smacked their children (Dawes, Long, Alexander, & Ward, 2006). This is problematic as corporal punishment is a risk factor for child abuse (Straus, 2000b). Furthermore, this sample showed much higher levels of physical maltreatment compared to an American sample (Gallup, 1995 as cited in Straus et al., 1998). Particularly of concern is the high prevalence of severe physical maltreatment in this sample, with nearly 9% of participants reporting that they had beaten their child as hard as they could in the past year, in comparison to 0.2% in the American sample. Four participants also reported that they had burnt their child in the past year, and four participants stated that they had threatened their child with a knife or gun. This was a large number compared to the American sample in which no participants (N= 1000) reported engaging in such acts. On the whole then, it appears that this particular sample displayed high levels of physical maltreatment actions, but relatively low levels of risky substance use.

In spite of the high levels of child maltreatment actions, no significant correlation was found between substance use and child abuse in this sample. However, qualitative data strongly linked these two variables together. Participants provided examples of how substances, and especially the crystal methamphetamine, "tik", were linked to physical abuse, sexual abuse, verbal abuse and financial abuse. All of these forms of child abuse have been linked to substance use in existing literature (Sidebotham & Golding, 2001). The qualitative data thus confirmed the strong correlations that have been found in previous literature between substance use and child maltreatment (Walsh et al., 2003).

With regard to the causal mechanisms of the relationship between substance use and child abuse, participants described how substances might be used as a means of excusing abusive behaviour directed towards children. This tied in with Miller's et al. (1997) second hypothesis, the *deviance disavowal hypothesis*, which suggests that child abuse results from substance use, as the drugs or alcohol allow a parent to blame the substances for any ensuing aggressive behaviour.

The lack of a statistically significant relationship between substance use and child maltreatment may be elucidated by two explanations. Firstly, the CTS-PC was limited in scope in that it only measured physical maltreatment. However, previous literature has

suggested that parental substance use may have the greatest impact on children through neglect (Barth, 2009).The qualitative data in this study also revealed that substance use can be closely tied to child neglect and other more general parenting malpractices (Bauman & Dougherty, 1983). Focus group participants provided examples of how substance use results in inadequate parenting care, supervision and protection. Participants also described how substances lead to mothers neglecting the physical, educational and medical needs of their children – yet neglect was not assessed in the quantitative study. Thus, it may be that substance use is more strongly correlated with child neglect as opposed to child abuse, thereby explaining the lack of quantitative findings linking substance use to child physical abuse.

Secondly, the lack of a significant finding may be explained by the fact that most of the mothers in this sample used substances infrequently and at low levels, thereby preventing the finding of a strong relationship between substance use and child abuse as reported in the past year. The low levels of substance use may be attributed to the fact that women are typically not allowed to reside in a shelter if they are found to be using substances. As such, most shelter participants (approximately 10% of the sample) reported close to zero levels of substance use. In the community centre settings, the mothers who were interviewed were typically those who were recruited at a crèche, suggesting that these were mothers who were involved in their children's education. It may be hypothesized that mothers who *do* abuse substances would be unlikely to take their children to school on account of their preoccupation with their drug use. This suggestion is supported by the focus group discussions, as when participants spoke of substance-using mothers, they typically referred to other mothers in the community and explained that they were neglectful of their children, particularly with regard to school. Hence, it appears that while the sample of participants interviewed and involved in the focus group discussions had low levels of substance use, they could easily link substance use to poor parenting when they spoke about other women in the community.

The finding of low substance use in this sample may therefore be due to recruitment techniques, whereby the majority of sample participants were linked to services, such as shelters or crèches. It may be that mothers who are particularly at risk of poor parenting on account of their substance use are actually those who are not involved with existing services. This proposition is supported when considering a research project currently being conducted in similar areas of the Cape Town vicinity, which has recruited high numbers of substance using women (Jones et al., 2010). This project uses novel recruitment methods known as

'street outreach techniques' whereby participants are recruited by outreach workers who visit local areas in which substance-using women are likely to frequent, such as bars, parks and other drinking venues. Thus, it appears that the recruitment method used in this study may provide some explanation for the nature of the results.

However, one particularly contradictory finding emerged from the focus group discussions: the idea that substances can actually improve parenting by enabling mothers to be more alert and proficient in their parenting tasks. This finding may be explained by the fact that 'tik' can be used as a form of an anti-depressant drug. Indeed, it may be suggested that many of the women in this study were experiencing high levels of depressive symptomatology, which slowed down their functioning as a parent. As such, 'tik' may have been used as a means of self-medication for depression, which consequently improved these substance users' parenting abilities (Hasin et al., 2002).

Parenting stress and substance use

This study found there to be high levels of parenting stress in this sample of mothers. In comparison to previous research considering parenting stress in a sample of mothers with children with special needs, the PSI/SF Total Stress mean score for this sample, in addition to subscale mean scores for Parenting Distress and Parent-Child Dysfunctional Interactions, were higher than the mean scores in special-needs sample (Willner & Goldstein, 2001). Furthermore, all the parenting stress subscale mean scores were above the 85th percentile of published norms for the PSI/SF, indicating high scores (Abidin, 1995). As such, it appears that this was a high-stress sample of mothers.

The exact nature of the parenting stress experienced by the mothers could then be explored using the qualitative data. The participants typically associated parenting stress with difficult child behaviours, similar to the Difficult Child subscale on the PSI/SF. Participants focused on the defiance of their children, noting that parenting stress was linked to behaviours such as insolence, bad language, aggression and hyperactivity. Yet they also referred to the burden of their role as the primary caregiver and a lack of community and social support, items typically captured by the Parental Distress subscale. No qualitative data emerged concerning items on the Parent-Child Dysfunctional Interaction subscale.

