

PARENTS' PERSPECTIVES ABOUT THEIR SONS' DRUG ADDICTION AND REHABILITATION PROCESS

PERSPECTIVA DE LOS PADRES SOBRE LA ADICCIÓN A DROGAS DE SUS HIJOS Y EL PROCESO DE REHABILITACIÓN

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Gladys M. **Laboy-García** ¹, Nelson D. **Cruz-Bermúdez** ^{1, 2}, Raúl **Sosa-Arrufat** ¹

¹Department of Psychology, College of Social Sciences, University of Puerto Rico Río Piedras Campus

²Institute for Psychological Research, College of Social Sciences, University of Puerto Rico Río Piedras Campus

ABSTRACT

The family plays a key role in the development and progression of substance use disorder (SUD) either by inducing risk, or promoting protection and resilience. However, only a limited number of studies have addressed how the families of individuals with SUD experience and perceive drug addiction and what attitudes toward treatment they display. The purpose of this study was to explore and describe how the parents of two Puerto Rican adult men with a history of SUD understand this phenomenon using an interpretative phenomenological analysis. Results show that parents perceived SUD as a negative phenomenon, but their arguments regarding their sons' drug addiction contained several misconceptions. Parents believed that the rehabilitation process was dependent primarily on their sons' willpower and intelligence, and they also considered trust to be one of the most important elements to obtain family support. We conclude that these parents used past experiences and their immediate social reality to construct particular conceptualizations of their sons' SUD. Our findings provide important information about family perspectives that can be used for SUD treatment and prevention strategies.

KEY WORDS: Family, parents, interpretative phenomenological analysis, substance use disorder.

RESUMEN

La familia juega un papel clave en el desarrollo y progresión del trastorno por uso de sustancias (TUS), ya sea mediante la inducción de riesgo, o promoción de protección y resiliencia. Sin embargo, solo un número limitado de estudios han abordado cómo las familias de personas con TUS experimentan y perciben la drogadicción y cuáles son sus actitudes hacia el tratamiento. El propósito de este estudio fue explorar y describir cómo los padres de dos hombres adultos puertorriqueños con historial de TUS entendían este fenómeno utilizando el análisis interpretativo fenomenológico. Los resultados muestran que los padres perciben el TUS como un fenómeno negativo, pero sus argumentos sobre la adicción a drogas de sus hijos contenían conceptos equivocados. Los padres creían que el proceso de rehabilitación dependía principalmente de la fuerza de voluntad e inteligencia de sus hijos, y también consideraban la confianza como uno de los elementos más importantes para obtener apoyo familiar. Concluimos que estos padres utilizaron experiencias del pasado y su realidad social inmediata para construir conceptualizaciones particulares del TUS de sus hijos. Nuestros resultados proveen información importante sobre la perspectiva de la familia que puede utilizarse para estrategias de tratamiento y prevención del TUS.

PALABRAS CLAVE: Familia, padres, análisis interpretativo fenomenológico, trastorno por uso de sustancias.

INTRODUCTION

Substance use disorder (SUD) is a deteriorating neuropsychiatric condition caused by complex interactions between genetic, neurobiological and psychosocial factors (Agrawal & Lynskey, 2008; Belcher, Volkow, Moeller, & Ferré, 2014; Cadet, Bisagno, & Milroy, 2014; Everitt et al., 2008; Kendler et al., 2012; Whitesell, Bachand, Peel, & Brown, 2013). Individuals with SUD downplay the negative consequences they face, have a hard time discontinuing the self-administration of substances and progressively reduce activities that are considered normal for most people (American Psychiatric Association, 2013). The National Institute on Drug Abuse (NIDA) defines addiction as a chronic brain disease given that drugs change molecular and biochemical neuronal processes over time, challenging addicts' ability to self-control and hampering also their capacity to resist intense drug craving (NIDA, 2012). Addiction to nicotine, cocaine, heroin and other substances shows high comorbidity with many mental illnesses such as anxiety, depression and attention deficit hyperactivity disorder (Kutlu, Parikh & Gould 2015; Quello, Brady & Sonne, 2005; Volkow, 2004). Despite these facts, most people hardly see SUD as a medical condition and very often, SUD patients and their families are held the sole responsible for this multifactorial problem (Corrigan, Kuwabara, & O'Shaughnessy, 2009; Thege et al., 2015).