With regard to the relationship between parenting stress and substance use, a small but significantly positive correlation was found between these two variables. This suggests that higher parenting stress is linked to increased substance use, although the lack of a significant mediation analysis prevents the reformulation of this relationship in a causal direction.

However, the qualitative data offers a means of explaining the causal mechanisms of this relationship: the stress-coping model of substance use was supported by the participants, suggesting that parenting stress precedes substance use (Cooper et al., 1998). Participants spoke of substances being utilized as a means of coping with reality and the demands of being a parent. However, the focus group discussions also suggested that participants had other coping mechanisms in order to deal with parenting stress, such as women's support groups, religious activities and the active learning of parenting skills. Thus, it appears that there was partial support for the use of substances as a means of reducing parenting stress.

Furthermore, a small but significantly positive correlation was found between parenting stress and child maltreatment, suggesting that parenting stress may also be linked to harsh disciplinary actions, in addition to substance use. This makes intuitive sense based on the measure of a child's difficult behaviour by the PSI/SF. This link has also been supported in the literature, as parental stress is associated with increased punitive parenting practices (Pinderhughes, Dodge, Zelli, Bates, & Pettit, 2000).

Limitations

This study had several limitations. Firstly, the sensitive nature of the required responses in the quantitative interviews may have obstructed participants' answers. Indeed, social-desirability bias may have been operating when participants answered questions regarding their substance use, disciplinary actions and perceptions of their children. As shown by the Defensive Responding scale of the PSI/SF, three participants could be classified as answering in a biased manner. This number would probably be augmented when considering the child maltreatment and substance use scales, which are much more closely tied to social norms of behaviour. Thus, it appears that the social desirability bias limited the validity of the quantitative answers.

This bias was possibly further heightened in the focus group discussions on account of my identity as a young, white, female student of a high socio-economic status. The fact that I am an educated English communicator also placed me in a position of power in the focus groups, particularly as English was not the first language of all the participants. As such, women may have adjusted their stories in order to relate what they believed I wanted to hear. They may have also refrained from discussing behaviours that diverged from societal expectations. This may have been an additional reason why most participants chose to speak about other women in the community, rather than themselves, when discussing child abuse and substance use in the focus groups. Thus, it is important to remain aware that my identity as the researcher influenced the findings of this study.

Finally, the quantitative component of this study failed to adequately address issues of cross-cultural differences. While the questionnaires were presented in two languages and interpreters were used if necessary, the actual constructs measured in this study may have lacked cross-cultural validity. For example, the notion of "time-out" as a form of discipline was foreign to many participants. As such, the limitations of the structured quantitative scores again need to be noted.

Conclusion

This study found quantitative and qualitative links between substance use, parenting stress and child maltreatment. Partial support was provided for a bi-directional relationship between parenting and substance use. Future research is needed in order to flesh out the nuances of these relationships more fully. Research is particularly needed to examine two factors in this same sample of at-risk mothers in the Cape Town region. Firstly, the relationship between substance use and child neglect (as opposed to child abuse) needs to be explored further, particularly with quantitative methodologies. Secondly, levels of depressive symptomatology in this sample, and the link between these symptoms and substance use, child maltreatment and parenting stress need to be examined.

This study has implications for the designing of parenting programmes. Firstly, this study has particular suggestions for the recruitment of mothers who are at risk of poor parenting. It appears that in order to locate these at-risk mothers, novel recruitment techniques need to be utilized as this sample of women is unlikely to be linked to services. "Street outreach techniques" may present one solution.

Secondly, it seems that parenting programmes should be designed in a multi-faceted manner, whereby both parenting stress and substance use are engaged with in interventions. Quantitative and qualitative data linked child maltreatment to high parenting stress and substance use respectively, suggested the need for a two-pronged approach when dealing with child maltreatment.

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Appendix A

The Demographic Section of the Questionnaire

1.	**Mother's date of Birth**
2	**Marital Status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
3	**Home language:** ☐ English ☐ Afrikaans ☐ isiXhosa ☐ other
4	**Race:** ☐ Coloured ☐ Indian ☐ Black ☐ White ☐ Asian ☐ other
5	**No. of children:** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ More than 4 children
6	**Education:** ☐ some primary schooling ☐ completed primary school ☐ some high school ☐ completed high school ☐ Post-Matric: Degree / Diploma ☐ Post-Grad Qualification
7	**Employment Status:** ☐ working or ☐ not working⇨ ☐ part-time or⇨ ☐ formal e.g. company ☐ full time ☐ informal e.g. flea- market stall
8	**Source/s of Income: (Tick all that applies)** ☐ work ☐ government pension ☐ partner/spouse ☐ child support grant ☐ disability grant ☐ money from family ☐ no income ☐ other (Specify):

Hunger Scale	**Yes**	**No**

9	**Does your household ever run out of money to buy food?**	☐	☐
10	a. Has it happened in the past 30 days?	☐	☐
11	b. Has it happened 5 or more days in the past 30 days?	☐	☐
12	**Do you ever cut the size of meals or skip any meals because there is not enough food in the house?**	☐	☐
13	a. Has it happened in the past 30 days?	☐	☐
14	b. Has it happened 5 or more days in the past 30 days?	☐	☐
15	**Do you or any of your children ever go to bed hungry because there is not enough money to buy food?**	☐	☐
16	a. Has it happened in the past 30 days?	☐	☐
17	b. Has it happened 5 or more days in the past 30 days?	☐	☐

18	**How would you describe the area in which you live?**	☐ suburb	☐ township
		☐ urban	☐ informal settlement
		☐ rural	☐ other
19	**How would you describe the dwelling in which you live?**	☐ formal house	☐ outbuilding in someone's backyard
		☐ a shack	☐ an apartment
		☐ other	specify
20	**During past for weeks, you have lived:**	☐ at home – where you normally live	☐ with your parents
		☐ at shelter	☐ at a boarding house
		☐ with a friend	☐ other specify:
21	**Which of the following do you or your family have at home? Please mark as many as necessary**	☐ television	☐ electricity
		☐ motor car	☐ telephone
22	**Child's Age:**	**Child's Gender:**	**Child's DOB:**

Appendix B

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

Q1	In your life, which of the following substances have you ever used? (Q1a, tobacco products; Q1b, alcoholic beverages; Q1c, cannabis; Q1d, cocaine; Q1e, amphetamine-type stimulants; Q1f, inhalants; Q1g, sedatives or sleeping pills; Q1h, hallucinogens; Q1i, opiates; and Q1j 'other drugs'	0 = no, 1 = yes
Q2	In the past 3 months, how often have you ever used the substances you mentioned (first drug, second drug, etc.)?	0 = Never 1 = Once or twice 2 = Weekly 3 = Monthly 4 = Daily or almost daily
Q3	During the past 3 months, how often have you had a strong desire or urge to use (first drug, second drug, etc.)?	0 = Never 1 = Once or twice 2 = Weekly 3 = Monthly 4 = Daily or almost daily
Q4	During the past 3 months, how often has your use of (first drug, second drug, etc.) led to health, social, legal or financial problems?	0 = Never 1 = Once or twice 2 = Weekly 3 = Monthly 4 = Daily or almost daily
Q5	During the past 3 months, how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc.)?	0 = Never 1 = Once or twice 2 = Weekly 3 = Monthly 4 = Daily or almost daily
Q6	Has a friend of relative or anyone else ever expressed concern about your use of (first drug, second drug, etc.)?	0 = No, never 2 = Yes, in the past 3 months 1 = Yes, but not in the past 3 months
Q7	Have you ever tried to control, cut down or stop using (first drug, second drug, etc.)?	0 = No, never 2 = Yes, in the past 3 months 1 = Yes, but not in the past 3 months
Q8	Have you ever used any drug by injection? (non-medical use only)	0 = No, never 2 = Yes, in the past 3 months 1 = Yes, but not in the past 3 months

Appendix C

The Parent-Child Conflict Tactics Scale (CTS-PC)

Parent-Child Conflict Tactics Scale (CTS)		
	Tick the number of times (the question) has happened	
	Scale	
In the **past year**, have you explained to (Child X) why something was wrong?	Once in the past year	☐ 01
	Twice in the past year	☐ 02
	Three or more times in the past year	☐ 03
	Not this past year but happened before	☐ 07
	This has never happened	☐ 00
In the **past year**, have you put him/her in time out or sent to his/her room?	Once in the past year	☐ 01
	Twice in the past year	☐ 02
	Three or more times in the past year	☐ 03
	Not this past year but happened before	☐ 07
	This has never happened	☐ 00
...shaken him/her?	Once in the past year	☐ 01
	Twice in the past year	☐ 02
	Three or more times in the past year	☐ 03
	Not this past year but happened before	☐ 07
	This has never happened	☐ 00
If 'yes' to question 96 go to question 97. if 'No' go to question 102.		
Has Child X ever received any injuries from these actions?	YES	☐ 01
	NO	☐ 02
Has Child X ever needed medical attention or seen a doctor because of these actions?	YES	☐ 01
	NO	☐ 02
Has anyone ever called the police because of these actions?	YES	☐ 01
	NO	☐ 02
Has anyone ever called social services because of these actions?	YES	☐ 01
		☐ 02

	No	
...hit him/her on the bottom with something like a belt, hairbrush, a stick or some hard object?	Once in the past year	☐ 01
	Twice in the past year	☐ 02
	Three or more times in the past year	☐ 03
	Not this past year but happened before	☐ 07
	This has never happened	☐ 00
If 'yes' to question 102. go to question 103., if 'No' go to question 107.		
Has Child X ever received any injuries from these actions?	YES	☐ 01
	NO	☐ 02
Has Child X ever needed medical attention or seen a doctor because of these actions?	YES	☐ 01
	NO	☐ 02
Has anyone ever called the police because of these actions?	YES	☐ 01
	NO	☐ 02
Has anyone ever called social services because of these actions?	YES	☐ 01
	No	☐ 02
Have you substituted a positive activity for whatever he/she was doing wrong?	Once in the past year	☐ 01
	Twice in the past year	☐ 02
	Three or more times in the past year	☐ 03
	Not this past year but happened before	☐ 07
	This has never happened	☐ 00
...shouted, yelled, or screamed at him/her?	Once in the past year	☐ 01
	Twice in the past year	☐ 02
	Three or more times in the past year	☐ 03
	Not this past year but happened before	☐ 07
	This has never happened	☐ 00
...hit him/her with a fist or kicked him/her hard?	Once in the past year	☐ 01
	Twice in the past year	☐ 02
		☐ 03
	Three or more times in the	