Like in many other jurisdictions of the United States, substance use and drug addiction are also prohibited and criminalized in Puerto Rico (Albizu-García, Negrón-Velázquez, González & Santiago-Negrón, 2006). SUD among Puerto Ricans has been associated with low education, poverty, unemployment and domestic violence (Alegria et al., 2004; Osuna Díaz, 2013) and because of the current policy illegal drug trafficking, recreational drug use and SUD are linked to dozens of social problems including murder and violence. According to

the latest survey of the Puerto Rico's Mental Health and Anti-Addiction Services Administration (ASSMCA, in Spanish), nearly 4% of the Puerto Rican population had problematic substance misuse (legal or illicit) deserving treatment (ASSMCA, 2009). The vast majority of people reporting problems with drugs were not aware of it and only a minor fraction was receiving treatment due to multiple factors including lack of enough programs, reduction of public mental health services due to economic crises and health reforms (Albizu-García et al., 2006; Alvarez & Goodnough, 2015). Today, the vast majority of the rehabilitation programs to treat SUD in Puerto Rico are operated by non-profit private organizations (e.g., faith-based) whose interventions (with very few exceptions) are not necessarily based on scientific evidence.

Besides the issue of insufficient mental health services, the stigmatization of people with SUD in Puerto Rico has perpetuated decades of discrimination and inequality against this population, including those who decide to seek physical and mental health services (Santiago-Negrón & Albizu-García, 2007; Varas-Díaz, Santiago-Negrón, Neilands, Cintrón-Bou & Malavé-Rivera, 2010). Stigmatization of illegal drug use and SUD results from the belief that those are deviant behavior in individuals who simply lack will power and are self-destructive (Varas-Díaz et al., 2010). Research has found that SUD are more highly stigmatized than other mental and physical health conditions (Livingston, Milne, Fang & Amari, 2012). Consequently, many patients with SUD suffer from stress, experience rejection and thus, they withdraw and isolate, further worsening their physical and mental wellbeing (Ahern, Stuber & Galea, 2007). Currently, SUD is major public health concern in Puerto Rico.

The Role of Families in SUD

The relationship between the family and SUD has been studied. On the one side, it has

been shown that domestic violence, maltreatment and poor parental supervision are familial risk factors linked to the onset of SUD especially in children and adolescents (Coviello, Alterman, Cacciola, Rutherford, & Zanis, 2004; Hill, Hawkins, Catalano, Abbott, & Guo, 2005; Huang et al., 2011; Milne et al., 2009; Norman et al., 2012; Simpson & Miller, 2002). Although much violence perpetuated against children is mostly unreported, the prevalence of child sexual abuse ranges from 2% to 62% (Norman et al., 2012). In some countries, the prevalence of physical and emotional abuse oscillates between 4% and 16% (Gilbert et al., 2009) and in most cases, child maltreatment is committed by parents or parental guardians (Gilbert et al., 2009; Norman et al., 2012). According to ASSMCA's latest juvenile survey, about 20% of the Puerto Rican adolescents have families with a history of substance misuse (ASSMCA, 2013).

On the other side, it has been shown that family bonding provides a support network for individuals with SUD and it promotes detoxification, treatment, protection and resilience (Kumpfer, Alvarado, & Whiteside, 2003; Locke & Newcomb, 2004; Sorensen & Bernal, 1987; Stone, Becker, Huber, & Catalano, 2012; Vakalahi, 2001; Velleman, Templeton, & Copello, 2005). The phenomenon of familism, which comprises normative and cultural beliefs underlying the centrality of the family unit as well as the support that each member owes to nuclear and extended relatives, also serves as a protective factor for SUD in Hispanics, Caucasian and Asian adolescents (Germán, Gonzales, & Dumka, 2009; Sabogal, Marin, Otero-Sabogal, Marin, & Perez-Stable, 1987; Ewing et al., 2015; Ramirez et al., 2004; Shih et al., 2010; Strunin et al., 2015; Wahl & Eitle, 2010). Familism creates durable attachments and family unit ensuring protection against deviant and anti-social behaviors, suicide and other disruptive conducts (Germán et al., 2009; Morcillo et al., 2011; Peña et al., 2011). In spite of these facts, the complexity of the family-SUD

relationship in different sociocultural contexts deserves further investigation.