	past year	
	Not this past year but happened before	☐ 07
	This has never happened	☐ 00
If 'yes' to question 109. go to question 110., if 'No' go to question 113.		
Has Child X ever received any injuries from these actions?	YES	☐ 01
	NO	☐ 02
Has Child X ever needed medical attention or seen a doctor because of these actions?	YES	☐ 01
	NO	☐ 02
Has anyone ever called the police because of these actions?	YES	☐ 01
	NO	☐ 02
Has anyone ever called social services because of these actions?	YES	☐ 01
	No	☐ 02
.. spanked him/her on the bottom with a bare hand?	Once in the past year	☐ 01
	Twice in the past year	☐ 02
	Three or more times in the past year	☐ 03
	Not this past year but happened before	☐ 07
	This has never happened	☐ 00
...grabbed him/her around the neck and choked him/her?	Once in the past year	☐ 01
	Twice in the past year	☐ 02
	Three or more times in the past year	☐ 03
	Not this past year but happened before	☐ 07
	This has never happened	☐ 00
If 'yes' to question 114. go to question 115., if 'No' go to question 118.		
Has Child X ever needed medical attention or seen a doctor because of these actions?	YES	☐ 01
	NO	☐ 02
Has anyone ever called the police because of these actions?	YES	☐ 01
	NO	☐ 02
Has anyone ever called social services because of these actions?	YES	☐ 01
	No	☐ 02
Has any adult sworn or cursed at him/her?	Once in the past year	☐ 01

	Twice in the past year	☐ 02
	Three or more times in the past year	☐ 03
	Not this past year but happened before	☐ 07
	This has never happened	☐ 00
...beat him/her up, that is hit him/her over and over as hard as they could?	Once in the past year	☐ 01
	Twice in the past year	☐ 02
	Three or more times in the past year	☐ 03
	Not this past year but happened before	☐ 07
	This has never happened	☐ 00
If 'yes' to question 119. go to question 120., if 'No' go to question 124.		
Has Child X ever received any injuries from these actions?	YES	☐ 01
	NO	☐ 02
Has Child X ever needed medical attention or seen a doctor because of these actions?	YES	☐ 01
	NO	☐ 02
Has anyone ever called the police because of these actions?	YES	☐ 01
	NO	☐ 02
Has anyone ever called social services because of these actions?	YES	☐ 01
	No	☐ 02
...said they would send him/her away or kick him/her out of the house?	Once in the past year	☐ 01
	Twice in the past year	☐ 02
	Three or more times in the past year	☐ 03
	Not this past year but happened before	☐ 07
	This has never happened	☐ 00
..burned or scalded him/her on purpose?	Once in the past year	☐ 01
	Twice in the past year	☐ 02
	Three or more times in the past year	☐ 03
	Not this past year but happened before	☐ 07

	This has never happened	☐ 00
If 'yes' to question 125. go to question 126., if 'No' go to question 130.		
Has Child X ever received any injuries from these actions?	YES	☐ 01
	NO	☐ 02
Has Child X ever needed medical attention or seen a doctor because of these actions?	YES	☐ 01
	NO	☐ 02
Has anyone ever called the police because of these actions?	YES	☐ 01
	NO	☐ 02
Has anyone ever called social services because of these actions?	YES	☐ 01
	No	☐ 02
..threatened to spank or hit him/her but did not actually do it?	Once in the past year	☐ 01
	Twice in the past year	☐ 02
	Three or more times in the past year	☐ 03
	Not this past year but happened before	☐ 07
	This has never happened	☐ 00
..hit him/her on some other part of the body besides the bottom with something like a belt, hairbrush, stick, or some other hard object?	Once in the past year	☐ 01
	Twice in the past year	☐ 02
	Three or more times in the past year	☐ 03
	Not this past year but happened before	☐ 07
	This has never happened	☐ 00
If 'yes' to question 131. go to question 132., if 'No' go to question 136.		
Has Child X ever received any injuries from these actions?	YES	☐ 01
	NO	☐ 02
Has Child X ever needed medical attention or seen a doctor because of these actions?	YES	☐ 01
	NO	☐ 02
Has anyone ever called the police because of these actions?	YES	☐ 01
	NO	☐ 02
Has anyone ever called social services because of these actions?	YES	☐ 01

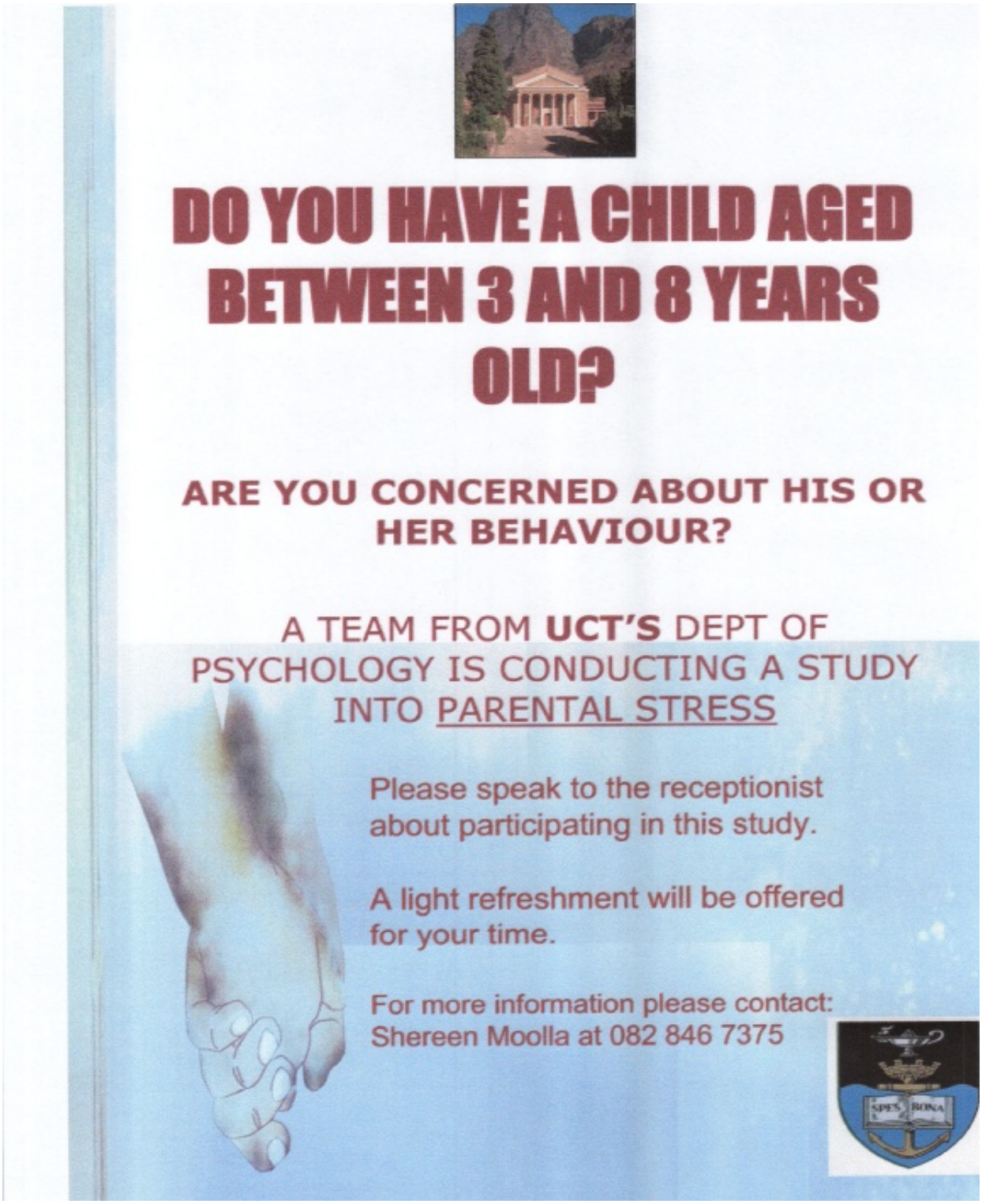
	No	☐ 02
Has any adult slapped him/her on the hand, arm, or leg?	Once in the past year	☐ 01
	Twice in the past year	☐ 02
	Three or more times in the past year	☐ 03
	Not this past year but happened before	☐ 07
	This has never happened	☐ 00
If 'yes' to question 136. go to question 137., if 'No' go to question 141.		
Has Child X ever received any injuries from these actions?	YES	☐ 01
	NO	☐ 02
Has Child X ever needed medical attention or seen a doctor because of these actions?	YES	☐ 01
	NO	☐ 02
Has anyone ever called the police because of these actions?	YES	☐ 01
	NO	☐ 02
Has anyone ever called social services because of these actions?	YES	☐ 01
	No	☐ 02
...taken away privileges or grounded him/her?	Once in the past year	☐ 01
	Twice in the past year	☐ 02
	Three or more times in the past year	☐ 03
	Not this past year but happened before	☐ 07
	This has never happened	☐ 00
...pinched him/her?	Once in the past year	☐ 01
	Twice in the past year	☐ 02
	Three or more times in the past year	☐ 03
	Not this past year but happened before	☐ 07
	This has never happened	☐ 00
...threatened him/her with a knife or gun?	Once in the past year	☐ 01
	Twice in the past year	☐ 02
	Three or more times in the past year	☐ 03

	Not this past year but happened before	☐ 07
	This has never happened	☐ 00
…thrown or knocked him/her down?	Once in the past year	☐ 01
	Twice in the past year	☐ 02
	Three or more times in the past year	☐ 03
	Not this past year but happened before	☐ 07
	This has never happened	☐ 00
If 'yes' to question 144. go to question 145., if 'No' go to question 149.		
Has Child X ever received any injuries from these actions?	YES	☐ 01
	NO	☐ 02
Has Child X ever needed medical attention or seen a doctor because of these actions?	YES	☐ 01
	NO	☐ 02
Has anyone ever called the police because of these actions?	YES	☐ 01
	NO	☐ 02
Has anyone ever called social services because of these actions?	YES	☐ 01
	No	☐ 02
…called him/her dumb or some other name like that?	Once in the past year	☐ 01
	Twice in the past year	☐ 02
	Three or more times in the past year	☐ 03
	Not this past year but happened before	☐ 07
	This has never happened	☐ 00
…slapped him/her on the face or head or ears?	Once in the past year	☐ 01
	Twice in the past year	☐ 02
	Three or more times in the past year	☐ 03
	Not this past year but happened before	☐ 07
	This has never happened	☐ 00
If 'yes' to question 150. go to question 151., if 'No' then all questions have been completed in this section.		

Has Child X ever received any injuries from these actions?	YES	☐ 01
	NO	☐ 02
Has Child X ever needed medical attention or seen a doctor because of these actions?	YES	☐ 01
	NO	☐ 02
Has anyone ever called the police because of these actions?	YES	☐ 01
	NO	☐ 02
Has anyone ever called social services because of these actions?	YES	☐ 01

Appendix D

Poster Advertising the Study



Appendix E

English Informed Consent Form for Participants Responding to the Survey

University of Cape Town

Department of Psychology

Consent Form

Dear potential participant,

Study Purpose

You are being asked to take part in a research study about parenting and child behaviour. We are researchers from the University of Cape Town (UCT). The purpose of the study is to find out how stresses in your own life may affect your parenting.

Procedures

If you decide to take part in this study, a researcher will interview you. The researcher will ask you questions about your family background, your children and your other relationships. This should not take longer than one hour. All information obtained from you will be kept strictly confidential and will be used for research purposes only.