Perspectives on SUD

The perspectives of individuals and families on SUD have been systematically measured too. Retka and Fenker (1975) investigated addicts' self-perceptions as a result of their participation in a treatment program and compared their actual perceptions with the self-perception attributed to typical addicts by treatment program personnel. Further studies have addressed addicts' recollected and perceived parenting during their childhood (Nurco, Blatchley, Hanlon, O'Grady, & McCarren, 1998; Schweitzer & Lawton, 1989), perceived parental acceptance and rejection, subjective appraisal of family relations (Glavak, Kuterovac-Jagodic, & Sakoman, 2003; Stoker & Swadi, 1990) and perceived causes of drug addiction (Brajević-Gizdić, Mulić, Pletikosa, & Kljajić, 2009). Alhyas and colleagues (2015) used a focus group approach to understand adolescents' perception of drug use and McLaughlin and collaborators (2006) explored the perceptions that a sample of health and social care professionals' hold of illicit drugs and found that most of them have strongly negative views of drug addicts, often expressing a preference not to treat them (see also McLaughlin & Long, 1996).

In terms of family perspectives, Alexander and Dibb (1977) investigated the interpersonal and social perception of families with addicted offspring and recently, Smith and Estefan (2014) elegantly reviewed the experiences of mothers whose children suffer from SUD. According to the authors, the mothers' perspectives about SUD are less studied since more attention is usually given to the family as a whole system. However, both authors interestingly point out that very often, mothers experience a deep sense of responsibility regarding their offspring's SUD because they are socially perceived as accountable for their children's involvement with drugs (Smith & Estefan,

2014; Usher, Jackson, & O'Brien, 2007). Moreover, it has been shown that mothers who have children with SUD have symbiotic ties with their sons, feel ashamed, show excessive protective attitudes and endure the burden of their children's disorder (Butler & Bauld, 2005; Emmelkamp & Heeres, 1988; Saatcioglu et al., 2006; Smith & Estefan, 2014).

Quantitative and/or qualitative studies aimed at understanding the perceptions, perspectives and/or attitudes toward drug use and SUD among Puerto Ricans are scarce. Varas-Díaz and colleagues (2010) found stigmatizing attitudes towards drug users among health care professionals in training and Osuna Díaz (2013) found indicators of social stigma in three different groups of Puerto Ricans: mothers who previously were heroin addicts, healthcare providers and people from the social support network. Nonetheless -to the best of our knowledge- we lack a more in-depth understanding of how the families of individuals with SUD, specifically how Puerto Rican mothers and fathers experience and perceive the addiction of their children, and how they make sense of this phenomenon based on their immediate social reality and cultural constrains.

Objectives and Theoretical Framework

Given that parents of individuals with SUD might affect the extent to which their offspring engage in treatment as well as the effectiveness of such interventions (Ritson, 1999), we decided to investigate how the parents of two former drug addicts understand their sons' addiction. Specifically, we pursued the following four objectives: (1) identify parents' previous experiences with drugs; (2) know their notion about SUD; (3) understand their perspectives on the rehabilitation process of their sons; and (4) explore the support network and dynamics of each family. We adopted a hermeneutic phenomenological framework and used the Interpretative Phenomenological Analysis

(IPA) (Smith & Osborn, 2003) to collect and analyze the data. Our ultimate aim was to generate enough information that could be transformed into more objective hypotheses to further investigate Puerto Rican families' perspectives on SUD. This paper is a secondary analysis of data that were previously presented by Laboy-García (2012).

METHOD

This study was authorized by the Institutional Review Board of the University of Puerto Rico at Río Piedras (protocol #1112-117) and complied with ethical standards for the protection of human participants in research. We conceptualized this investigation as an illustrative/descriptive case study (Baxter & Jack, 2008; Creswell, 1998) designed to understand the participants' perspectives through their narratives in their particular social context. We followed the IPA described by Smith and Osborn (2003), even though we introduced a few modifications at different instances during the procedure.

Participants

Two couples composed by the mother and father of two adult men who were receiving treatment for SUD in an inpatient private rehabilitation center in Puerto Rico at the time of the study volunteered to participate. The selection of the families was done by availability and convenience. The only inclusion criterion was that both parents needed to be actively engaged in the treatment process of their respective sons. Couples did not need to be legally married to participate and previous SUD treatment was not a criterion. Right before the interviews, we explained to each participant the study's rationale and procedure, and they all signed an informed consent form. Treatment at the rehabilitation center included medical and psychological care, family counseling, occupational therapy and educational services.