Risks, Discomforts & Inconveniences

Some of the questions we ask may cause you to remember sad or difficult things from your own past, or cause you some embarrassment. Please remember that we keep this information absolutely anonymous: your name will not be put on the questionnaire, and this consent form will be stored separately from your interview responses.

Benefits

There are no direct benefits for your participation in this study, but we hope that the knowledge we will gain from this study will assists in improving future parenting programmes.

Alternatives

You may chose not to participate in this study and this decision will not affect you relationship with this organization in any way.

Voluntary Participation

Participation in this study is completely voluntary. You are free to refuse to answer any question. Your decision regarding participation in this study will not affect your relationship with the centre and or services you might access at the centre. If you decide to participate, you are free to change your mind and discontinue participation at any time during the interview.

Privacy and Confidentiality

We will take strict precautions to safeguard your personal information throughout the study. Your information will be kept without your name or other personal identifiers, in a locked file cabinet. Study data will be kept on a password-protected, secure computer. Only the researchers will be able to access your personal information.

The only exception is that if, during the interview, we discover that there are problems in the relationship between you and your child, we will ensure that you are linked to the appropriate services, to help you with this.

We will conduct the interviews in a private room from the centre. Any reports or publications about the study will not identify you or any other study participant.

Questions

If you have questions, concerns, or complaints about the study or questions about a research-related query, please contact

1. Cathy Ward 021 650 3422
2. Shereen Moolla 082 846 7375
3. Abigail Miles 084 427 980

If you have any other questions or concerns about this study, please feel free to contact the Department of Psychology on 021 650 3438.

Signatures

{Subject's name}_____ has been informed of the nature and purpose of the procedures described above including any risks involved in its performance. She has been given time to ask any questions and these questions have been answered to the best of the investigator's ability. She has been given a signed copy of this consent form.

_____ _____

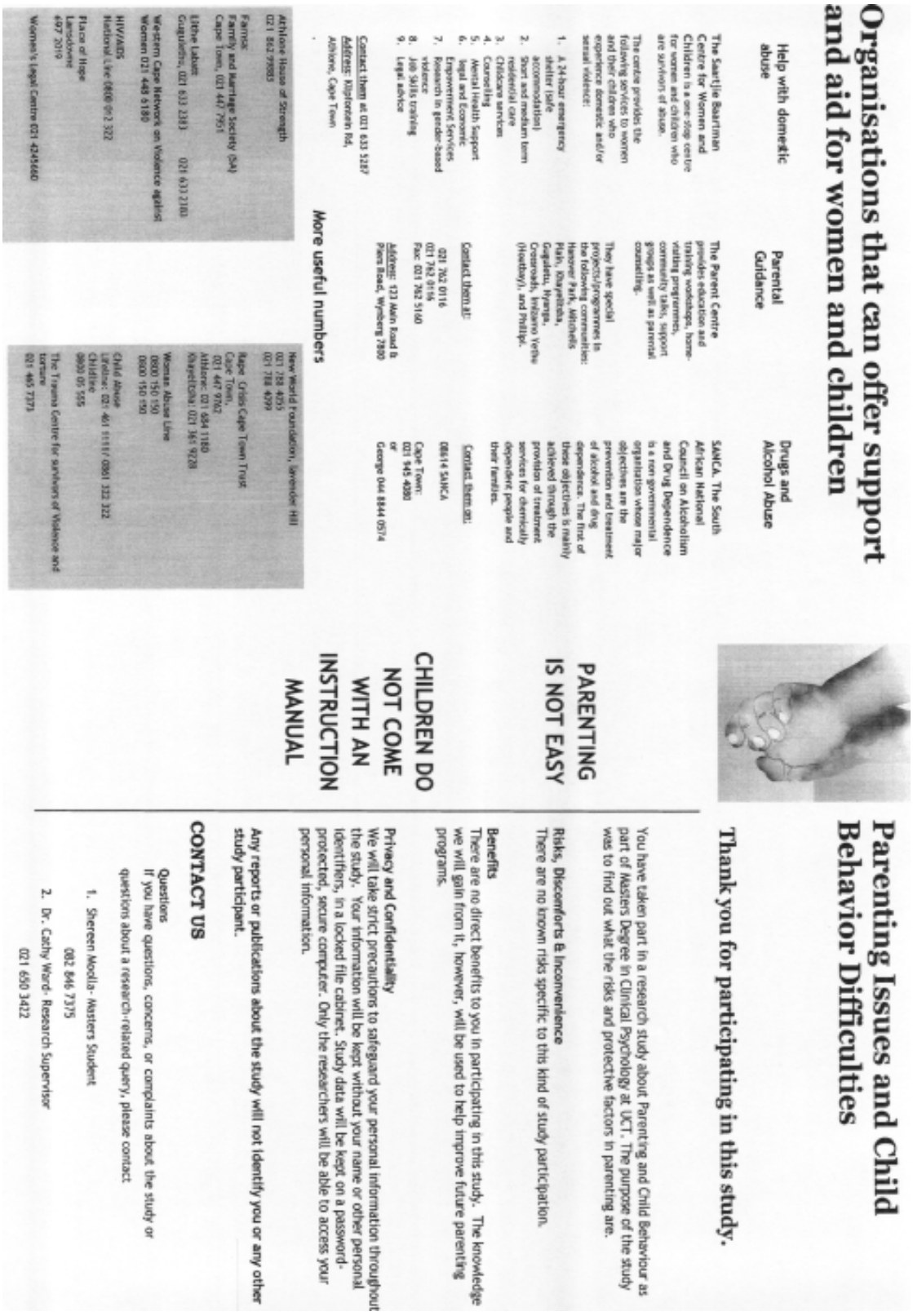
Investigator's Signature Date

I have been informed about this research study and understand its purpose, possible benefits, risks, and discomforts. I agree to take part in this research as a subject. I know that I am free to withdraw this consent and quit this project at any time, and that doing so will not cause me any penalty or loss of benefits that I would otherwise be entitled to enjoy.

Subject's Signature (verbal consent) Date

Appendix F

The Brochure Given to Participants on Completion of the Study



Parenting Issues and Child Behavior Difficulties

Thank you for participating in this study.

You have taken part in a research study about Parenting and Child Behaviour as part of Masters Degree in Clinical Psychology at UCT. The purpose of the study was to find out what the risks and protective factors in parenting are.

Risks, Discomforts & Inconvenience
There are no known risks specific to this kind of study participation.

Benefits
There are no direct benefits to you in participating in this study. The knowledge we will gain from it, however, will be used to help improve future parenting programs.

Privacy and Confidentiality
We will take strict precautions to safeguard your personal information throughout the study. Your information will be kept without your name or other personal identifiers, in a locked file cabinet. Study data will be kept on a password-protected, secure computer. Only the researchers will be able to access your personal information.

Any reports or publications about the study will not identify you or any other study participant.

CONTACT US

Questions
If you have questions, concerns, or complaints about the study or questions about a research-related query, please contact

1. Shereen Moolla- Masters Student
   082 846 7375
2. Dr. Cathy Ward- Research Supervisor
   021 650 3422

CHILDREN DO NOT COME WITH AN INSTRUCTION MANUAL

PARENTING IS NOT EASY

Organisations that can offer support and aid for women and children

Help with domestic abuse	Parental Guidance	Drugs and Alcohol Abuse
The Saartjie Baartman Centre for Women and Children is a one-stop centre for women and children who are survivors of abuse. The centre provides the following services to women and their children who experience domestic and/or sexual violence: 1. A 24-hour emergency shelter (safe accommodation) 2. Short and medium term residential care 3. Childcare services 4. Counselling 5. Mental Health Support 6. Legal and Economic Empowerment Services 7. Research in gender-based violence 8. Job Skills training 9. Legal advice Contact them at: 021 633 5287 Address: Klipfontein Rd, Athlone, Cape Town	The Parent Centre provides education and training workshops, home-visiting programmes, community talks, support groups as well as parental counselling. They have special projects/programmes in the following communities: Hanover Park, Mitchells Plain, Khayelitsha, Gugulethu, Nyanga, Crossroads, Ikwezeni Vethu (Heatway), and Philippi. Contact them at: 021 763 0116 021 763 0156 Fax: 021 762 5160 Address: 123 Main Road & Plein Road, Wynberg 7800	SANCA. The South African National Council on Alcoholism and Drug Dependence is a non governmental organization whose major objectives are the prevention and treatment of alcohol and drug dependence. The first of those objectives is mainly achieved through the provision of treatment services for chemically dependent people and their families. Contact them on: 0861 4 SANCA Cape Town: 021 945 4080 or George (044 8844 0574

More useful numbers

Athlone House of Strength 021 862 99883	New World Foundation, Lavender Hill 021 703 4251 021 788 4099
Famsa: Family and Marriage Society SA) Cape Town, 021 447 7951	Rape Crisis Cape Town Trust: Cape Town, 021 447 9762 Athlone: 021 684 1180 Khayelitsha: 021 361 9228
Lithe Labari Guguletu: 021 633 2383 021 633 2183	Woman Abuse Line 0800 150 150 0800 150 150
Western Cape Network on Violence against Women 021 448 6180	Child Abuse Lifeline: 021 461 1111/ 0861 322 322 Childline 0800 05 555
HIV/AIDS National Line 0800 012 322	The Trauma Centre for survivors of Violence and torture 021 465 7373
Place of Hope Lansdowne 447 2019	
Women's Legal Centre 021 4245660	

The questions you were asked in the interview may have sparked your interest regarding positive parenting.

Here is some information:

Research has shown that:

Feeling confident in one's own parenting is a protective aspect against frustration in parenting. To gain confidence parents can learn new skills and get information about parenting to realize their child's true potential.
Additionally being consistent in the way you respond to your child helps him or her cope in the midst of family conflict.

Conflict between parents is associated with child misconduct and misbehaviour

Parental stress creates a tense parent-child relationship. Stress may come from worries about food, money, housing, your child's behavior, school progress or fights with your partner. Research has shown that parents who report higher levels of stress may resort to physical punishment of their children easier than parents who are less stressed.

Reducing parental stress is one of the key components social agencies such as child welfare address when working with parents in conflictual relationships. Reducing parental stress typically involves assisting the families with basic needs or working to alleviate situational crises.

⇩

Social support may alleviate parenting stress and buffer children from negative outcomes associated with parental stress Social support diminishes the risk of physical abuse of the child.

Interventions that increase the support the mother receives from either her partner or from a social network like friends or family, has a major positive impact on her parenting style.

Factors take make parenting harder:

- Domestic violence
- Drug abuse
- Alcohol abuse
- Lack of social Support
- Depression and other anxieties
- Parental stress

Even parents in relatively secure circumstances feel unsure when they find themselves facing the normal and common problems of children growing up at various stages (Ref: The Parents' Centre, online, 2010).

Factors take make parenting easier:

- Good social support from friends and family
- Better communication between parents
- Access to social services such as health care and social child support
- Communicating with your child's teacher
- Getting help and information about your parenting concerns

POINTS TO REMEMBER

It is important to recognise that caring for a child who has some sort of behavioural problem is difficult for many parents to cope with and if support and resources are inadequate, parents are at risk for increased health problems, depression or feelings of incompetence.