Interview Questions

We intentionally designed and formulated the interview questions by taking into account the four objectives of the study and publications on SUD. We pre-established the following four sub-themes according to our objectives: (1) drug-related experiences; (2) notion of SUD; (3) notion of rehabilitation; and (4) support network and family dynamics. After a careful revision of the questions, we made the interview guide following the pre-established themes in that particular order (see above). Sample questions are shown in Table 1. The pre-establishment of sub-themes is an adaptation of the IPA that we incorporated to maintain a coherent structure in the interviews and analyses without necessarily losing the essence of the IPA.

TABLE 1.
Sample interview questions.

<u>Drug-related experiences</u>
Did your father or mother consume any type of illegal drug?
Did you have any experience with drugs when you were at school?
<u>Notion of SUD</u>
What image comes to your mind when people talk about drug addiction?
How do you feel about your son's drug addiction?
<u>Notion of rehabilitation</u>
How did you decide that your son should enter a rehabilitation program?
What is your experience now that your son is in the rehabilitation program?
<u>Support network and family dynamics</u>
Does your family support your son in this process?
How has your family dynamics changed following your son's drug addiction?

Semi-Structured Interviews

Semi-structured interviews (Smith, 1995; Smith & Osborn, 2003) were carried out with each parent under strict privacy and confidentiality at the rehabilitation center to facilitate the procedure and maintain participants in a semi-natural setting. Interviews were carried out by the first author, audio-recorded and transcribed verbatim for analysis. Interviews were done

in Spanish and the mean duration was one hour. Given that the participants were allowed to elaborate their answers without time restriction, some interviews were longer and therefore, they contain richer descriptions. The interviewer added other questions to clarify ideas and capture details. In spite of this, we obtained almost the same kind of information from each participant since interviews had only minor differences.

Data Analysis

The first author transcribed the four interviews and read each transcript several times to highlight interesting and significant content. She made general comments about each text following Smith and Osborn (2003). She then divided each transcript into units of analysis (e.g., sentences, paragraphs) and grouped these units under each of the sub-themes previously established. At this point, two authors made individual revisions of the data and discussed preliminary observations. The first author incorporated all the comments to each transcript, searched for connections or differences between the texts and identified emerging topics within the pre-established themes. She also acknowledged emerging singularities of each participant and elaborated major interpretations (Laboy-García, 2012). For the present analysis, we all reviewed the original observations and annotations and then added further interpretations and discussions. We then condensed all the interpretations and analyses into a single narrative account described here.

RESULTS

We divided this section into the four sub-themes of the study. Under each sub-theme, we provide summarized narratives with representative quotes of each participant. We translated the text into English as needed while writing this paper. Participants were named Mother A, Father A, Mother B and Father B and their sons, Art and Bill, respectively. Demographics of the participants are in Table 2.

TABLE 2.
Demographics of the participants.

Participant	Age	Education	Employment
Mother A	49	BA	teacher
Father A	53	HS diploma	carpenter
Mother B	55	HS diploma	retired
Father B	71	HS diploma	Army retired

Note: BA, bachelor degree; HS, high school

Drug-Related Experiences

Here we present the participants' statements about personal drug use, history of SUD in the nuclear and extended family, and knowledge about legal and illegal drug use and SUD in their communities either in the past or at the moment.

Mother A said she knew about drugs when she was a teenager, but never used drugs. Her parents never used drugs, but her father was "alcoholic". She also admitted her younger brother was a "crack cocaine addict". When she was asked about drugs she knew, she replied: "That I have heard of because I've never used drugs: marijuana, cocaine, crack, heroin, alcohol and cigarettes".

Father A mentioned he knew about drugs when he was already married since drugs were unknown in his childhood neighborhood. His father used to drink alcohol and smoked cigarettes, and his younger brother consumed alcohol. He mentioned that when he got married, his wife and he never hanged out with drug users. When we asked about drugs he knew about, he mentioned marijuana and also "cocaine, heroin, [and] crack which are rocks".

Mother B said she had no previous experience with drugs because she was raised in an overprotective home. She said she did not drink alcohol and neither her father nor her brothers ever consumed drugs in the past. She admitted she knew about drug use in her community, but stated that she and her husband never established close

relationship with drug users. Mother B added that she heard about marijuana when she worked at a school. She stated that students who smoked marijuana at her workplace were different and that their personalities changed.

Father B mentioned he knew about drugs when he was 14 years old. He said his relatives did not use drugs when he was a child, but he admitted that his father, grandparents, brothers and uncles used to drink alcohol (beer and rum). He stated that he never used drugs, but admitted that he began "drinking beer I believe when I was around 17 or 18 years old. In the Army I got the cigarette vice." He also said: "I used to drink beer...but then I got the cigarette vice and still I haven't been able to quit. But I stopped drinking alcohol 25 years ago." He also mentioned that he knew that some co-workers used to smoke "marijuana, cocaine and heroin" at work. When asked about drugs he knew about, he answered "heroin, cocaine, crack [and] marijuana". He said marijuana smoking was common in the Army.

Notion of SUD

We present here information regarding how and when the participants knew about their sons' SUD, their thoughts about drugs and addiction and what were their experiences during that process. We also wanted to know if parents had beliefs and/or attitudes that could be considered either risk or protective factors for SUD. Representative narratives are presented in Table 3.

Mother A realized Art was having drug problems when people told her he was smoking cigarettes and missing school. Eventually, Art began stealing their belongings and turned aggressive. When we asked her what comes to her mind when she hears drug addiction, she replied that it is something negative that destroys the family (Table 3).

TABLE 3.
Representative Quotes of the Participants.

Participant	Notion of SUD	Notion of Rehabilitation
Mother A	"I didn't expect it, it was horrible for us, and for the family in general... it affects the person and destroys the family".	"He decided voluntarily; he used to say 'I cannot do it anymore'. I told him, you're already an adult, go get help, the psychiatrist's help...it now depends on you".
Father A	"I've never been interested even in cigarettes. This has been a very hard experience, very hard".	"You must decide when you want to get better because otherwise there is no point of insisting and insisting if you don't want".
Mother B	"...this is a harm that the whole society faces and nobody is exempted from this. It affected me closely because of my older son. But I give the glory to God because I raised them Christians in the evangelic church, but he [Art] withdrew... A boy that was good at school, and that's why I say we're not exempted. You have poor and rich people [with SUD]. They say in each family at least somebody comes to this".	"...you should not push him to enter because he will get out. The step [of going into treatment] must be taken by the addict and not by the parents. We keep praying and praying, but they won't stop [using drugs] until they get tired of it".
Father B	"You're a medical emergency student, a health-related branch. You know how damaging this is. You've told us about how many addicts you have picked up from the streets. How come you have fallen into this?...you will destroy yourself, you must quit".	"The vice isn't easy to quit, but you, in your condition, you can quit. Why? Because you still haven't reached the puyazo [meaning intravenous drug administration]. People who self-inject drugs face difficulties when trying to rehabilitate, but you don't. And after all, you don't use every day' ...He has intelligence. Why didn't he use it? Why didn't he use it and fell into this sad situation?"

Father A realized Art was having a drug problem because he knew Art's friends were using drugs. He said that when he thinks about drug addiction, the first image coming to his mind is that drugs are damaging people. He mentioned that knowing Art was using drugs was "terrible" and he felt like a part of his life was consumed.

Mother B said she knew Bill was using drugs because he confessed even though she already knew about it. She began looking for treatments immediately, but Bill kept using drugs until he finally decided to quit. She admitted that the first thing coming to her mind regarding drug addiction is the question of why and who invented drugs (Table 3). When we asked her how she felt knowing that Bill was using drugs she replied:

Well, I feel, not irresponsible, I'm just saying, dear God...we all have to face it, some of us have the privilege

to face a different problem and we now face this burden...What happened? He took the wrong way, bad company, bad choices that we didn't teach him. Remember you teach them at home and when they go to the streets they find their friends, 'so-called friends' and they believe more in their friends than in their parents. So this is what happened to my son, the [bad] company and friends could do more than parents' advises. My kids smoke because their dad smokes. My husband used to drink [alcohol] but they never saw him drinking because he quitted alcohol a year after we got married. But he wasn't an everyday drinker, he drank once in a while, but I didn't like it. The cigarette, he wasn't able to quit because he started to smoke a long time ago when he was very young...He's a nervous person and so my kids therefore drank and smoked. And, you know, they say

after cigarette and alcohol you go figure youth, they started trying drugs. I thank God because there are drugs that kill...but my son didn't get to those bad drugs...I used to tell him (Bill) don't give up that God is there; go find him because he's the only who will help you, only God can take you out of that hole you're in...

Father B admitted that Bill began smoking around age 14, but he felt he did not have the moral right to advise him. He remembered he knew that Bill was using drugs when he applied for a job and was screened for drugs. He recalled that when the result came positive for marijuana and cocaine his "world came down" (Table 3). When we asked him about the first thing coming to his mind regarding SUD, Father B answered the following:

The suffering (became teary eyes and gasped). The painful that this is...to know that a relative or close friend picks up this vice. Because that is the last thing in life, drugs vice. Destructive; it's very painful. Life becomes squared and it becomes hard to deal with the drug vice. I'm now experiencing it directly. And I know now, consciously, the suffering resulting from the vice. It's a shame that these boys don't listen when you give them advise and they always find the least favorable friendships; and they all deny it, but you know that they're doing it. But it's hard, it's hard...

Notion of Rehabilitation

Under this sub-theme, we grouped participants' narratives related to the rehabilitation and treatment for SUD of their sons and how they have embraced this experience. Representative narratives are presented in Table 3.

Mother A mentioned she and her husband took Art to a psychiatrist specialized in addictions, but he did not finish the treatment. She said that he attended only two appointments because he denied the drug problem to the psychiatrist. She stated: "Then he said he was fine, that he didn't need anything, and told the psychiatrist that he knew more than him". Eventually he refused treatment and she told her son "it's your problem". She stated: "He didn't want anybody's help...then as time went by, he continued consuming [drug], things disappeared, he was selling everything" (Table 3). She mentioned also that her sister-in-law talked to him and brought him to the program when he finally decided to enter the program. She stated that eventually Art experienced a relapse and she told him "it is you, it depends on you to come out of that world". About the recovery, she stated the following:

It depends on the person, I know it's difficult, it's tough, but depends on him to get out of this...and he can make it, he can, he's a brilliant guy...I now feel relaxed, I'm not worried that something might happen to him on the streets, or that he continues stealing or asking for money.

She also mentioned she feels better and less preoccupied because the rehabilitation "has been very positive".

Father A mentioned that he told Art: "You must decide when you want to get better because otherwise there is no point of insisting and insisting if you don't want". He admitted that Art decided to quit and then entered the rehabilitation program. He said he now feels more relax as Art moves ahead to get better.

Mother B mentioned that when Bill admitted his drug use problem and she told him the following:

It's fine, go find a place and when you find it, enter the program. If you fight, we can fight because this is not only one's fight; it must go hand in hand, family and student...whoever has a vice must stand up by himself. He was in other programs, but he left.

Mother B recognized that even though they faced difficulties when Bill was trying to enter the program, she now feels happy knowing that he is moving forward. She said she would like to bring other addicts to that particular program.

Father B mentioned that Bill went to five rehabilitation programs in the past in Puerto Rico and in the United States. He said Bill decided to enter the current program after he was hurt with gunshots. Father B said he was confident that Bill was going to move ahead because he had the desire to change. He stated the following:

I told him, you must change your life. Your life is on the edge...you're in a hole, but you can get out...I don't remember what he did, but he was beaten...God has protected him, but I know he understood the message and he's fine now. I used to tell him 'you're a good person, you can leave this vice.

Support Network and Family Dynamics

Under this theme, we grouped the participants' narratives related to how they are involved in the recovery process of their sons and how the participation of other family members changed over time.

Mother A stated that her family thought it was good to have Art in rehabilitation. About Art's younger brother, she said:

His brother doesn't come to see him because he is angry; his little brother [laughs] is studying for forensic

psychologist. He didn't want [Art] to have a relapse. It depends on him. He trusted [Art], but he took his belongings and sold his things.

Regarding the rest of the family, Mother A stated that most family members do not visit Art regularly and that "my mom used to come sometimes, but not anymore". In terms of the family dynamics, Mother A replied the following:

Well, before we trust him, we used to work this out with him. But after he fell into this, we completely lost the trust on him... The thing that affects me the most is his irresponsibility, borrowing money; he owns money to a lot of people...and lying to us when we wanted to help him. The worst are the lies. I don't sleep thinking, you know. And emotionally you get affected, you feel even guilty, but I, we gave him an advice; we [raised] him with values, in the Catholic Church, with computers and his belongings. But he, it is not easy [laughs].

Father A admitted he did not know whether or not the family supports Art's rehabilitation process. Like Mother A, he also mentioned that his younger son stopped visiting Art because he did not trust him. He said that before Art's drug problems the family was more united and that he and his wife support each other to have everything functioning properly. Father A mentioned that he expects to have the family reunited when Art finishes his treatment and expects him to be like he was before the SUD.

Mother B stated her whole family supported the rehabilitation process. She said Bill used to argue with his dad, but eventually they would both apologize to each other. She narrated the following:

[My husband] is there, but he's very dry, he doesn't give love, doesn't

express love. And you know, not all children are equal, so Bill, who is the oldest, he felt restrained like he didn't have the love from his dad that he always wanted; that closeness to express his feelings. So, he used to always come to me because he was like afraid [of his dad].

She then said that the rehabilitation program brought Bill closer to his father and now they are more united.

Father B said that the familial support did not change during the rehabilitation process, but mentioned that his neighbors did not know about Bill's SUD (Bill wanted to be kept secretly). He noted his wife's suffering during the process:

If someone has suffered that would be [Mother B]. Sometimes I am amazed to see that woman's strengths [became teary eyes]. Regardless of those things, she doesn't lose her faith and hope of seeing her son fine. When he lived with us there was no peace at home, just pure hassles...when he was in the vice, it was a war with no peace. We couldn't sleep; I used to go to bed and I didn't sleep. Sometimes I would watch television over night smoking cigarettes one after the other. But now we're living the life we always wanted to live, in peace, in the tranquility of our home knowing that he's fine, that he's been helped out, and that he's giving the maximum.

DISCUSSION

The perspectives of four parents, whose sons were in treatment for SUD, are presented in this paper. The method for data collection and analysis allowed us to capture their points of view within their immediate sociocultural context. We discuss relevant findings according to our objectives.

Regarding drug-related experiences, two thought-provoking findings caught our attention. First, it seems that these parents were pretty much used to SUD given that they were exposed to people who used substance in the past. For instance, Mother A admitted that her father was alcoholic and her brother was a crack addict. Additionally, Mother A, Father A and Father B said that their parents, uncles and/or brothers used nicotine and alcohol, and Father B admitted regular consumption of nicotine and previous alcohol consumption. The exception was Mother B who reported no drug use or exposure during her childhood. Our interpretation is that such experiences might have influenced their attitudes toward SUD and rehabilitation. This is likely a variable that modulates peoples overall perspective on SUD. We recommend further studies to systematically explore the interaction between prior SUD experiences and attitudes toward SUD.

The second interesting fact about their experiences was that they basically knew all the proper names of common illegal substances. One of them, Mother A, classified nicotine and alcohol also as drugs. This is very unusual because the term "drug" is commonly used for illegal substances such as marijuana, heroin and cocaine. People conceptualize alcohol as a recreational substance that is different from drugs perhaps because of the "drinking culture" phenomenon (Allamani & Mattiacci, 2015). However, despite knowing the proper drug names we found also that Mother B and Father B referred to SUD as a vice, which implies moral depravity or fault, and it is a negative cultural stigma towards addiction. Our interpretation is that most likely these parents learned both the correct and inappropriate terms in their respective communities when they were growing up and also while dealing with their sons' SUD. In addition, we suspect that they use these terms on a daily basis. Taking together, these results raise an important issue which

is the type of language we use to refer to SUD given that language can positively or negatively affect the social perception of SUD (Broyles et al., 2014).

For instance, proper vocabulary facilitates effective communication between patients, parents, and health care professionals and it can be used to dismantle the negative stereotypes and stigma associated with addiction. Furthermore, the correct language allows patients to regain their self-esteem and increases public awareness of SUD as a medical condition (National Alliance of Advocates for Buprenorphine Treatment, 2008). We think that these issues have clear implications for mental health care professionals providing service to people with SUD and investigators carrying out addiction-related research.

Regarding the parents' notion about addiction, we found interesting their actual descriptions. For Mother A, drug addiction was "horrible" and for Father A, it was "terrible". Mother B, who seems to be a very religious person based on her narrative (she mentioned God and the church several times during the interview), admitted that her family was suffering. For Father B, drug addiction was "painful" and "destructive". When the participants were describing drug addiction, their facial expressions reflected sadness and sorrow and their voices changed (personal observations). This is a clear indicator of their feelings toward their sons' SUD. Nevertheless, parents' explanations of SUD were circumscribed to how they felt about it, not necessarily what drug addiction is. Moreover, their explanations of how their sons became drug addicts reflected clear misunderstandings. For example, Mother B told us that Bill became drug addict when he began hanging out with the "wrong" friends and moved away from church. Based on our findings, we conclude that the parents did not have a clear understanding of the underlying causes of SUD.

We found that none of the parents provided any medical argument to support their definitions of SUD nor described addiction as a brain, mental or psychiatric disorder. Generally speaking, most people (and very likely these parents too) do not conceptualize SUD as a brain disorder, and given that the whole concept of addiction is socially and culturally constructed, its definition is different within a particular place or group of people and it varies across cultures and time (Clark, 2011; West, 2001). Moreover, people ascribe more liability to individuals with SUD than to those with other mental disorders (Thege et al., 2015), precisely because they do not see addiction as a disease. This is definitively another layer of stigma for SUD. We think that a clear understanding of the psychobiological components of SUD could be important to promote a sense of agency toward recovery among patients with SUD and families. Most importantly, it could lower mistaken expectations people have about treatment and recovery (see below).

Alternatively, it is possible that the parents indeed knew that SUD was a psychiatric condition, but they were avoiding referring to it as a disease because they were ashamed. Once again, SUD is more stigmatized than other psychiatric disorders and mothers tend to feel guilty and accountable for their offspring's problems with drugs (Smith & Estefan, 2014). Likewise, it must be difficult to talk about this situation with unfamiliar people such as researchers. We did not explore in detail how each parent constructed his or her definition of SUD, but it would be important to address it in future studies.

Regarding the parents' notion of rehabilitation, three myths that we found are important to discuss. First, they thought that their sons had the capacity to discontinue drug use because they were smart enough to do so. Mother A said that Art had the potential to leave drugs behind because he was a "brilliant guy" and Father B stated that Bill was intelligent. Second, they said that the

rehabilitation was dependent on Art's and Bill's desire and will to quit. For Mother A, Art's SUD was his "problem" and he was the one who needed to "get help" to "come out of that world". For Father A, Art needed to decide when to "get better". Mother B also used phrases such as "go find a place" (referring to a treatment program) and "whoever have a vice must stand up by himself". Likewise, she said that people keep using drugs "until they get tired of it". Third, they seem to believe that there is a linear progression between initial drug use and SUD. For example, Mother B said that her children do smoke cigarettes because her husband smokes cigarettes and added that "after cigarette and alcohol...they started trying drugs". In addition, Father B said that Bill was able to quit drugs because he was not using intravenous drugs and individuals who self-inject drugs are the ones that face difficulties during treatment. Thus, we conclude that these parents believe that their sons' intelligence and capacity to choose correctly are the main factors that will make them quit even though decision-making is largely compromised in SUD (Keramati & Gutkin, 2013). We found these elements as negative factors that potentially affect the treatment and rehabilitation outcomes.

Finally, we conclude that trust is very important for these parents to maintain the support of the family. Mother A said that Art's younger brother did not visit him because he no longer trusted Art. Eventually, she added that the family lost confidence on him and that his lies were very detrimental for them. She also admitted that Art's grandmother no longer visits him. Father A also expressed his lack of trust. Mother B and Father B did not refer to trust directly, but they expressed that they felt more united and are no longer afraid of the drug addiction problem at that point.

Concluding Remarks and Recommendations

The main significant finding of this study is that parents' misconceptions about SUD have led them to create false expectations of the treatment outcomes. They believe that

their sons consciously decided to get inside the world of drugs and therefore, the parents find themselves victims of their sons' SUD. Moreover, they see SUD as a burden or punishment that they need to face and overcome with faith, and they believe that the rehabilitation will bring stability and security to the family. Rehabilitation programs both public and private must incorporate formal education to fulfill the particular needs of the patients, parents and families who search for treatment. In addition, language is an element that must be revisited in future research and treatment development (Broyles et al., 2014).

The fact that this study was carried out with only four parents does not allow us to make generalizations to the population. Additionally, we were not able to collect more information given the time limitation of the interviews. Nonetheless, we believe that our findings are a contribution to our current understanding of parents' perspectives on SUD and it is our hope that these findings are helpful to conceptualize effective treatments and prevention strategies for SUD.

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