PARENTING AND VIOLENCE

The rates of violence against women and children in South Africa remain alarmingly high. There is strong evidence to indicate that exposure to violence has severe and enduring health and mental health consequences. It is important to acknowledge that a parent's task is made all the more difficult in the context of family violence.

Appendix G

English Informed Consent Form for the Participants in the Focus Groups

University of Cape Town

Department of Psychology

Consent Form

Dear potential participant,

Study Purpose

You are being asked to take part in a research study being conducted by a researcher from the University of Cape Town (UCT). This study is exploring parenting and child behaviour. The purpose of the study is to find out how stresses in your own life may affect your parenting.

Procedures

If you decide to take part in this study, a researcher will conduct a group interview with you and a group of eight to ten other women. This group interview should not take longer than one and a half hour. The group interview will be audio recorded for later transcription purposes. All information obtained from you will be kept strictly confidential. We hope that other members in the group will also maintain this confidentiality.

Risks, Discomforts & Inconveniences

Some of the questions we ask may cause you to remember sad or difficult things from your own past, or cause you some embarrassment. Please remember that we keep this information absolutely confidential: none of the information you reveal will be publically linked to your name.

Benefits

There are no direct benefits for your participation in this study. The knowledge we will gain from it, however, will be used to help improve future parenting programs.

Alternatives

You may chose not to participate in this study and this decision will not affect you relationship with this centre or any other shelter or care facility.

Voluntary Participation

Participation in this study is completely voluntary. You are free to refuse to answer any question. Your decision regarding participation in this study will not affect your relationship with the centre and or services you might access at the centre. If you decide to participate, you are free to change your mind and discontinue participation at any time during the interview.

Privacy and Confidentiality

We will take strict precautions to safeguard your personal information throughout the study. Your information will be kept without your name or other personal identifiers, in a locked file cabinet. Study data will be kept on a password-protected, secure computer. Only the researchers will be able to access your personal information.

The group interview will take place in a private room. Any reports or publications about the study will not identify you or any other study participant.

Questions

If you have questions, concerns, or complaints about the study or questions about a research-related query, please contact

1. Cathy Ward 021 650 3422
2. Shereen Moolla 082 846 7375
3. Abigail Miles 084 427 980

If you have any other questions or concerns about this study, please feel free to contact the Department of Psychology on 021 650 3438.

Signatures

{Subject's name}_____ has been informed of the nature and purpose of the procedures described above including any risks involved in its performance. She has been given time to ask any questions and these questions have been answered to the best of the investigator's ability. She has been given a signed copy of this consent form.

_____ _____

Investigator's Signature Date

I have been informed about this research study and understand its purpose, possible benefits, risks, and discomforts. I agree to take part in this research as a subject. I know that I am free to withdraw this consent and quit this project at any time, and that doing so will not cause me any penalty or loss of benefits that I would otherwise be entitled to enjoy.

_____ _____

Subject's Signature (verbal consent) Date

I understand that the focus group discussion will be transcribed. I understand that only the researchers will have access to the tape and to the transcriptions. I agree to the recording of the group's discussion.

_____ _____

Subject's Signature (verbal consent) Date

Appendix H
Focus Group Schedule

Two groups of eight to ten women were formed at two NGO's in the Cape Town region. The women were largely Black and Coloured mothers.

Materials needed:

- Digital recorder
- Refreshments

[Provide refreshments (tea, coffee, biscuits)]

Hello. My name is Abigail Miles. I am from the University of Cape Town, and I am here today to conduct research into the stressors that parents face and how they cope with this stress. This project is part of a bigger study on parenting. You were previously involved in this study when you participated in the individual interviews. Results from this research will be used to improve future parenting programs. Thank you for agreeing to take part in this discussion.

You will be asked to respond to some questions in this discussion, and comment on other women's responses in this group. Remember that everything you say in the discussion will remain confidential. That is, I won't talk about it in a way that makes it possible for anyone to know what you, personally, have said. I ask each of you to do that, too, for each other. It is important that you feel comfortable sharing your opinions with the group. If at any point you feel uncomfortable talking about something, please feel free to leave. There will be no penalty.

Well, let us begin with the discussion. I will be tape-recording this conversation, but as I said before, I will not mention any of your names in the final report. As I explained earlier, I am interested in knowing about the types of stress that parents face, and what coping mechanisms they use to deal with this stress. Perhaps we can begin by talking about what kinds of stress parents face.

1. When do your children make you feel annoyed, angry or tired? Do you ever feel that you just cannot cope as a parent?
2. When you look around this community, how do you see mothers responding to their difficult children?
3. Do they ever have a drink when they are feeling angry with their children? Do they ever use a drug like "tik" to escape their frustration with parenting?
    i. Probe very particularly for discussions regarding substance use amongst mothers.
4. How do drugs and alcohol affect parenting?

Thank you very much for giving up your time to join in this discussion. As I said to you earlier, I will have the tape transcribed, and I will remove from the transcription any of your names that may have been mentioned. I will also destroy the tape. The report from this project should be ready by the end of October, and a copy will be sent to this organization.

PLAGIARISM DECLARATION

1. I know that plagiarism is wrong. Plagiarism is to use another's work to pretend that it is one's own.
2. I have used the *American Psychological Association* (APA) convention for citation and referencing. Each significant contribution to, and quotation in, this essay / report / project / from the work, or works, of other people has been attributed, and has been cited and referenced.
3. This essay / report / project / is my own work.
4. I have not allowed, and will not allow, anyone to copy my work with the intention of passing it off as his or her own work.
5. I acknowledge that copying someone else's assignment or essay, or part of it, is wrong, and declare that this is my own work.

SIGNATURE: