

“There’s literally nothing else I can do apart from cope.”

A Foucauldian discourse analysis of shame, coping, and the operation of power in parents’ narrative accounts of adolescent substance use.

Thesis submitted in partial fulfilment of the requirements for the
Professional Doctorate in Counselling Psychology
at London Metropolitan University

Sharon Walker

19025630

School of Psychology
London Metropolitan University

September 2025

Wordcount 29,404

Declaration

I hereby declare that the work submitted in this dissertation is fully the result of my own investigation, except where otherwise stated.

Name: Sharon Walker

Date: 1/9/25

Acknowledgements

I would like to thank my family. My Dad for always having my back, my grown-up children for supporting every step, and my sister for always being there.

Thank you to my peers at London Met, for all the encouragement and moral support.

Thank you to my supervisor, Dr Angie Cucchi, for having the highest of expectations and supporting me rigorously in my attempts to reach them.

I am also grateful to all the participants; thank you for trusting me with your stories.

For my Mum, who never got to see me do this, but always believed I could.

Table of Contents

Acknowledgements	3
Glossary	8
Definition of abbreviations	9
List of Tables	9
Abstract	10
Chapter 1. Introduction	11
1.1 Background and rationale for study.	11
1.2 Adolescence as a developmental stage.....	12
1.3 Adolescent substance misuse (ASM) as experimentation or addiction.	12
1.4 Parental Roles and Relationships	13
1.5 Moral crisis and experiences of shame, stigma, and blame	13
1.6 Relevance to Counselling Psychology	14
Chapter 2. Critical Literature Review.....	17
2.1 Table 1: Search criteria for literature.....	17
2.2 Review of literature.....	17
2.2.1 Parental role and relationships	17
2.3 A moral crisis: shame, blame, and stigma	18
2.4 Coping	20
2.5 Social construction of parents.....	21
2.6 Governmentality through Family.....	21
2.7 The social construction of adolescence	22
2.8 The social construction ASM: Medicalisation and addicts	23
2.9 Disciplinary power, normalisation, and disempowering parents.....	24

2.10 Implications for Counselling Psychology	25
2.11 Gaps in research	26
2.12 Research question	27
Chapter 3. Methodology	28
3.1 Aims	28
3.2 Qualitative research.....	28
3.3 Epistemological position	29
3.4 Ontological position	29
3.5 Methodology.....	30
3.5.1 Historical context and theoretical framework.....	31
3.5.2 Michel Foucault: Discourses, power, and knowledge.....	32
3.5.3 The family as a regulatory institution.....	33
3.5.4 Discourse and subjectivity	34
3.5.5 Disciplinary power: Surveillance and normalisation	35
3.5.6 Technology of the self and narrative as a confession.....	35
3.6 Design.....	36
3.6.1 Foucauldian Discourse Analysis	37
3.6.2 Participant recruitment and eligibility.....	38
3.6.3 Inclusion and exclusion criteria	39
3.6.4 Data collection and materials.....	40
3.7 Data analysis, synthesis, and interpretation.....	41
3.8 Ethical Considerations.....	45
3.9 Reliability, validity, authenticity	46
3.10 Reflexivity	47
Chapter 4. Analysis.....	50
4.1 Participants	50
Eloise.....	50

Claire.....	50
Jane	51
Susan	51
Annie.....	52
4.2 Discourses.....	52
4.3 Discursive constructions of Adolescents.....	53
4.3.1 Adolescent as vulnerable teenager	54
4.3.2 Adolescent as addict.....	56
4.3.3 Adolescent as a stranger	57
4.4 Constructions of Substance Use	59
4.4.1 Substance use as addiction.....	60
4.4.2 Substance use as self-medicating.....	62
4.4.3 Substance use as lifestyle choice	63
4.5 Constructions of parents identities, roles, relationships, and subjective experiences.....	65
4.5.1 Parent identities.....	65
4.5.2 Parenting role.....	67
4.5.3 Parent relationships	72
4.5.4 Moral Failure	75
4.5.5 Parent subjective experiences; shame, stigma, and coping	79
4.5.6 Implications for Counselling Psychology	82
Chapter 5. Discussion	84
5.1 The Family as a regulatory institution.....	84
5.2 Parents identities, relationships, and parenting roles	86
5.3 Constructing the adolescent substance user as a stranger or an addict	89
5.4 Discourse of hierarchy: resistance, reinforcement, or negotiation?.....	92
5.5 Moral failure; shame, stigma, and coping	94

5.6 implications for counselling psychology: working with individuals	98
5.7 Implications for counselling psychology: working with families	100
5.8 Limitations of study	101
5.9 Contribution to the field of Counselling Psychology.....	101
5.10 Future research.....	103
Chapter 6. Conclusion and Evaluation	104
References	105
Appendices	122
Appendix A. Flyer for recruitment	122
Appendix B. Information for participants.....	123
Appendix C. Fully informed Consent Form.....	124
Appendix D: De-brief Form.....	125
Appendix E: Distress protocol.....	126
Appendix F: Interview Schedule (45 mins)	127

Glossary

Adolescent	1) “in the process of developing from a child to an adult” (Oxford, 1991) 3) Aged 13-17
Substance Misuse	1) ‘the practice or habit of taking too much of a harmful drug or drinking too much alcohol’ (Oxford, 1991) 2) The Diagnostic and Statistics Manual of Mental Disorders (5th Edition) (DSM-5) (APA, 2013) defines substance use disorder as ‘Uncontrolled use of substance despite negative consequences to one’s health, work, study, family and day to day functioning’ (DSM-V, 2013). 3) This review assumes not all adolescents who engage with substance misuse will be diagnosed with ‘substance use disorder’ but may still experience a significant detrimental impact upon all aspects of their lives. This review further differentiates ‘substance misuse’ from substance ‘use,’ which might be characterised more as a one-off or occasional use of substances without significant impact on a person’s life.
Parent	1) “to be or act as a parent to a child” (Oxford, 1991) 2) Whilst aware of the potentially problematic normative assumptions laden within the use of the term ‘parent,’ for simplicity and flow in writing I have chosen to use the word ‘parent’ as an inclusive term, to incorporate all those acting within the role of ‘parent’ and parenting an adolescent, including but not limited to biological, adoptive, foster, stepparents.

Definition of abbreviations

BPS	British Psychological Society
HCPC	Health and Care Professions Council
ASM	Adolescent substance misuse
SUD	Substance use disorder
CBT	Cognitive Behavioural Therapy
BEST	Behavioural Exchange Systems Therapy
MDFT	Multi-Dimensional Family Therapy
FDA	Foucauldian Discourse Analysis

List of Tables

Table 1	Search Criteria for Literature Review
Table 2	Identified discourses, sub-discourses, subject positions, and power mechanisms

Abstract

This qualitative study applied a Foucauldian discourse analysis to explore the discourses which characterised and constructed parents' narrative accounts of their experiences of parenting an adolescent who misused substances. The analysis identified three dominant discourses; risk management, moral crisis, expert/science, and a counter discourse of 'hierarchy,' with which parents were able to negotiate the limitations and possibilities of the subject positions offered by each, enabling them to remain within established regimes of truth whilst narrating a story of deviance which often tested boundaries of inclusion. Expressions of stigma and shame most often accompanied constructions of thoughts or actions which were inconsistent with internalised norms of an 'ideal' parent. Substance using adolescents were constructed as someone unknown to parents making possible the expression of intolerable or unwelcome feelings towards them without demonstrating rejection of their child. Parents actively used and resisted these discourses, performing confessions, self-surveillance, and self-responsibilisation, within their narratives. Evidence from this analysis is interpreted as demonstrating sovereign, bio, and disciplinary powering both upon and through families as an institution of governmentality, through mechanisms of subjectification, self-surveillance, normalisation, and confession. Attempts to subvert and resist were found in the use of a hierarchy discourse which crucially offered subject position shifts for the narrator, but its use overwhelmingly reinforced the binary subject positions of 'coping,' as opposed to 'not coping' produced by dominant discourses, and in doing so, sustained subjective experiences of shame, normalised significant emotional distress, and prevented parents from seeking support.

Future research might consider further exploration of parents' accounts alongside the accounts of their adolescent children, siblings, and/or treatment practitioner, to further explore the impact and operation of power through use of different discourses within this field.

Chapter 1. Introduction

1.1 Background and rationale for study.

According to the United Nations Office on Drugs and Crime World Drug Report (2025), as of 2023, 316 million people worldwide had used drugs in the past year (UNDOC, 2025). They reports a significant rise of over 10% of the use of pharmaceutical drugs amongst minors, and that although drug use among young people is rising, over 50% of 16- to 24-year-olds perceive occasional cannabis use as low risk (UNDOC, 2025). The Crime Survey for England and Wales (CSEW, 2025) estimated that 8.7% of people aged 16 to 59 years (around 2.9 million people) reported using any drug in the last 12 months for the year ending (YE) March 2025. Drug use was higher among people aged 16 to 24 years, with 15.1% reporting any use in the last 12 months, with a slight decrease in the use of nitrous oxide, and hallucinogens among those aged 16 to 24 (CSEW, 2025). More than 14,352 adolescents were in treatment for substance misuse in the year 2023-24 in the UK, a 16% increase from the previous year (Gov.uk, 2025). 87% of those in treatment reported using cannabis, with rising numbers misusing inhalants and ketamine. 80% of these adolescents reported having started using substances before their 15th birthday. 97% of those treated were living in the family home. However, figures from the Crime Survey for England and Wales (CSEW, 2025) suggest the numbers affected could be significantly higher, at approx. 150% of 16-24 yr. olds. And with over 7 million 10–19-year-olds in the United Kingdom (ONS, 2023) this suggests the prevalence of adolescent substance misuse (ASM) is considerably higher than the number recorded as accessing treatment. The majority of those recorded as in treatment were referred through social services, youth justice, or local authority education services (ONS, 2023), suggesting it may only be when substance misuse and associated negative behaviours rise to a level which demands external professional services to become involved that adolescents might

access and/or engage with treatment. This points to the possibility of a vast number of families coping with adolescent substance misuse without external support.

1.2 Adolescence as a developmental stage

Adolescence is a developmental stage characterised by physical growth, independence seeking and psychological changes (Morojele & Ramsoomar, 2016). Substance misuse has been linked with impeded cognitive and emotional development (Myles & Willner, 1999) and other risk-taking behaviours (Bruner & Fishman, 1998) which can also occur at this stage of development. Whilst substance misuse is harmful to all people (Baigent, 2003), substance misuse in adolescence is different from adult experiences (Choate, 2015) due to many factors attributed to this transitional period. Adolescents may be more inclined to experiment with risky behaviours and less able to consider the long-term consequences of their actions (Orford, et al., 2010). Adolescence is also a time when mental health disorders may emerge, which can confuse how parents understand their child's behaviours (Choate, 2015:463).

1.3 Adolescent substance misuse (ASM) as experimentation or addiction.

Progression from experimentation to addiction is often subtle and parents typically first see initial drug use as typical teenage behaviour (Choate, 2011). Studies show adolescent substance misuse can have a profound and devastating impact upon family functioning, and the psychological and emotional health of parents and siblings (Dykes & Casker, 2021; Orford, et al., 2010; Groenewold, 2016). The effects of substance misuse upon adolescents can range across all areas of a young person's life, including school, health, and family relationships (Usher, et al., 2005) and can increase the likelihood of dependency in adulthood (Trucco, 2020). It is reported that 5% of deaths of young people under 30 worldwide are attributed to alcohol misuse (WHO, 2016). Increased rates of drug experimentation are reported in 14–17-year-olds, who are known to explore use of cannabis and party drugs, including substances such as amphetamines and opioids (Bonomo & Bowes: 2001; Jackson & Mannix 2003).

1.4 Parental Roles and Relationships

Parents are seen as playing a crucial role in providing protection and reducing risk (Liddle, 2010). Research literature demonstrates positive outcomes evaluated through random clinical trials of treatments of combined family therapy with individual cognitive behavioural therapy (CBT), (Liddle, 2010; Waldran, et al., 2001; Bertrand et al, 2013; Henderson et al, 2010; Liddle, et al., 2009; Karver, et al, 2018) and one study suggested the only factor of significance in positive outcomes is parental engagement (Higham, et al., 2011), According to Bertrand, et al., (2013), it is essential for any intervention to take into account the parent-adolescent relationship, and the mental health of parents (Bertrand et al., 2013:). Gruber & Taylor (2006) argue that to fully understand addiction, it must be seen from a family perspective. Dykes and Casker (2021) suggest that family members adapt and take on additional roles to compensate for, or protect against, behaviours associated with substance misuse, concluding “It is evident that substance abuse is a family’s priority, and it also automatically becomes a family’s disease” (Dykes & Casker, 2021:223).

1.5 Moral crisis and experiences of shame, stigma, and blame

Phenomenological studies highlight that parents feel disempowered and isolated, and experiencing stigma, shame, and undercurrents of blame from professionals (Usher et al., 2005, 2007; Choate, 2011, 2015; Flensburg, et al., 2022; Haines-Saah, et al., 2019). Parents may not engage in treatment or seek support for themselves despite experiencing major long term psychological and health effects. Research has demonstrated the profound effect alcohol and substance misuse can have upon families (Dykes & Casker, 2021), and although less research has focused specifically when the user is an adolescent (Hoeck & Van Hal, 2012), these studies suggest parental engagement with professionals may be a more complex demand than previously appreciated due to the nature of parents’ experiences coping with ASM, therefore understanding these complexities is vital for practitioners in this field.

Within my previous work environment as a specialist teacher working with secondary student, students disclosing substance use is often met with a zero-tolerance policy by their school, increasing student suspensions and potentially damaging parent-school, child-school, and parent-child relationships. These are often adolescents who are at the early stage of ASM, not accessing treatment programmes, but it is likely that family life is significantly impacted already (Dykes & Casker, 2021) and such zero tolerance responses, suspensions, and punishment of other behaviours which may stem from ASM such as lateness, inattentiveness or conflict, can further exacerbate difficulties between school and family and may add to rather than address or support family distress. Another consequence within education is the introduction of further systems of professionals around the family, such as Early Help, Social Care, CAMHS, and this brings a further complex range of demands upon parents (Hoeck & Van Hal, 2012), and potentially increasing distress and feelings of blame, of which each individual professional involved may not necessary be aware.

1.6 Relevance to Counselling Psychology

Counselling Psychology prioritises a commitment to empathic and collaborative engagement with clients based on humanistic values (Rogers, 1951) and as a profession which aims to help clients explore the “emotional difficulties that emerge out of our interaction with the world and others” (BPS, 2014, p. 15-16). As research clearly demonstrates high levels of distress and emotional difficulties experienced by parents of adolescent substance misusers, with Hoeck and Van Hal (2012) referring to parents of adolescents who engage in ASM as “a hidden and isolated group” (Hoeck & Van Hal, 2012:1), this is an area of significant relevance for Counselling Psychology.

Studies show the greatest level of harm from ASM is found in areas of social disadvantage (Devaney, 2017), and as Counselling Psychology developed with a clear spirit of social justice (Cutts 2013; Kennedy & Arthur, 2014), this also suggests ASM is an area which

Counselling Psychology should critically engage with. The HCPC sets out specific guidance for Counselling Psychologists including the need for them to “understand psychological models related to working [...] with service users, couples, families, carers, groups and at [...] organisational and community level; (HCPC, 2012:14). Research which enables and empowers parents’ voices to impact professional understanding, policy, or practices, is therefore a good fit with the spirit of social justice embedded in the philosophy of Counselling Psychology.

This topic is of specific relevance to Counselling Psychologists and other practitioners working with family and adolescent support services, individual addiction services, and in particular those applying systemic and family models of therapy. There is evidence to show that the Behaviour Exchange and Systems Therapy (BEST) and Multi-Dimensional Family Therapy (MDFT) are both effective models to apply in practice with a range of adolescent disorders (Tombourou, et al., 2001; Lewis, 2020; Liddle, 2010). These approaches look to create change in the family environment (Couture & Strong, 2004). MDFT is constituted by three distinct frameworks which inform clinical practice and builds on research and knowledge bases in domains of risk and protective, developmental, and ecological factors involved in ASM. However, these treatments focus predominantly on difficulties within the family, and research continues to demonstrate that the most harm from substance misuse occurs in socially disadvantaged areas where, Devaney (2017) argues, external factors such as socio economic or gender inequalities may contribute to the onset and prevalence of ASM. This may be an intensifying feeling of blame, and frustration, in parents, that factors they feel play a significant role in the onset and maintenance of their child’s ASM which are outside of the family, are not a focus for, or even considered, in their discussions and therapeutic experiences with professionals.

Haines-Saah, et al., (2019) critically explore how parents, adolescents, and substance use, have been socially (re)constructed through dominant treatment discourses, and how the

discourses within family therapy maintain and sustain an underlying assumption of a normative ideal family. They argue this ideal potentially pathologizes some families and maintains an underpinning assumption that parents alone are responsible for prevention of substance misuse. This underlying assumptions may contribute to the experiences of blame, shame, and stigma which parents report (Usher et al., 2005, 2007; Choate, 2011, 2015; Flensburg, et al., 2022; Haines-Saah, et al., 2019), and which prevents many from seeking treatment (Dykes & Casker, 2021), and may also exclude alternative experienced-based solutions which could address these external contributory factors (Devaney, 2017). Given parents are experiencing significant personal, familial, financial, and social distress (Dykes & Casker, 2021), it is likely anticipating or experiencing perceived blame from professionals will reduce help seeking by families, and may impact the level of engagement and outcome of interventions with significant repercussions for parents, adolescents, and wider society if ASM continues. Given this, and the fact that research repeatedly stresses the importance of parental involvement in ASM treatment (Bertrand, et al., 2013; Hoeck & Van Hal, 2012). gaining further understanding of the role of discourse, language, and practices of Counselling Psychology in the social construction of parents, adolescents and ASM, seems critically important to identify how they may be reinforcing and sustaining unhelpful normative ideals.

In this introduction I have provided background information and rationale for the topic of study, defined and characterised ASM, and outlined relevant systemic approaches to treatment of ASM, along with a key criticism of these approaches. In the next chapter I will outline in more detail the findings from relevant research studies in the field of ASM including studies which have focused on parents' experiences, and the social construction of parents, adolescents, and ASM.

Chapter 2. Critical Literature Review

2.1 Table 1: Search criteria for literature

Initial Search criteria	“Counselling Psychology” & “parents’ experiences’ & “adolescent [teenage] substance misuse,”
Additional searches	“Adolescent [teenage] alcohol misuse” “Adolescent [teenage] cannabis use” “parent’s experiences” “Foucauldian Discourse analysis” “Social constructionist” “Social construction [of adolescence] [of parents] [of addiction] [of substance misuse]”
Search engines:	PsycINFO, Google Scholar, Web of Science

2.2 Review of literature

2.2.1 Parental role and relationships

Research has highlighted that within family factors such as deficits in parenting, parenting styles, and parental behaviour and attitudes all correlate with increased risk of ASM (Miller & Cook, 2017). A strong parent-child relationship is seen as a protective factor when it comes to preventing substance misuse during adolescence (Kumpfer & Alvarado, 2003). However, the links between parent-child relationships and substance misuse are complex. Hoeck and Van Hal (2012) state that “a number of studies clearly revealed a link between parent-child connectedness (including the ability to talk about problems) and behavioural health indicators (including risk behaviour such as substance misuse)” (Hoeck & Van Hal, 2012:9). Conflict can arise because of the substance misuse and associated behaviours, to the degree that it becomes a dominant feature of the parent-child relationship and significantly damaging to it (Butler & Bauld, 2005), thereby reducing the protectiveness of the relationship, and in fact becoming a risk factor instead (Hoeck & Van Hal, 2012).

Parents are seen as playing a crucial role in providing protection and reducing risk when the substance misuser is an adolescent (Liddle, 2001). Indeed, the overall “burden of managing the problems associated with adolescent substance [mis]use inevitably falls on the family, particularly the parents” (Usher et al., 2005: 423). A significant study by Pearson (2000) concluded that parents respond to ASM in one of three ways; 1) engaging with the problem; 2) tolerating the problem; 3) withdrawing. These findings have been replicated by later qualitative studies which have further explored how parents engage with, confront or excuse ASM (Jackson & Mannis, 2003). Usher, et al., (2005) also identified that parents withdraw, but only after many attempts to change the adolescent’s behaviour and support them within the family unit. Indeed, that parents will go to great lengths to protect their child, often at the expense of their own health (Jackson, et al., 2007).

2.3 A moral crisis: shame, blame, and stigma

Phenomenological studies have found that parent’s experiences of distress are often compounded by feelings of shame when interacting with rehabilitation services (Jackson & Mannix, 2003; Usher et al., 2005). Corrigan, et al., (2006) found that stigma related to drug dependence was worse than for other health conditions, such as schizophrenia, and that family are likely to be blamed for the start of substance use, facing social exclusion or isolation and be seen as neglectful parents (Corrigan, et al., 2006). Usher et al (2005) found that parents felt they were also blamed by their child. Parents report feelings of betrayal, loss, isolation and often experience threats of violence at home (Jackson & Mannix, 2003). Flensburg, et al., (2021) argue that parents may also be reluctant to seek help because of the complexities of dealing with a sense “that something is wrong [...] and something needs to be done about it” (Emerson, 2015:1), a feeling which arises when life does not happen as we feel it *should* (Francis, 2012). Flensburg, et al.,’s (2021) finding that parents use excuses and justifications in their accounts, demonstrates this feeling of needing to legitimise or explain past (in)actions

and an anticipation of blame. Flensburg et al (2021) argue this reflects a wider culture of blaming parents also identified in other studies (Barker & Hunt, 2004; Jackson, et al., 2007). Choate (2011) suggests as parents move through stages of suspicion, enabling and confrontation they continue to struggle with feelings of blame and shame.

Haines-Saah, et al, (2019) highlight how parents blamed themselves whilst simultaneously outlining the lack of resources and support available to them. They argue this demonstrates a normative expectation of parental surveillance and control (Haines-Saah, 2019) that is embedded throughout youth cannabis use discourse. (Haines-Saah, et al., 2019). Parents are positioned as solely responsible for the prevention of ASM and this rests upon not only their skills of communication but also the quality of their relationship with their child (Haines-Saah, et al., 2019) with some parents feeling like they no longer know their own child (Choate, 2015).

Haines-Saah, et al., (2019) found that parents themselves use the expert discourses which reinforce these normative assumptions about what their relationships, skills, and role, as parents should be. They suggest that parents' use of these discourses demonstrates the process of self-responsibilisation, an integral part of adopting a subject position made available by dominant and prevailing discourses, and a mechanism through which disciplinary power operates. Furthermore, they point out that individuals are not simply "discursive dupes" (Haines-Saah, et al., 2019:136) just inhabiting categories or identities, but actively construct their story, with agency and intent. In doing so parents themselves reproduce the responsibility for ASM as firmly with themselves and within their relationship with their child, neglecting the influence or impact of other external factors, such as health, social, or economic inequalities, which may be contributing to the onset or ongoing ASM (Haines-Saah, et al. 2019). As such, this reveals the processes of normalisation and subjectification with parents taking up the sole responsibility for the prevention of ASM (Haines-Saah, et al., 2019) This internalising of responsibility creates a sense of shame and perception of blame which may

explain a normalisation of extreme levels of distress in descriptions of coping that parents report (Choate, 2015; Orea & Ozgul, 2007).

2.4 Coping

Research highlights parents' sense of a necessity to cope, often without external or professionals support and often as their lives are completely transformed by their child's drug use (Orea & Ozgul, 2007), described by Choate (2015) as "coping rather than living the life envisioned" (p463). For parents, coping will often mean ignoring their own needs to be able to attend to their child's and this aligns with key assumptions inherent in a model known as parental determinism (Lind, et al., 2016), which suggests that children's futures are determined by parent's abilities, and which sustains an ideal of a mother who puts the needs of others before themselves (Lind, et al., 2016). Even though Hoech & Van Hal (2012) found joining a parent support group can be empowering and supportive, most research continues to show that parents are reluctant to seek such support, or engage in treatment because of feelings of shame, failure, and being perceived as not a good parent (Gruber & Taylor, 2006; Orford, et al., 2019). Additionally, those parents that do reach out to primary care practitioners report feeling let down and increasingly disempowered, which can also affect their efficacy in parenting siblings (Gruber and Taylor, 2006; Orford, et al., 2010, Velleman & Templeton, 2010)).

Choate (2015) found it can take parents up to two years to identify ASM, with parents often seeking alternative explanations for behaviours, experiencing confusion as the substance use creates a sense of chaos in the family. Upon confirmation of ASM, parents report a profound emotional impact, isolation, and considerable stress-related difficulties including insomnia, anxiety and depression, and suicidal ideation (Groenewold, 2016; Orford et al, 2010). Maltman, et al., (2020) suggest parents cope with very little professional support (Maltman, et al., 2020), identifying two directions coping can take, that of holding on, or letting go. They also suggest each parent may cope in either way further causing stress in families. Coping by holding on is

linked with many symptoms of ill health, also identified in other studies (Maltman, et al., 2020; Orford, 2017). Coping by letting go is often accompanied by grief and guilt, and without cutting the child off completely can provide a way for parent to move forward and focus on their own needs.

2.5 Social construction of parents

Within the field of ASM, Devaney (2017) argues that drug policies and discourses have reduced the complex and nuanced problem of ASM to a within family problem. Devaney (2017) points out how with a Ministerial Task Force in 1997, families were re-imagined as being part of both the problem and the solution. This reflects a construction of affected families as ‘pathological’ and ‘dysfunctional,’ and in need of professional intervention to improve their functioning and communication skills (Devaney, 2017). This discourse constructs parents as rule-setters and arbiters of the kind of behaviour that is permissible, positioning them as agents of prevention. But parents are simultaneously constructed as joint agents for recovery, which Devaney (2017) argues delegates responsibility with fair consideration of the social and emotional complexities of family life (Barker & Hunt, 2004).

Devaney (2017) draws on the Foucauldian (1988) theoretical concepts and outlines how parents are constructed as being responsible for their own and their families health, and through this process of self-responsibilisation become self-governing. Through the use of dominant institutional discourses parents reinforce inherent underlying normative assumptions, and families become key socialising institutions. Devaney (2017) argues that family therapy also reinforces these normative assumptions.

2.6 Governmentality through Family

Foucault’s (1991) concept of governmentality concerns activity which affects, shapes or guides people’s behaviour, and argued that this was predominantly achieved through the discourses and practices of regulatory institutions such as health, education, politics, and the

law. Foucault asserts that discourses, and practices “systematically form the objects of which they speak” (Foucault, 1972, p.54). Discourses can “facilitate and limit, enable and constrain what can be said” (Willig, 2021:133), and in doing so they construct not just ways of understanding our social and individual worlds, but also ways of being. In this way, modern individuals and families are governed in line with ‘social economic and political objectives’ (Rose, 1999:213)

Devaney (2017) points out that harm linked to substance misuse is most often found in the most disadvantaged areas of society and that factors such as social class, age, gender, family position, place, and culture mediate the impact of substance misuse harm upon families (Orford, 2017). Devaney’s (2017) argument is that by constructing families as the key socialising institution, these other social, cultural, and political factors are relegated, made irrelevant. This conceptualises the family as a “closed system [...] impervious to external influences” (Flensburg 2021:256) and constructs parents as agents of recovery, designating responsibility for outcomes onto parents as well as for the onset of ASM.

Dahlstedt & Fejes (2014) explore the parent makeover within the cultural TV makeover genre and suggest parents are expected to be educated in their role as parents (Dahlstedt & Fejes, 2014). Rose (1999) argues that within neoliberal society, governance is based on the principle of responsibilisation; the constitution of citizens as free and responsible subjects, responsible for creating their own lives based on their own ideals, circumstances, and ambitions (Rose 1999). Ultimately, this creates a complex dynamic of governmentality upon and through parents and families. (Dahlstedt & Fejes, 2014).

2.7 The social construction of adolescence

Research has traced the social and historical construction of adolescence through social, political, and psychological discourses. Arribas-Ayllon & Walkerdine (2008) point out that early 1920’s studies that focused on child poverty and juvenile delinquency created the concept

of adolescence as an object worthy of study. Erikson's (1963, 1968) later theory constructed adolescence as a specific developmental stage, with its own specific conflict and characteristics, describing adolescence as a time of identity vs. confusion; a crisis of forming identification with same-age peers outside of the immediate family. Studies emphasise the incompleteness of adolescence, as a step nearer by not quite adulthood (Farrugia & Fraser, 2017; Lesko, 2001) and recent neuroscientific conceptualisation of the teen brain support this picture of immaturity, susceptibility to peer pressure and risky behaviour (Bessant & Watts, 2012; Kelly, 2012).

Farrugia & Fraser (2017) argue neuro-science constructions of youth and addiction share core assumptions which impact drug education and policy and reinforce existing assumptions and judgments about both. Youth are often defined as dangerous or delinquent, and descriptions focus on presumed deficiencies (Touzard, 2011). These constructions of adolescence position adolescents as simultaneously active agents with decision making autonomy and as vulnerable and requiring protection from adults, which has significant implications for how the problem of ASM is constructed.

2.8 The social construction ASM: Medicalisation and addicts

Something is often constructed as a problem which it has the potential to disturb the prevailing social order and social norms (Emerson, 2015; Sanders & Young, 2002). Social problems, such as ASM, are often explained in terms of parental actions or choices and the conditions of childhood and upbringing (Barker & Hunt, 2004; Flensburg, et al., 2021). How and when ASM is defined as a problem constructs a particular understanding of what is happening and is therefore crucial for what opportunities for potential solutions are considered possible (Bacchi, 2009). Which substances are defined as illegal is constantly contested and redefined by consumers, the relevant industries, governments, health professionals, and other interested parties (Fraser, et al., 2017). Greenwood (2015) asserts that even Sigmund Freud

(1856-1939) experimented with using cocaine, prescribing it for himself, patients and family (Greenwood, 2015), however today substances other than alcohol remain illegal in the UK, and therefore substance use and the substance user become associated with a level of criminality, and amorality when constructed by dominant discourses such as criminal justice, law, and politics.

However, Kuusisto, et al., (2023) found that the medicalisation of substance use, and the discourse of addiction is increasingly found in everyday life. Foucault (1971, 1975) outlined medicalisation as one of several discourses which could be identified as discourses of social control arguing that individual lives are profoundly experienced and understood through discourses and practices of medicine and its allied professions. Medicalisation redefined deviant behaviours as illness rather than crime, reframing the problem as a medical one rather than social or criminal (Pitts, 1968) and moved the problem away from the public legal realm into the hands of medical and scientific experts (Conrad, 1975). This process encourages a reliance upon experts for guidance and advice and can appear to lift moral, if not criminal, responsibility from an individual, but in reality, does not (Zola, 1972).

2.9 Disciplinary power, normalisation, and disempowering parents

Foucault (1991) asserted that disciplinary power operates through processes of normalising judgements (Foucault, 1975). Bae (2016) draw on Foucault's concepts of governmentality and normalisation as tools to examine the policy of a key parenting programme in early childhood education in New Zealand. Bae (2016) argues developmental psychology assumptions are privileged and have become naturalized in education discourses (Burman 2008; MacNaughton 2005), perpetuating a myth that standardised knowledge given by developmental psychology may provide answers to all the complexities and challenges that parents and families can face (Bae, 2016). Such prioritisation of expert knowledge risks disempowering parents, as well as practitioners (Cottam & Epsie, 2014). Cottam & Epsie

(2014) explore the discourses of current UK legislation such as Every child Matters (2004) and the Children's Act (2004) and argue parents are constructed by these legal discourses as in need of help. They identify a salvation discourse, seen in a tone which constructs those parents who do not comply with prevailing knowledge as immoral, and implicitly reinforcing an assumption that working hard will reap the best results. This almost puritan discourses positions professional adults as having a moral duty to save children, privileging expert knowledge and aligning it with morality, which when coupled with a privileged scientific discourse, creates an authoritative moral expert and a disempowered and potentially immoral (if in disagreement) parent position. Furthermore, these discourses are drawn upon even when there is no expert present (Cottam & Espie, 2014). Wilson (2003) suggests that when professionals adopt this expert position it can make it harder for them to empathise with parents and can have the effect of invalidating or completing subjugating cultural, social, and familial knowledge. In contrast, a collaboration discourse offers the subject position of good enough parent, which they suggest may empower parents. (Cottam & Espie, 2014:474).

2.10 Implications for Counselling Psychology

Counselling Psychology is built on philosophy which embraces “a pluralistic and interdisciplinary attitude” (BPS, 2014:15) and as such may often find itself positioned “at a busy junction of diverse and sometimes competing ideologies, frameworks and paradigms” (Douglas 2010:2). Whilst psychological treatments for addiction, and systemic family therapy models are based within medical, systemic, and psychological frameworks, understanding how discourses, language, and practices, are functioning within these frameworks is also important to a profession which is concerned primarily with health and removing distress, rather than identifying or reinforcing labels of pathology (Woolfe, 2016). So, studies which suggest discourses and practice within psychology treatment, programmes and policies may sustain a

pathological perspective of families and adolescents, and that interventions by expert's risk disempowering parents (Cottam & Espie, 2014; Furedi, 2004)

Counselling psychologists who wish to provide treatment and support for adolescents and families experiencing ASM without alienating or disempowering parents, the adolescent or themselves might take into consideration how discourses and power are operating in and through the language of our intervention and how these may be positioning, defining, constructing, those involved or limiting potential possibilities for intervention. The challenge for Counselling Psychology, and for meaningful change to occur in systems, practices and policies in the field of ASM, is that development to empower parents, and adolescents, may require a level of disruption to normative assumptions which otherwise may be reinforced through our professional language, discourse, and practice.

2.11 Gaps in research

The literature reveals that adolescent substance misuse is a complex and multi-faceted issue. Phenomenological analysis studies enable a reader to immerse themselves in the experiences as lived by the parent and have created a vivid picture of the experiences of shame, and stigma that parents experience, of a sense of immorality associated with ASM which provokes social exclusion and isolation, and a perception of blame which constructs parents as failures and may prevent parents seeking support. Our understanding is further developed from recent studies adopting a discourse analysis perspective, exploring how political, educational, medical, and psychological discourses construct parents, adolescence, substance misuse, and parenting, with specific focus on substance use prevention policies and treatment practices. These critical studies have offered another lens through which to view the social construction of families, parents, adolescents, and ASM, and which suggest the operation of power within, and governmentality through, families, particularly through normative ideals inherent in those discourses. Much of the research is from across the globe, from Australia, Canada, Holland,

Sweden, and Ireland (Eire). No studies were found in the United Kingdom, and no studies were identified which explored the experiences of parents whose adolescent was not in treatment for substance use disorder (SUD). Considering the possibility that the occurrence of adolescent substance misuse may be much more prevalent than diagnosis of substance use disorder, (Priory, 2019), there is a notable gap in research around the discourses available to parents to construct their experiences of parenting adolescents who have misused substances in the UK and not accessed treatments.

2.12 Research question

What discourses characterise and structure parents' narrative accounts of parenting an adolescent who has engaged in substance misuse?

Chapter 3. Methodology

3.1 Aims

This study adopts a social constructionist position to explore the construction of parent's narrative accounts of parenting an adolescent who has misused substances. By focusing on the discourses which construct and characterise parents' narrative accounts, it aims to identify the discursive worlds the parents are inhabiting, within which the ways of being offered to them are situated (Willig, 2001). In doing so, it also aims to explore the operation of power upon and through families.

3.2 Qualitative research

This study adopted a qualitative methodology aimed at gaining insight and a deeper understanding of an aspect of human experience (Silverman, 2001), more specifically how individuals' experiences are socially constructed. For qualitative research, contextual and situational factors are not variables to be controlled or kept constant, they are valued as central to the data collected, as meaning and realities are contextual and situated. (Willig, 2001). In line with a qualitative perspective, this study aimed for depth and richness of data analysis rather than generalisability or universality of findings. Qualitative approaches require a significant level of reflexivity which ensure robustness, reliability and validity in the analysis and discussion of data (Willig, 2001) and I have tried to be reflexive throughout the process of this research study. This is summarised in section 3.9.

A quantitative methodology was considered, including methods such as survey or use of psychometrics assessments to measure factors such as emotional, social, effects or help seeking attitudes. Whilst this exploration would be valuable, particularly with a large sample of participants, these methods rely on a positivist perspective in that they aim to capture an objective and measurable reality. Instead, the approach adopted by this study is a social constructionist view that realities are socially constructed by and through language and social

practices. Therefore, a qualitative approach was deemed more suitable to access and reflect this shifting fluid construction of parents' realities.

3.3 Epistemological position

Social constructionism rests upon an assumption that all knowledge is constructed through social processes, and that as language constructs, rather than represents, reality (Willig, 2001), we can only access these versions of reality which are socially constructed by and through language and practices (Burr, 2003; Willig, 2001). This social constructionist approach to research adopts a critical stance towards the taken-for-granted ways in which we understand the world and ourselves and emphasizes the social, historical, and cultural meaning making (Burr, 2003). This perspective has significant repercussions for psychological knowledge and exploration. Personality and character become historically, culturally, and relationally (re)constructed, rather than being a stable entity within an individual (Burr, 2003). This means that rather than having a constant and stable self within us, our identity is constantly recreated through historically and culturally specific contexts, discourses, and practices (Hedges, 2005). Our sense of self and the identity we enact is fluid, situational, and continually reconstructed through language, relationships, and interactions. In acknowledging the constructive properties of language, a social constructionist perspective offers a way to consider how wider social influences sustain individuals' experiences of their reality, as well as their sense of a stable self. Exploring discourses at work in everyday language, has also been found to highlight how psychological research has become deeply enmeshed within social and political understanding (Martin et al., 2015).

3.4 Ontological position

In contrast to a world seen by realists as fixed and unchangeable, a social constructionist position is usually associated with a relativist position (Burr, 2003) of fluid and multiple individual realities. This position has been criticised for minimising very real experiences as merely perspective (Speer, 2000). This study adopts a less polarised position of critical realism

(Harper, 2011) which recognises that our subjective realities are constantly (re)constructed through language and social practices but also accepts that an external world exists which provides the “mechanisms that give rise to conditions that make possible the formation and maintenance of particular discourses” (Willig, 2001:142) through which we access versions of reality. By accepting the relativism of individual experiences, *and* that social structures and systems exist independently from the discourses which construct them (Parker, 1998), a critical realist position aims to critique these systems and processes through the discourses which construct them.

Recent social constructionist studies have explored how the concepts of parent, adolescence, family, and substance use are socially constructed. Taylor (2012) argues family itself is far from being a “quasi-natural formation bedrock of unassailable values, it is in fact a continually contested fiction that masks its own histories of becoming” (Taylor, 2012:210). Taylor (2012) points out that family holds power by its ability to produce well-disciplined subjects and a family that fails to do so may lose its authority over its members to state or sovereign powers. Discourses within drug prevention and parenting practices enable this operation of power which produces subject positions, with associated ways of being which have real implications for possible actions, and the individual subjective experiences of parents. (Devaney, 2017; Haines-Saah, 2019).

3.5 Methodology

This study adopts a social constructionist framework which draws upon the ideas and analytical concepts of Michael Foucault, (1926-1984), a French philosopher who placed language, discourse, and discursive practices, as critical to the construction of knowledge, power, and subjects.

3.5.1 Historical context and theoretical framework

Psychology emerged from the age of enlightenment, which, according to Jager (1991) attempted to achieve the universality previously provided through religion, through human, scientific endeavour and reason, citing how when experimental psychology was first requested to be introduced as an academic discipline at the university of Cambridge in 1877, it was at first refused on the grounds that it would “insult religion by putting the soul on a pair of scales” (Hearnshaw, 1989:125). Martin, et al., (2015) argue that psychology did not develop in a linear fashion but from early biology, chemistry and social and political explorations and concerns of the 18th, 19th and 20th centuries. Greenwood (2015) points out that ideas and concepts, which are now in the realm of psychology, emerged within the philosophical and physiology enquiry that arose from predominantly social, and political, concerns. Early attempts to respond to social and moral problems, such as prostitution and homelessness, were combined with efforts to manage those experiencing extreme moods, intellectual disability, or psychosis. Thus, these early social concerns created the early beginnings of the field of psychology which has gone on to shape much of our modern western world (Greenwood, 2015). By the end of the 20th century, positivist, empirical modernist attempts to identify universal truths in sciences and social sciences had shifted, taking a discursive turn to a post-modern focus on how language and social practices were central to the development of knowledge and our understanding of our social worlds (McGhee, 2001; Rorty, 1967; Arribas-Ayllon & Walkerdine, 2008).

Within linguistics, a post-structuralist turn was also shifting understanding of language, by recognising how language constructs rather than merely describes, shaping what we can think about and our social and individual realities (Neimeyer, 1998; Wittgenstein, 1953). These key shifts towards post-modern and post-structuralist thinking were accompanied by economic and political paradigm shifts to policies influenced by neoliberal ideology emphasising free markets, economically responsible citizens, and individual private enterprise (Burr, 2003).

Arribas-Ayllon & Walkerdine (2008) suggest psychology made an understanding of the social world and its ability to govern individuals possible in the same way post-structuralism enabled a way to show how psychological knowledge itself emerged through exploration of social life. They draw on the thinking of French philosopher, Michel Foucault; his political critique of emerging neoliberalism, his genealogical approach to identifying the historical, cultural, and social construction of knowledge, and the operation of power through knowledge and assert that psychology is “no less than an account of the reorganization of political power in western societies” (Arribas-Ayllon & Walkerdine, 2008),

3.5.2 Michel Foucault: Discourses, power, and knowledge

Michel Foucault (1991) conceptualised discourses as at their most influential when they embody taken-for-granted knowledge, assumptions which we hold implicitly and with which we make sense of practices, labels, and interactions (Stedman & Dallos, 2009). These implicit assumptions are how discourses function, and how power operates through them, as the assumptions are what give the language and practice meaning. Shared assumptions are how ideas are put into practice, and shared assumptions regulate how we can behave, what we can do, what we can say, and how we feel (Hall, 2001). Power operates through knowledge and the implicit assumptions contained therein (Boscolo & Bertrando, 1996). Foucault (1977) argued that discourses conflict and collude to create regimes of truth which are legitimised and continually reinforced by their continued use, and that knowledge is culturally and historically situated.

Foucault defined the exercise of power as the “way in which certain actions modify others” (Foucault, 1982:788), and outlined three main forms of power: sovereign, biopower, and disciplinary power. Sovereign power heralds from head of state or government, through law and government policy. Biopower operates through institutional, political and health regulation of the body and policies which normalise and reinforce the authority of expert

policies and practices. Disciplinary power operates predominantly through processes of surveillance, subjectification and normalisation in everyday social practices, language, and discourse. What is crucial to the operation of disciplinary power is that it operates through someone feeling as though it is their choice to behave in a certain way (Riley, et al., 2021).

Much of Foucault's research focused on institutions including medicine, psychiatry, education, politics, and law which provide the dominant discourses and practices which shape society. For Foucault (1980b) no-one could stand outside of, or apart from, the operation of power, as power is not just a limiting, controlling, force, but one which constructs, creates, and produces (Boscolo & Bertrando, 1996). It is the operation of power which produces realities, positions people, creates roles and responsibilities. Resistance to power is merely the other side of a coin, as resistance is also always present, and constructive (Foucault, 1977), as through resistance to dominating discourses, new discourses can emerge and yields new knowledge. (Prado, 1995).

Emerging neoliberalism in economic and political policies of twentieth century began to shift responsibility from the state onto individuals (Foucault, 2008: Burr, 2003) and increasingly disciplinary, and bio, power operated to guide and modify behaviour as opposed to earlier physical, public, sovereign methods of authority. The power and privilege of sovereign authority was subtly shifting from church and state to knowledgeable experts, and with it, responsibility for the production of responsible future generations shifted also from state and society into the private realm of the family (Taylor, 2012).

3.5.3 The family as a regulatory institution

Foucault asserted that power operates in society in three main ways; sovereign, disciplinary and biopower, all of which operate through regulatory institutions, including the family (Foucault, 1980, 1988). Foucault initially conceptualised the family as a “traditionally sovereign institution whose power has been slowly diluted over time” (Taylor, 2012:211). In a

1975 lecture *Abnormal* Foucault claimed a new kind of family was born in the 19th century, one that is panoptic, medicalised, and normalising, where Foucault claimed the sovereign power parents once held over their children was a fiction, and that it is practices of normalisation now constitute the family including vigilance and constant surveillance. The family then, can be constructed as an institution of both sovereign and disciplinary power. (Taylor, 2012;12).

3.5.4 Discourse and subjectivity

Discourses are in constant conflict and require constant negotiation to construct meanings, positions, and understandings (Ball, 1990). Foucault (1972) called this battle ground a discursive field where some discourses will collude to create and sustain a regime of truth. Regimes of truth allow us to understand our reality and ourselves, they can create as well as limit what we can think or say, and what we can feel and express in any given situation (Hall, 2001).

Subjectification is the taking up of a position made available by collections of discourse within any regime of truth by an individual (Henriques, 1984). Subjectification produces subject positions which are not static, but fluid and in constant reproduction as people shift between occupying various positions which are related to the different parts of their lives, roles they fulfil, and practices they are involved in (Riley, et al., 2021). In this way, a Foucauldian framework does not provide a theory of subjectivity but can provide an important basis for the analysis of subjectivity (Arribas-Ayllon & Walkerdine, 2008:92)., as discourses “establish the limits of ‘who we are’ and ‘who we can be’” (Arribas-Ayllon & Walkerdine, 2008:117). Discourses shape not just who we can be, but how we experience ourselves, and how we experience our worlds. (Burr 1998; Willig, 2021; Riley, et al., 2021).

3.5.5 Disciplinary power: Surveillance and normalisation

Foucault's original concept of surveillance as a mechanism of power was based on Jeremy Bentham's idea of an ideal prison system, the panopticon. Foucault (1991) argued that subject to constant surveillance, people will begin to regulate and monitor their own behaviour. The production of normality, and its opposition, deviance, is intertwined with controlling and modifying behaviour through a process of self-surveillance. Normalising power operates through social institutions and practices where deviation from the norm is avoided (Foucault 1991) Normalising is pervasive throughout everyday interactions and practices; judgements of normality are everywhere (Foucault 1975) including as we self-monitor against internalised expectations produced by the discourses and practices of dominant and discourses, particularly those of state institutions such as education, politics, medicine, or law.

Bae (2016) argues that when compared with internalised normative ideals, families which deviate from these norms can be pathologized. (Bae, 2016). Devaney (2017) draws attention to how families were initially constructed as obstacles to state efforts within drug treatment policy discourses, and how a key function of the family within a disciplinary society was to exercise its sovereign power to hand over the abnormal person (substance user) to the authorities for normalising intervention (Devaney, 2017). Devaney (2017) goes on to say that a Foucauldian perspective offers an alternative understanding to what is termed non-compliance of some families, which may instead be framed as "struggles against the privileges of knowledge" (Foucault, 1982, p. 781), and specifically as "attempts to challenge psychiatric power and expertise" (Devaney, 2017:362).

3.5.6 Technology of the self and narrative as a confession

Foucault uses technology to refer to practical forms of rationality for the government of self or others. (Foucault, 1988) differentiating between technologies of power (sovereign, state, law) and technologies of self. Technologies of the self are forms of self-governance and

permit individuals to “transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality” (Foucault 1988:18). Individuals can “shift between occupying different positions related to different part of their life parts of their lives and the discourses to which they are exposed” (Riley, Robson, Evans, 2021:288).

Confession is a technology of the self (Foucault, 1988) which, Foucault argued, became a priority with the emergence of Christianity. Foucault (1988) argued these verbal disclosures or confessions, initially to attain purity of the self, became linked to science and scientific enquiry. Foucault (1976) traced the Western tradition of confession through religious practices and within crime, education, and psychiatry, arguing that individuals are primed to produce narratives of themselves which become a mechanism of power and control. Through these narratives a person is not merely describing themselves, the self is produced by the narrative, in line with societal and cultural expectations. From a social constructionist Foucauldian perspective, a narrative account is not just a story told within a context but itself is a social practice (Ewick & Silbey, 1995), an active construction and reconstruction of identities and events (Dallos & Vetere, 2021). A narrative autobiographical account is therefore particularly suitable for Foucauldian Discourse Analysis (Arribas-Ayllon & Walkerdine, 2008).

3.6 Design

This was a qualitative study which used Foucauldian discourse analysis to identify and explore the discourses which constructed parent’s narrative accounts collected through semi-structured interviews. Quantitative and alternative qualitative approaches were considered. Interpretative phenomenological analysis foregrounds the researcher in the interpretation of data and attempts to demonstrate rigour by using detailed criteria for analysis and providing a transparent account of the analytic process (Levitt et al, 2018). Interpretative phenomenological analysis can give voice to and highlight participants experiences and provide significant insight into these (Smith, et al., 2022) and was considered for its ability to raise the profile of the voices

of parent participants. However, this approach accepts rest firmly upon language as representational. (Willig 2021), seeing language as descriptive rather than constructive. Another qualitative approach considered for its critical close analysis of text and social interaction was grounded theory, however it was felt that the focus on social action and objective categorisation emerging from data rather than being constructed by it. This study also does not intend to generate a theory from the data as grounded theory attempts to do. Therefore, these approaches, along , along with quantitative methods such as surveys or factor analysis which rely on positivist principles of fixed and measurable reality, were felt to be not consistent with social constructionist principles of fluid, multiple and socially constructed realities. This method relies on the use of categorising of data as if the choice of categories emerges from rather than being produced by the language. Grounded theory sees language as representational and performative and does not give adequate recognition to the constructive nature of language. Therefore, neither of these approaches were considered a good enough fit for a social constructionist critical realist study.

3.6.1 Foucauldian Discourse Analysis

Foucauldian Discourse Analysis (FDA) is a form of analysis which aims to explore how our social and individual realities are constantly negotiated and recreated through language and social practices (Wetherall, 1998). Foucauldian Discourse Analysis is an approach which emphasises power relationships by focusing on language and the power operating through it (Burr, 1995), as well as how individual subjects are constructed and positioned by power operating through the use and resistance of dominant discourses in social practices and language. FDA offers a way to explore, question, disrupt or resist assumptions as they are reconstructed through and by dominant and authoritative discourses in society (Willig, 2021).

Cottam & Espie (2014) argue that identifying discourse, and actions permitted, and subject positions created by them, gives a way to illuminate power relations between parents,

children, and professionals, and can illuminate and add insight into social phenomenon that is experienced individually, such as courtesy stigma (Goffman, 1963; Flensburg, et al., 2022). FDA aligns well with the social constructionist epistemological position by offering a way to explore, question, disrupt or resist assumptions as they are reconstructed through and by dominant and authoritative discourses (Willig, 2001). In doing so, FDA aligns with the principles of social justice underpinning Counselling Psychology (Cutts 2013; Kennedy & Arthur, 2014) by providing one viable way to identify potential for beneficial changes or disruption to harmful norms in social, cultural, or institutional, language and practices.

3.6.2 Participant recruitment and eligibility

The study was advertised using a flyer (Appendix A) which invited participants. The flyer was placed digitally on BPS research website, and a Counselling Psychologist Facebook Group. I also placed a paper flyer in a community centre where I was aware addiction support groups met. I circulated the flyer amongst friends and professional associates including with an ASM support agency, adolescent, and youth justice teams within the local authority. Four to six participants were sought initially, and this number was approved by the ethics committee at London Metropolitan University as appropriate for the project.

The recruitment process proved particularly difficult and I noted that although many people I spoke with about the study would share their own experiences in conversation this was not reflected in volunteer rates. Perhaps reflecting the stigma associated with ASM, very few participants came forward despite widespread circulation. The study took place in a rural county in South-East England. Although only five participants were recruited they were considered reflective of the community from which they were drawn in terms of socio-economic status. All would be considered either low-middle, or middle class. All had been married either before or at the time of the ASM. It is also noted that all participants were mothers, despite the flyer specifically stating ‘parents’ and this perhaps reflects something

about the role of mothers more generally, or their availability for involvement. All participants were biological mothers, aged between 45-65, although inclusion criteria allowed for step, foster or otherwise legal guardians. Of the five participants, one was still married, three were divorced or separated, and one remarried. The adolescents that had misused substances are now in their twenties, or in one case, thirties. Although it is recognised that this is a small number of participants, it was considered to be sufficient data collected to provide detailed, nuanced, and in-depth qualitative analysis.

Literature consistently supports small sample sizes in qualitative analysis, where the focus is on depth of engagement with the data, and richness in analysis over a large number of responses (Cresswell, 2013, Moustakas, 1994; Braun & Clarke, 2013; Guest, et al., 2006). In Foucauldian discourse analysis, the depth of analysis required often necessitates smaller sample sizes (Goodman, 2017) and it is generally agreed a smaller number of participants allows for more detailed exploration of language (Yip, 2024). The validity of discourse analysis is not considered relative to sample size (Potter & Wetherell, 1987) and with these arguments in mind, I concluded that although the participant number is small, it was methodologically sound for this qualitative approach (Guest, et al., 2006).

3.6.3 Inclusion and exclusion criteria

Inclusion criteria and information about the study (Appendices A& B) refers to adolescent misuse rather than use. This was to differentiate the problematic use of substances, whether it was one off, ongoing, or led to further substance abuse later. Recognising that these criteria are particularly subjective and that the study relied on parental self-selection, it was assumed that parents who wished to take part in the study self-identified their child's use of substances as having a sufficiently detrimental impact upon their child's life to be classed as misuse rather than simply use, and that participants self-identify at what point substance misuse *becomes* problematic (Choate, 2015). I include alcohol (mis)use in the term substance misuse

as excluding alcohol use seemed arbitrary as alcohol use so commonly co-occurs with substance use in adolescents (Geijer-Simpson et al., 2023; Segrott et al., 2019).

It is hoped this study highlights the complex, unique, and nuanced experiences of these parents. Discourse analysis does not look to gain homogeneity in its sample of participants (Taylor, 2021). Rather, this method accepts and seeks out the heterogeneity inherent in human populations, attempting to capture in-depth and complex data, permitting the inclusion and exploration of multiple realities, and attempting to capture the complexity of a social phenomenon, seeing the imposition of homogeneity as potentially excluding valuable insights from different participant groups. Such heterogeneity is a good fit with the values of diversity and social justice enshrined in underlying principles of Counselling Psychology (Cutts, 2013; Kennedy & Arthur, 2014). Parents who were themselves in treatment for substance dependency or addiction, or whose adolescents were currently in treatment, were excluded. It is acknowledged this study was unable to provide interpreters or use of sign language.

3.6.4 Data collection and materials

Data was collected through semi-structured interviews considered appropriate for FDA (Arribas-Ayllon & Walkerdine, 2008). It is assumed that interviews are a social situation where discourses which are public will be articulated (Riley, et al., 2021). Semi-structured narrative interviews were carried out virtually using Microsoft Teams ensuring accessibility and less disruption due to distance or travel complications.

Focus groups were also considered as a data collection method, as Onwuegbuzie, et al., (2009) suggest they are a superior method for gathering naturally occurring discourse but were ruled out. For practical reasons arranging simultaneous availability for all participants was difficult to arrange. More significantly, due to the nature of the topic being discussed potentially evoking powerful emotional responses, it was considered participants would need the privacy of individual interviews to have time and space to tell their story in sufficient depth. This was

prompted by the finding that shame and stigma have been experienced by many parents of adolescent substance users (Orford et al, 2010; Jackson & Mannix, 2003; Usher et al, 2005) which may makes participating in focus groups a restricting, intimidating, or limiting social practice for these participants.

The interviews lasted between 45 and 50 minutes and were audio recorded using a good-quality recording device. In the interviews, I monitored myself in role as interviewer, to be non-judgemental and empathetic but to not slip into the role of therapist and to take care not to ask questions other than the additional prompts on the schedule. From this epistemological position, no-one stands outside of the discourse, researcher included (Foucault,1990). It is recognised that the interviewer also takes part in constructing objects and mobilising discourses through the questions chosen (Kvale & Brinkmann, 2009).

The Interview schedule (Appendix F) contained nine questions designed to be open and aimed to capture the broadest spectrum possible of parental experiences and perspectives. As recommended for researchers who are attempting to invite narrative responses, I attempted to use a combination of broad questions, e.g. “tell me about your experience?” with slightly more specific prompts, e.g. “can you tell me about what happened next?” In this way the questions differed from other types of interviews, as they were designed to elicit a narrative or story response, rather than an opinion or interpretation, about aspects of parenting that previous studies have suggested may be impacted by ASM (Usher, et al., 2007; Groenewold & Bhana, 2017; Choate, 2015; Dykes & Casker, 2021; Haines-Saah, et al, 2019). The interview schedule (Appendix F) was piloted with a fellow trainee to ensure they were as open as possible to elicit a story telling response.

3.7 Data analysis, synthesis, and interpretation

The Foucauldian Discourse Analysis (FDA) attempted to explore how the participants (re)construct their worlds, position themselves and what is gained or lost from these

constructions in terms of what can be done, said, or understood (Potter & Wetherell, 1987). Using FDA approach, the analysis attempted to identify the ideas with which people are able to make sense of themselves, how these ideas are made possible and the consequences of these possibilities for how someone can feel, think or be (Riley, et al., 2021).

Foucault himself stated he was not attempting to “dictate how things should be” (Foucault, 1994:288) and there has been no overall consensus within research as to how to apply a Foucauldian perspective. For this analysis, I followed the six suggested stages outlined by Willig (2001) for FDA discourse analysis. The steps were 1) identification of discursive resources 2) identification of discourses 3) action orientation 4) subject positioning 5) practice 6) subjectivity.

Step 1. Discursive constructions

The analysis began during transcription and reading each transcript to become more familiar with content. I asked what or who is being constructed by the overall narrative, by parts of the narrative, identifying key constructions for each transcript and synchronising across transcripts. The analysis also explored how these constructs were signposted or emphasised rhetorically within the narrative accounts, exploring not only what is being said, but how it is being said. For example, a participant might look for agreement from the interview with phrases such as “isn’t it,” or they may not finish a sentence if what they have introduced feels unsayable (Riley & Wiggins, 2018, Wiggins, 2017). In line with Foucault’s (1984a) notion of “problematization,” I also identified where the participant explicitly labelled their talk as a problem, for example through emotional tone, emphasis, stopping mid-sentence, laughter, hesitation, repetition, or explicit disclaimers orienting to dispreferred identities.

Step 2. Discourses

During transcription and (re)reading emerging broad themes, issues, and ideas relevant to the research were identified. I identified all sections of text which contributed to the

construction of each of the discursive objects and asked what language is being used and what effect is using that language having on the narrative and on what / how each object is constructed. As each analysis progressed, phrases were coded according to the discourse/s they fell within and highlighted as illustrative extracts. All the extracts coded from each transcript were collated together using Microsoft Excel. The transcripts were analysed, and the emerging preliminary discourses were coded throughout the data. Codes can be viewed as the components of themes [discourses], the larger 'patterns of meaning, underpinned by a central organising concept' (Clarke & Braun, 2017:297).

This process aligns with the analytics of Potter and Wetherell (1987). A full analysis of the historical and cultural implications of each discourse was beyond the scope of this paper. Each discourse was mapped along with sub discourses, and consideration given to their historical and cultural position. The subject positions for each sub discourse were identified and labelled, and time was spent considering the possibilities and limitations of adopting each subject position that individuals can adopt or position others into (Willig, 2001). I considered what each sub-discourse normalised and in doing so constructed as deviant, and the knowledges or ways of being each sub-discourse downplayed or subjugated.

Step 3. Action orientation

This part of the analysis began to look more closely at the discursive contexts within which different constructions of the object are being deployed, and I asked, what is gained from constructing the object in this way (Willig, 2001). I asked, what is the function of this construction, and how does it relate to other constructions? I also explored how these discourses interacted with each other, and how these constructions related to wider social and cultural discourses.

Step 4. Positionings

The analysis then explored what subject positions were made available and constructed by each discourse, considering how participants constructed their own and that of others by placing them within these discourses (Willig, 2001). The subject position within a discourse identifies ‘a location for persons within the structure of rights and duties for those who use that repertoire’ (Davies & Harrer, 1999:35 cited in Willig, 2001:136). “In other words, discourses create subjects as well as objects” (Willig, 2001:136). Adopting a subject position has direct implications for subjectivity, ways-of-being in the world. Subject positions offer a particular “discursive location from which to speak and act, rather than prescribing a particular part to be acted out.”

Step 5. Practice

This stage of analysis was concerned with how discourses make possible or shut down possibilities for action (Willig, 2001) and what is normalised within them. I considered what these discourses made possible to do in practice by adopting the available subject positions. I considered what wider discourses gave these discourses their validity and rationality and explored the underlying assumptions upon which meaning is jointly accessible. This stage also considered knowledge that have been disqualified as inadequate to their task, therefore not acknowledged as truth (Foucault, 1980) but which emerged as less privileged knowledge, not completely disqualified but with less authority but which enabled criticism or resistance to be performed and may thereby have the potential to bring about change (Foucault, 1980).

Step 6. Subjectivity

This last step in analysis considered what the consequences are for the taking up of subject positions offered by discourses and what implications this might have for the individuals’ subjective experiences (Willig, 2001).

3.8 Ethical Considerations

Ethical approval for this study was sought and given from the London Metropolitan University Research Ethics committee before commencing recruitment.

3.8.1 Confidentiality

Confidentiality and informed consent protocols ensure participants' rights and privacy were upheld with detailed procedures outlined to safeguard data security and participant confidentiality and anonymity. Participants were asked to ensure their own privacy in attending the Zoom call in a private room, and the researcher also ensured the same. Recording was made on a separate recording device, rather than using transcription tools. These recordings were deleted once they had been transcribed which was undertaken as soon as possible after the interview and transcriptions were anonymised to protect participant anonymity, including removal of any identifying names or places. Transcription involved some transcription notation to include a sense of how participants spoke including standard punctuation marks (comma, question mark, repetition, pauses, and delays as well as ellipsis). Data and recordings were processed and stored in line with London Metropolitan University Data Usage Guidelines for research (London Metropolitan, 2025) and GDPR Data Protection Act (Gov.uk, 2018).

3.8.2 Informed consent

Participants were fully informed about the nature of study and topic of discussion (Appendix B), including sharing information, focus of study, interview questions (Appendix F) before completing and signing their consent (Appendix C). Participants were given opportunities before the interview to ask any questions. It was hoped this helped participants feel prepared and indeed feedback was given that it was helpful to consider the questions before the interview. Participants were made aware of the purpose of the study (Appendix B) and how their data would be used for analysis. Participants were reminded of their right to withdraw their consent for any or no reason when signing consent, before and after the interview took place

3.8.3 Protection of participants

It was likely that participants may experience a level of distress when discussing difficult and painful experiences from the past and a distress protocol (Appendix E) and post-interview debrief (Appendix D) was in place to mitigate these effects and to signpost follow up support services. Questions were asked carefully, with every care taken to be non-judgemental and accepting and in all responses. I was careful to check in with participants at the start and end of their interview, and monitored throughout, in line with the distress check in outlined in the distress protocol (Appendix E). As a trainee Counselling Psychologist, I have experience in managing mild to moderate distress in clients which I was able to draw upon to gauge participant distress and respond appropriately. No participant showed signs of elevated levels of emotional dysregulation, albeit a protocol was in place in case this should happen. If there were signs of mild distress, I followed protocol by allowing time and offering to stop or take a break. Participants were also given the questions in advance of the interview in order to give them time to consider their answers and mitigate distress during the interview.

3.8.4 Debrief

Participants were de-briefed according to the debrief protocol outlined in the debrief form and signposted to local support groups (Appendix D) following the interview.

3.9 Reliability, validity, authenticity

The hallmark of qualitative studies is the richness of their data, to the extent that concepts that are identified and finalised are said to be saturated (Glaser and Strauss 1967) which was considered to be achieved in this analysis. Lincoln & Guba (1985) suggest another key aspect of validity in qualitative research emerges from the level of trustworthiness within the analysis, consisting of “credibility, transferability, dependability and confirmability” (p300). Guba and Lincoln later added a fifth criterion, that of authenticity. I believe these criteria were met by my approach throughout, from representing a range of different realities, to helping participants understand the matter under investigation, aiming to potentially

stimulate further action and enquiry, and a process which may empower those taking part through reflection and validation. I attempt to meet the criteria for in-depth analysis and rich description in Chapter 4, where I (re)construct extracts from participants stories with respect, dignity, and authenticity, remaining true to their experiences whilst also drawing out how these are constructed discursively.

3.10 Reflexivity

Willig (2001) separates reflexivity into personal; one's own values, beliefs, and experiences; and epistemological, referring to how underlying assumptions during the research may unknowingly influence analysis, I have attempted to address both in this summary. I recognise my own role in devising, creating, constructing, analysing, and editing this study. It is recognised that "the process of analysis is always interpretive, always contingent, always a version or a reading from some theoretical, epistemological or ethical standpoint" (Wetherell, 1998, p. 384) whichever method is applied. I therefore aimed to be reflexive at all points in the process, from research design, question design, interview, and in my analysis. When listening to the stories of participants then I had to be careful not to over identify, and to bracket my own experiences when aware this was occurring. I waited until all interviews were complete before beginning my analysis process. After initial reading through and noting phrases, rhetorical devices, and discursive constructions, I amalgamated extracts into one excel document and from them was able to continue the analysis on all the data rather than on individual transcripts. When analysing, I took time to revisit the material several times to create a distance between what was said and any subjective response, aware that I was not a neutral observer of data (Silverman, 1997). I found that recategorizing the data into discourses helped with this process. This enabled me to more clearly explore how discourses created potential for subjectivities, rather than seeing the discourses as constructed by participants (Dobson, 2012).

Reflexivity is crucially important with an FDA approach, as I recognise that my own knowledge is situated within historical, cultural, and social discourses and practices outside of which I cannot understand my own existence, nor connect with that of others. I am a 53-year-old, white, heterosexual, cis-gender, woman. I am a mother, teacher, and trainee counselling psychologist living in the UK in an affluent well-resourced local authority. I am divorced and brought my six children up in a single-income working-parent household. I bring these personal identity factors into this reflexive statement as I recognise that each of them reflects values and inherent normative ideals about family, parenting, and moral responsibilities, which will have influenced my experiences of ASM and my choice of topic for this project. My own position on drug use had been fairly distant and mostly indifferent until my own children reached adolescence. As a teenager I had experimented with alcohol but was less interested in cannabis, and terrified of heroin mostly due the 1980's 'Don't die of Ignorance' UK government campaign. As my children reached teenage years, I was not naïve about possibilities of drug and alcohol experimentation that may occur. I was, I realised with hindsight, naïve to the nature of substances now available, the prevalence of, and ease of access to, substances; and had no idea of the devastating effects ASM can bring to a family. Unlike so many difficult aspects of parenting that parents, family, and friends, share and support each other with, ASM seemed uniquely isolating. And my own experiences of trying to navigate and negotiate parenting an adolescent who is using substances inspired this research.

Nightingale and Cromby (1999) suggest that including reflexivity is a way to explicitly address the researcher's influence on the research process. Throughout the process from choice of subject, focus of study, criteria for participants, questions to ask and types of interview method chosen, it is recognised it would be impossible for these not to be influenced or shaped by my own experiences and identity (Clarke & Braun, 2017). It is also recognised that my own writing is a (re)construction itself. Rather than attempt to achieve objectivity, my own

subjectivity was explored explicitly throughout the process, by attempting to define terms with neutrality and inclusivity throughout my writing, and through personal reflexive processes, including journaling, personal therapy, supervision, and peer supervision.

Reflexivity, being cognisant of my own views, position, background and biases, enabled me as much as possible to recognise and consider the influence and operation of power in the research process as (Berger, 2013), but it is impossible to remove myself completely from the research process. I identify as left of centre politically and have strong personal values of social justice. This has definitely influenced my choice of careers, as a teacher, and as a counselling psychologist. As a specialist teacher these values drive my work with children who are close to school exclusion and experiencing social, emotional, and mental health difficulties. The occurrence of ongoing ASM has a truly devastating impact upon those students that are referred to my service, often resulting in breakdown of school placement, removal from family, school exclusion, or youth justice intervention. Working for a local authority, I work closely with colleagues in social care, mental health, and youth justice and am therefore keenly aware of the legitimacy of parents fears about how these systems, processes, and forms of treatment, may impact their family life.

My own questions therefore were included in the analysis. Other examples of my reflexive process included taking time to consider my rationale behind each decision made during the research design, data collection, and data analysis, and discussing steps carefully in supervision. I reflected on each interview to consider how I may have approached it differently and apply any learning for the next interview. Even beginning the initial literature search, I began with searching for studies from other perspectives to ensure I felt I could engage robustly with all the literature and to try to make explicit implicit assumptions I may be holding. I also felt this process aligned with the Counselling Psychology principle of pluralism, welcoming and finding value and space for different perspectives (Cooper & McLeod, 2015).

Chapter 4. Analysis

In this section I will introduce the five participants and their contexts for their narrative accounts. I will identify and explore the key constructions identified in the analysis, of parents, adolescents, substance use, shame and stigma, and coping. I will explore how the dominant discourses construct and characterise these concepts and what actions, thoughts, and subjective experiences they create or deny, considering what may be normalised by each and what wider discourses may lend them credibility. I explore what subject positions each discourse produces, and the subjective implications of adopting these in terms of possibilities and limitations in what can be said, thought, or done. I outline what power mechanisms are operating within and through these discourses positioning the family as a key regulatory institution, or *dispositif* (Foucault, 1978), of moral regulation. The findings are summarised in Table 2.

4.1 Participants

I have used pseudonyms throughout.

Eloise

Eloise is a married white woman in her fifties working in education with children with additional and special educational needs. Eloise described her experiences of two of her sons' use of cannabis, along with her stepdaughter's severe misuse of alcohol, and the distress, chaos, and complications to their family life that ASM brought. Now in their thirties, one son has stopped using cannabis, the other now occasionally uses cannabis use as a lifestyle choice. Eloise is down to earth, and kind-hearted, and recounts these significant events which impacted her family life with hindsight, humour, and hope.

Claire

Claire again is also in her late fifties, middle class white woman working in social care. Claire rebuilt her life with her sons after fleeing a violent marriage thirty years ago. Her narrative account describes how one of her sons began using cannabis and then other drugs as a teenager,

causing significant difficulties as he dropped out of college, then left his job, and his relationships behind. Claire is currently almost completely estranged from her son, whom she describes as having fallen into a life of addiction.

Jane

Jane is a softly spoken divorced mum in her late fifties, working in a school. Jane's account describes her son's growing dependence on cannabis whilst at school, which led to him experiencing psychosis and being retained under the Mental Health Act (1983) in a psychiatric hospital for assessment. He was diagnosed with bipolar disorder for which he received treatment and his cannabis use stopped whilst in hospital. Now in his twenties,, he has lived with Jane since his discharge and having encouraged him to go back out to meet with friends, and to work, Jane describes her feelings of anger and devastation at his starting to use cannabis again. Jane's son still lives with her, is continuing to use cannabis, and is not currently in employment or training.

Susan

Susan is early fifties and separated from her husband. Working in a corporate role, Susan is lively, chatty, and professional. Susan describes her son's difficulties with cannabis and 'party drugs' in his teenage years in particular the struggle it presented for their relationship, and her marriage. Her story describes her son's substance use at college, including his arrest and their decision to ask him to move out which she recounts as feeling she may have lost her son completely. Now in his late twenties, Jane describes their current position as one of compromise, and a close relationship. Jane is aware her son still uses cannabis, but she prioritises his mental health and wellbeing, and her relationship with him, over this continued substance use.

Annie

Annie is vivacious, bright, and warm- hearted middle-class white woman in her early sixties. Annie describes her first marriage to a drug user as chaos and reflects that she didn't realise at the time the extent of his drug use. Annie's reflects on how the drug and alcohol related behaviours of her first husband may have played a part in her sons later turn to alcohol and cocaine and sees similarities in their behaviours. Her son's substance throughout his adolescence and early adulthood put him at risk of significant harm on several occasions and almost cost him his job, his marriage, and his life. Annie, now remarried herself, supported her son as he battled his addiction and he is now drug and alcohol free. They have a close relationship, and Annie is actively involved in his and his family's life.

4.2 Discourses

Table 2. Summary of discourses, sub-discourses, subject positions, and power mechanisms identified

Discourse	Sub Discourses	Subject positions Parent	Subject positions Adolescent	Mechanism through which power operates
Risk Management				
	Fear of Risks	Helpless observer Mediator parent Vigilant parent	¹ Potential addict Potential criminal Vulnerable child Teenage risk-taker Excluded adult	Surveillance Monitoring & intervention (Biopower)
	Contagion and Contamination	Protector parent Helpless observer Mediator	Contaminated character Vulnerable child	Normalisation Subjectification (Disciplinary)
	Parental authority, control, and prevention	(Dis)empowered parent Mediator parent (Not) Coping parent	Vulnerable child Potential addict Teenage risk-taker	Care and control Direct discipline (Sovereign)

¹ Terms like “potential addict” or “damaged character” may appear to be psychological truths, rather than discursively constructed categories. These positions are not static; there is fluidity and movement between them.

Moral Crisis				
	Shame and Stigma	(Ir)responsible parent (Not) Coping parent	Excluded / stigmatised user	Confession Normalisation Subjectification Self-surveillance Self-responsibilisation Shame (Disciplinary)
	Moral Failure	Moral compass parent Failed parent	Vulnerable child Teenage risk-taker	
	Damaged character	Moral compass parent Betrayed parent Protector parent	Deviant/excluded adolescent Vulnerable / Helpless addict Reformed character	
Expert / Science				
	Medical, Addiction	Helpless observer Enabling parent Informed parent	Addict / Stranger Recovering addict Self-medicator	Confession Self-surveillance Normalisation Subjectification Care and control Surveillance
	Parenting, developmental	Informed parent Ideal parent (Not) coping parent	Teenage risk taker Vulnerable teenager	
	Therapeutic (	Nurturing parent Informed parent	Self-medicator Vulnerable child	
Hierarchy				
	Hierarchy of Substances	Informed parent Protector parent Moral compass parent Liberal parent	Lifestyle user Risk taker Vulnerable addict	Normalisation Confession Resistance
	Hierarchy of priorities	(Ir)responsible parent Informed parent Liberal parent Enabling parent	Lifestyle user	

4.3 Discursive constructions of Adolescents

The adolescent user was constructed in contrasting ways, often simultaneously; as an addict, a teenage risk taker, a self-medicating neurodivergent, and a lifestyle-choice user. Parental authority and control, fear of risks, and expert parenting discourses, are drawn upon to construct the adolescent as a vulnerable, risk taking, teenager. Expert medical, science, and therapeutic discourses characterise the adolescent user as mentally unwell, an emerging and

genetically predisposed addict, or self-medicating anxiety or trauma. The vulnerability of both constructions is emphasised by the use of fear of risks, and contagion discourses.

4.3.1 Adolescent as vulnerable teenager

One of the expert science discourses identified could be classed as a developmental discourse which also includes, informs, and draws from psychological and parenting discourses. These construct ASM in terms of a developmental phase, usually of experimenting, risk taking, and separation from parents. Eloise draws on the understanding of risk taker teenager stage produced by these discourses which normalises substance use at this age as experimentation.

“All of them have experimented with drugs or alcohol, every single one of them as they hit teenage years”

The developmental and parenting expert discourses collude to emphasise the vulnerability and risk taking of adolescence as a developmental phase. Susan describes her initial lack of concern, which is validated by understandings of experimentation produced by these wider discourses.

“Right at the beginning I thought it was kind of like just a one off, I suppose It was a bit naïve about it, and I just thought it was a very silly thing to do in the park”

The developmental / parenting expert discourse produces a subject position of informed parent for adolescent parenting, and with it, an implicit but significant requirement for change in parenting role and duties, from protector and responsible parent who directs and controls behaviours, to a parent who guides or coaches through less direct practices of observation, monitoring and promoting independence. Central to parenting discourse is the constructions of an ideal parent/child relationship, which Susan alludes to when she affirms,

“We always had a close relationship; it’s not like we haven’t”

These are requirements which are at odds with the management of ASM putting parents in a continually conflicting position. Similarly, adolescents are constructed as experiencing manageable turbulence, and conflict with parents is normalised by a developmental discourse which sees asserting independence and challenging authority as appropriate and necessary developmental behaviours. This construction of adolescence is often called upon in explanation of parent responses to behaviours which stemmed from ASM, but which were interpreted at the time as being normal adolescent behaviours. It is also used in resistance, as in this extract, where relying on developmental explanations which couch behaviours in terms of developmental phases is almost blamed for the misunderstanding being confessed.

"I think I made the mistake of thinking it's just a phase that he'll grow out of"

The contagion and contamination discourse constructs adolescents as vulnerable and predominantly constructs substance use as something that can be caught through social proximity. The developmental / parenting expert discourse collude to produce positions for significant relationships outside of the family and Jane talks about how she feels her son has been influenced by social groupings, and by the proximity to other cannabis smokers in his local village. Here she constructs her son as vulnerable, and also construct drug use as a social problem, rather than a family, parenting, or psychological problem, in this way, use of this discourse subtly resists those expert discourses.

"I think it's contextual as well because so many people in [this area] do it, so many people in [this area] smoke weed specifically."

The contagion discourse normalises a core idea that substance use spreads through proximity to other substance using people. Jane talks about how she feels it is almost as if her son were in the wrong place at the wrong time and then, how the use of cannabis contaminated other areas of his life, associating with people or making choices he would otherwise not have.

“The weed smoking led to other lifestyle choices and other patterns of behaviour that wouldn’t have happened without the weed smoking. ...It became a point where he was associating with certain types of people that I’m convinced he would not otherwise have”

Constructing the substance use, and her child, in this way makes possible an expression of sympathy for an addict whose life is contaminated by substance use. The subject positions potential addict and vulnerable addict are produced by the contamination discourse which also seems to claim authority by drawing on discourses of genetics and addiction.

4.3.2 Adolescent as addict

This risk management discourse constructs the adolescent addict as vulnerable, with a co-occurring subject position for parent as helpless or disempowered parent, positions which frame the parent as having little agency to intervene effectively, the subjective experience of which is expressed as one of fear, worry, and helplessness. These vulnerable teenager subject positions demonstrates the risk of contamination and contagion, from substances, and from others socially, which would shift the child into an addict position. Jane uses the risk management discourse when she is trying to describe her concern not just for the physical risks of cannabis but also how it may interact with mental health. In doing so, she positions herself as disempowered despite attempting to guide and intervene in her sons cannabis smoking but also constructs him as particularly vulnerable to what is constructed as the devastating impact of cannabis.

" I think this is dangerous as in, I don't think this is good for your physical, you know your brain, I don't think it's good for your health"

Although this worry was expressed often about the health and safety of using substances or contagion from practices associated with it, an emerging subject position of protector parent reflected multi-layered external threats not just from consequences of substance use, but attitudes and actions of others because of it. Annie describes another time she feared for her son's life, when he had lost a fight with a dealer he had owed money to and was thrown out of

the nightclub by bouncers. Here her worry constructs how her son was treated as somehow less than human by the actions of those who moved him, without care or concern for him, his safety, or his health.

“They, the club, just picked him up and moved him outside, they didn’t give a fiddler; they just moved him outside”

In doing so, Annie uses a discourse which positions her as concerned, shocked, but disempowered because she could do nothing to prevent it or intervene. Her son is constructed as vulnerable to be being treated as an addict, in danger from, excluded by, others. The fear of risks discourse was produced fears of four main types of risk from substance use: physical, health, legal and social. Eloise describes the fear of risks of harm from behaviours which were connected to drug use, being out late at night, not being fully able to control where her stepdaughter may be or may be capable of doing. She describes her own emotional reactions to worrying about these risks, and frustration of not being able to communicate to her stepdaughter that it was the risk of harm, rather than the risk of the alcohol, that concerned her the most.

“I was annoyed about the whole situation, not because she was drunk, because it was so dangerous, it was so dangerous”

4.3.3 Adolescent as a stranger

A discourse of damaged character is often drawn upon in the narrative to make sense of the changes in their adolescent’s behaviour due to substance use. This discourse constructs substance use as a damaging entity, and the adolescent as having been changed and damaged by it, framing the parent as an observer of this deterioration. The adolescent is positioned as a damaged character and now in some way incapable or not functioning as expected with their behaviours and damaged characteristics are attributed to the substance use rather than the person by discursively framing the substance use as the cause of this damage. Clair talks about

just how significantly and detrimentally continued cannabis use impacted her sons character, and changed the person she knew her son used to be,

“I just think it makes him unreliable and lazy. You know, he just can’t cope, you know, he can’t even get out of his flat on time in the morning, he can’t function and be a working person all day he cannot cope”

The damaged character subd discourse, like others in the moral crisis group of discourses, positions the narrator as an unrelated observer from where they are then able to describe concerning behaviours which attributed to a damaged character, a version of their child that substance use has forever broken, damaged, or tarnished; and by doing so, this version of their child is differentiated from their original character. The unfamiliarity of the changed adolescent, their damaged character and therefore the unpredictability of what they may do is given as preventing understanding and limiting possibilities for intervention. Claire highlighted this shift in her son’s nature, reflecting on how she moved to a position where she felt she could no longer trust him and how substance use had taken away his ability to sustain a socially acceptable and productive role.

“he can’t cope, you know he can’t even get out of his flat on time in the morning, he can’t function and be a working person all day he cannot cope, and you know I couldn’t have trusted him, you just couldn’t”

This discourse was also drawn upon by Susan, when she describes her own fears that what was previously valued and important to her son was diminished or replaced by substance use, diminishing his character and strengths, and producing an observer parent position, fearful and helpless, and her sadness as she realised she may not know her son as well as she had felt she did and a very real sense of his changed identity.

“But it was scary that he was choosing his reliance or his desire for that over everything else that I thought he really truly worshipped and

valued, “And I thought, for a period, and I just thought, you’re not who I thought you were”

The change in behaviour is framed as evidence of such a significant shift in the adolescent, as this discourse also contributes to producing their adolescent as an unknown stranger. Adopting different available positions achieves and maintains a paradox that is the subjective experience of having failed to meet the expectations of norms and also being able to attribute that failure to a version of the adolescent that is not their true child but someone unknown.

“It became a point where he was associating with certain types of people that I’m convinced he would not otherwise have”

The discourses of parental authority and control, moral failure, and expert addiction also work together to construct the adolescent as an unknown, by framing behaviours such as unpredictability, risk taking, not listening to parents as indicative of this changed identity. This study identified the use of medical expert addiction discourse in constructing the adolescent user as irresponsible, unable to look after themselves, almost infantilizing them as in this extract.

“I’d always try and talk to him, and he would lie, he would say yeh I’m going home now, and he wouldn’t. Like a child, like a child in the playground that just didn’t want to go home, but he didn’t want to stop drinking, he had to drink until there was complete oblivion”

By creating the adolescent as a stranger, it permits a wider range of subjective responses about their behaviours and actions that might otherwise be unacceptable. Substance use is constructed by this discourse as an unexpected hi-jacker and disruptor of an otherwise ordinary and ideal family, and parent and child story.

4.4 Constructions of Substance Use

Substance use was constructed as a teenage risk-taking behaviour, self-medicating against poor mental health or neurodivergence, an addiction, or a lifestyle choice. The fear of

risks discourses primarily constructed substance use as a devastating and destructive force, and a contaminating and contagious danger. By contrast the hierarchy discourses construct substance use relative to other legal substances such as coffee or alcohol, and in later adulthood as a tolerated lifestyle choice.

4.4.1 Substance use as addiction

The narratives were characterised by expert and science discourses which are produced by and reinforced by institutions, particularly health, mental health, education, and the law. A clear example is medical discourse about addiction, which in this extract constructs the adolescent user as an addict, with inherent assumptions of irresponsibility, lacking capacity for self-care and almost infantilizing them. Annie describes her son in this way, as she talks about how she saw him when she tried to talk with him about his use of alcohol and cocaine in dangerous nights out.

“I’d always try and talk to him, and he would lie, he would say yeh I’m going home now, and he wouldn’t. Like a child, like a child in the playground that just didn’t want to go home, but he didn’t want to stop drinking, he had to drink until there was complete oblivion”

Critically this discourse is drawn upon to position the adolescent as vulnerable and genetically predisposed to addiction. Both Annie and Claire refer to the possibility of genetic predisposition to addiction, seen in this comment from Clair.

“I question is it in the genes, his dad does a lot of cocaine which I didn’t realise the extent to that until quite a while after we were divorced, so that made me think is there some sort of genetic substance misuse gene”

Annie also remembered these feelings of fear of the consequences of not being able to stop substance use, both because of the situation her son might find himself in, but also because of the impact of the drugs on his body. She recalled one time that he collapsed inside a nightclub, nearly lost his life in the ambulance to hospital.

“I immediately rang his dad and the two of us went up together even though we weren’t together and on the way, I kept ringing the hospital and the ambulance had been stopped twice because his heart had stopped”

Annie also recounted her son driving his car whilst under the influence of drugs, he was on his mobile phone to her at the time of the accident. Annie remembered begging him to get off the phone and get out of the car and then hearing the crash. The legal ramifications of these event were second only to her terrifying fear for his physical safety.

“He didn’t do any damage to himself but obviously he lost his license, and I remember thinking oh my god if you got drugs tested at work you got found out you’d lose your job”

Constructing the substance use as a devastating force or addiction permits the attribution of behaviours to the these rather than to the individual, enabling strong emotional responses to be directed at this character rather than their child. It also permits harm reduction behaviours and thinking which can include making compromises, facing up to the substance use without focusing on the moral failure and permits the reinstatement of nurturing and rescue behaviours. It produces subject positions such as rescuer, enabler, and protector parent, each offering different possibilities for intervention. Drawing on the authority of mental health and psychiatric discourses gives credibility to the parent’s resistance. It demonstrates knowledge inherent in these discourses and attempts to subvert that knowledge with knowledge from personal experience; however, the attempt serves actually to reinforce the assumptions of original authority it draws upon. One example is the position, enabler, and this extract shows Eloise actively resisting this through sarcasm to frame her actions, but which actually functions as a confession through which disciplinary power operates to reinforce the assumption of the wider addiction discourse.

“I don’t know if I am enabling her, possibly I am this massive enabler”

In two of the narratives, damage to their child's character was considered enduring and ongoing, permanently inhibiting their child's relationships with others. This discourse also produces subject position for the adolescent of an incapable addict and is drawn upon by Claire as she describes her estrangement from her adult son currently.

"Oh, there's no relationship, there's no proper relationship... you can't have a conversation with him"

Using the moral failure discourses makes possible a position of betrayed parent, from which it is possible to express feelings of hurt, harm, and confusion, and express a need for withdrawal which gains credibility and authority from expert science discourse of addiction.

4.4.2 Substance use as self-medicating

Other expert discourses drawn upon were those of therapy, mental health, and neurodivergence, medicalise the substance use, and position the user as vulnerable, predisposed, or a patient. Eloise briefly explores a connection between her son's ADHD and substance use.

"Two of my children had ADHD, interesting with the weed smoking the one that doesn't [have ADHD] is the one who finds it harder to stop"

Jane draws on her concerns for her son's mental health and how it may interact or relate to his use of, and inability to stop using, cannabis.

"he was actually sectioned 4 times in that year and so I, I mean I still don't know if the weed smoking is as well as or linked to it, I, I, actually have no idea, but in my to my mind, my thinking is that if you're brain isn't a sort of typical brain then introducing a psychotropic drug is probably more dangerous than to somebody who doesn't have bipolar"

The medical discourse also constructed the adolescent slightly differently to the subject positions available from addiction discourse which were fairly polarised. This discourse produced pathological positions related to diagnoses which are drawn upon to subvert the

addiction discourse and seem to offer a way to bring into the narrative other factors outside of the family dynamics. It also provided patient and carer subject positions from which to produce their child beyond the substance use.

"I link it to the fact that he's not happy, happy, and I think he thinks he needs it to relax, to put himself in a slightly different place each day so that he feels more at one"

4.4.3 Substance use as lifestyle choice

A counter discourse functions in resistance to the established discourses (Foucault, 1988) and two potential counter discourses were identified that position substance use, and parental priorities, within hierarchies. The use of these discourses was less and often predicated by a qualifying comment such as Jane stating.

"Even though I'm not a medical professional"

and often appeared to be discounted by the narrator before it is even expressed, as here again Jane starts her reflection with.

"I actually have no idea, but in my mind, my thinking is..."

This discourse seems to function as a counter discourse because it disrupts boundaries in place through legal, medical, and psychological discourses for example in how substances are classified. Instead, substances are constructed within a hierarchy, with some more or less tolerable. Jane goes on to say,

"If it was taking coke that would've been for me in my head a lot more of a serious problem you know"

This counter discourse of a hierarchy of substances produces differing boundaries, framing different substance use within different bounds of acceptability, and producing an informed or liberal parent position to draw upon wider institutional discourses of law, medicine,

developmental, parenting, and may enable sharing of knowledge that may be otherwise subjugated by these discourses, such as personal or local knowledge and experiences. When Jane reflected on her discovery that her son had used more than cannabis, she reconstructs a heated emotional reaction.

"There was spice in his system, so that made me really angry"

This expression of anger denotes moral outrage consistent with wider discourses around substance use, but actually just places cannabis further down the scale of substances which also includes alcohol and coffee as a stimulant. When Susan reflects on the current understanding between her son and her regarding their cannabis and alcohol use, she frames this as a lifestyle choice.

"I wish he'd stop [smoking cannabis] but equally he wishes I drank less wine so, and I'm choosing not to, and he's choosing not to"

With the hierarchy of substances discourse, the significance of the drug is not based on legal or medical classification but is based upon impact upon the person, or impact upon their lives or others' lives.

"I'm going to include alcohol in misuse of substances because that's even though its legal I think it's as damaging as all the rest of them"

This discourse is used to construct the adolescent, more often young adult user, as making a choice, rather than being vulnerable to risk, contagion, or inherited disease. The adolescent becomes a self-medicating or lifestyle user, as in Susan's reference to a lifestyle choice here.

"I realised that it wasn't, that it was more a lifestyle choice than just a 'let's do it because we're young and bored'"

Constructing substance use in this way redistributes some of the responsibility for the choice being made onto this newly constructed individual. In conjunction with the subject

positions of tolerant parent and liberal parent, this enables a demonstration of resigned responsibility in favour of prioritising the parental relationship with their child. Eloise references this early in her narrative, stating.

“Mostly as a parent I would rather they smoked, if they’ve got to do something, smoke weed than alcohol, because alcohol tends to lead to quite a lot of chaos”

The hierarchy discourses appeared to be particularly useful in constructing an alternative to the coping or not coping parent positions offered by risk management, moral crisis, and expert/science discourses, in the form of these liberal or tolerant parent positions.

“I’ve I think ...accepted that its part of his life, even though I don’t want it to be, it seems to be something he, it’s one of his daily building blocks”

4.5 Constructions of parents identities, roles, relationships, and subjective experiences

Parents’ identities, subjective experiences, and relationships with each other and with their adolescent, were constructed through dominant discourses in particular risk management, and moral crisis. In terms of their actions or responses, and ways of coping with those subjective experiences, mostly discourses of experts, both neuroscience, parenting, and therapeutic discourses were drawn upon, with the hierarchy counter discourses offering the respite of temporary alternative positions for coping where these dominant discourses did not allow, particularly in terms of parent-child relationship.

4.5.1 Parent identities

Each narrative uses the moral failure discourse to produce the subject position improved or informed parent, constructing the narrator as having learnt, grown, or improved in some way from the past self being narrated, as Annie reflects how she feels she has grown from the experience.

“It has almost equipped me to be a more supportive person in this day and age to a youngster”

Often the narrator is constructed now as an informed parent, or wise parent in comparison to an irresponsible parent or naïve parent or powerless intervener of the past, and self-surveillance of past behaviours and confession of a previous ways of being or thinking heralded as critical in that process of improvement, Jane expresses this in terms of her ability to help others.

“if someone else is saying they’re worried about it then I will share my situation about it in the hope that, it doesn’t make it any more right, but in the hope that they’ll probably might be surprised erm and it might help them put their situation into a maybe a little bit of a better place, so I feel more like I could help others”

In one case, this was coupled with a construction of both adolescent and parent as having learnt and developed into people to be ‘proud’ of.

*“it’s okay now because I’m not talking about this person I’m ashamed of, I’m not talking about a person who’s f***ing up their life, I’m talking about somebody who actually I’m really proud of”*

In identifying how these discourses position parents, there is evidence of disciplinary power operating through processes of subjectification, normalisation, and confession. The discourses produce subject positions which when adopted are defined by their reactions to the inherent internalised expectations, which are framed by wider social values and reinforced through the uptake of these positions and their discourses. Moral values, expectations, and failures, are socially constructed, and through these processes ensure that failing becomes a personal failing, as well as one which bears much wider moral and social implications, creating a devastating and fearful subjective experience put into words by Jane.

“I think it just affects you; it changes your whole world view you know, you, I think the world seems a darker place when you have a child who’s misusing substances”

4.5.2 Parenting role

Together the sub-discourses of parental authority, contagion, and risk management work to create parent subject positions of responsible, helpless, disempowered, failing, and adolescent subject positions of vulnerable child, substance user stranger, contaminated character, each of which have within them limited ways of being and ways of acting. Confession functions as a technique of the self, allowing parents to express feelings of guilt whilst simultaneously reinforcing the internalised ideals they have been unable to achieve.

A discourse of parental authority emerged which draws credibility from a wider societal and institutional discourses that position the family as an institution within which parents are constructed as sovereign figures of authority. Political, educational, and legal institutions, practices, and policies attribute responsibility to parents for meeting the legal, educational, psychological, health, and social needs of their children. Framed by these discourses, a responsible parent subject position is produced as holding pastoral power, inherent with duties of regulation, observation, boundary setting, care, and control. Through the process of subjectification, a parent takes on these moral and social responsibilities. However, the narratives analysed often demonstrated forms of resistance to this discourse from the parents when narrating their experiences of ASM. The resistance, often in the form of humour or irony, functioned to highlight a perceived distance between the narrator's experience and their expectations of a normalised 'ideal' responsible parent. In saying you can't just do what is expected of you, there is resistance to the idea produced by the discourse that parenting practices are one size fits all. But at the same time this resistance reinforces the knowledge that the discourse it resists creates, that parents have the responsibility to boundary set. This is highlighted by Eloise who laughs as she shrugs her shoulders when she reflects on how little authority she felt she had at the time.

“You can't just go, oh can you stop doing that, and they do! It didn't matter what I said, how I said it and how many times I said it, it wouldn't have stopped him”

The resistance, as she actively resists the knowledge within authoritative parenting discourses by expressing and denying it, produces a present reflective parent position, as well as an unattainable ideal authoritative parent. By contrast, her past self is constructed as disempowered, through her subjective experience of feeling ineffective or almost helpless. This confession of past ineffectiveness simultaneously constructs a more informed present parent, creating temporal distance between past disempowered self and current informed self, setting up the substance use as a disruptive protagonist, a force which caused this earlier shift in parental identity. This position permits the expression of subjective feelings of shock, grief, and frustration at the inadequacy of normalised parenting techniques, articulated again through the mechanism of confession.

Adopting the position of failing parent within a confessional mode, permits the expression of vulnerability but also demonstrates moral surveillance, and in doing so, reconstructs the parent as continuing in the responsibility. This self-surveillance is a form of disciplinary power operating to influence not just how past events can be described and future actions, but also to produce alternative subject positions. The mediator parent position offers a strategic alternative to failing parent in that it legitimizes different actions that would be possible to understand from the position of ideal parent who can draw authority from other dominant discourses which construct ASM through a lens of experimenting, or social use. This alleviates anxieties caused by not meeting internalised goal of complete cessation of substance use. This shifting position makes possible the management of risk through mediating and negotiating rather than direct discipline and physical control.

The parental authority discourse assumes vigilance as key parental responsibility, and normalising practices such as boundary setting, monitoring whereabouts, warning of dangers,

and positions others, for instance peers, as sources of risk. Here disciplinary power operates through ongoing and increased surveillance. Annie remembered talking with her son and attributes these attempts to a vigilant and informed parent position, a demonstration of legitimate practices associated with ideal parent, such as talking through dangers, accepting experimentation, recognising peer pressure. In doing so, this reconstructs and sustains those implicit moral expectations that a parent be alert, informed, and ultimately in control by setting boundaries, guiding behaviour, and communicating openly.

“I did have the conversation about erm, it’s okay to like try it a little bit but don’t let it lead on to other things and don’t be pressured by other people”

This demonstrates that families are sites where parents are not only responsible for monitoring and regulating their child’s behaviour, but their own also through self-surveillance and confession. This self-responsibilisation emerges in the confession of not meeting these internalised expectations, for instance in not being sufficiently vigilant in recognising the substance use initially. Jane describes this, as she confesses to not knowing immediately that her son was using cannabis

“My first reaction to it was a gradual finding out I think, so when he was first doing it I didn’t know immediately I didn’t know for a while”

Understanding behaviour in terms of normative assumptions of expert medical and developmental discourses featured throughout the analysis. This served to produce the informed parent, demonstrating reflection and authority from these dominant discourses to defend or explain past (in)actions. It also constitutes the present informed parent as being in a process of learning and improving as a parent, a socially acceptable position. Dahlstedt & Frejes (2014) argue that a neo-liberal ideal parent is constantly in a process of self-development and self-improvement, and these shifting subject positions enables the production of this parent

in line with this neoliberal 'ideal', despite confessing to what might otherwise be perceived as failure. An example is.

"I think I made the mistake of thinking he would just grow out of it"

This extract also draws on ideas of developmental phases which contain behaviours which will be grown out of as a child develops and is also an illustration of how expert medical and psychological ideas have become taken for granted ways of understanding adolescence. It is almost a resistance, framing it as a mistake made by the parent to believe the assumptions of the discourse, a misattribution of a developmental explanation for the behaviour seen. But in using this reference, the shared understanding which makes it make sense reinforces the inherent assumptions of the discourse.

Disciplinary power is operating through surveillance predominantly, but also through a form of normalisation, shaping behaviour that is accepted within the home, but setting or allowing alternative norms or standards for outside of the home. Susan recounts how she remembers her thought process at the same her husband and her were considering telling their son to move out if he did not stop using cannabis. Susan describes a sense of only having control over what happened in her house.

"If he's doing it anyway he's gonna do it wherever he wants even if he doesn't do it here and it's that loss of control I think and knowing that, as an 18-year-old lad that the time by then he could do whatever he chooses to do we can only try to control what he did in the house"

There was also resistance to the parental control discourse, which shaped a subject position of helpless or disempowered parent. These subject positions emerge from actions taken to address experienced challenges to parental control, in expressions of perceived loss of parental authority and control. Here, Claire expresses this, what she felt was an impossible dilemma of how to respond without any sense of control, by shifting outside of her story momentarily to reflect in the present moment

“Yeah of course I worried but also...there's only ...well what do you do, you know, lock him away?”

This parental authority discourse seems to create a binary of control or failure which does not make room for other factors which may play a role in ASM, such as poverty, social inequality, or experiences of trauma. It also has the effect of reducing the agency of the adolescent into passive subject positions or vulnerability, where ASM is done to, rather than chosen. By minimizing the agency of the adolescent in choosing ASM, it has the effect of limiting the possibilities requiring agency for recovery. The analysis also identified the reflection of an internalised ideal parent through the confession of delays in recognising ASM. Choate (2011) found “Many parents got diverted into believing that the problems must be something other than drug use” (Choate, 2011:1362), typically attributed to adolescent behaviours which are legitimised by wider developmental discourses. This delay in realising that their adolescent was using substances, or that the use was not just a one off, is consistent with previous studies of parental experiences.

“My first reaction to it was a gradual finding out I think, so when he was first doing it I didn't know immediately I didn't know for a while”

A moral failure discourse is drawn upon to emphasise key moments in the narrative, for instance when substance misuse was discovered, moments when judgement is anticipated and there is a need for informed self-reflective parent position to narrate from to observe and question the actions of her past self. Here Jane uses this discourse to produce a reflective informed parent position from which to demonstrate incredulity at what she constructs as actions consistent with a past naïve parent position. She reflects.

“So, I felt at the time, I'm not happy about this, but I didn't feel as, you know like, this is a serious problem, and I didn't feel I needed to intervene sort of thing. Which now I'm saying it, and I've thought about it a lot afterwards and I thought, am I stupid? Am I irresponsible?”

This fear of risk discourse produces an emotional subjective experience of fear and worry and legitimises parenting supervisory practices such as observation and monitoring behaviour, which impact and influence the routines, interactions and relationship between adolescent and parent. These practices can distance the relationship and interactions even further from normalised ideals internalised from other societal institutional discourses such as mental health, developmental and parenting, and education. Demonstrating this subjective emotional experience of worry and fear in justification of these changed practices is therefore appropriate and produces a responsible parent meeting the ideal expectations for care, love, and concern, and highlights attempts to meet the obligation to prevent ASM and protect their child. It also produces all and any substance use as dangerous, immoral, and high risk. Contradictory but persistent parental subject positions are produced by this discourse, which characterise these narratives throughout as parents shift between them, including that of helpless parent, and protector parent. Adolescents too are constructed simultaneously in conflicting ways, as vulnerable from genetic inheritance and social contagion, but also resistant to being controlled and unmanageable, both requiring protection but being unprotectable, at risk and risk taking.

4.5.3 Parent relationships

It seems it is only through adopting different subject positions that a parent can express their conflicting subjective emotional experience. Susan describes how she spoke with her son about his use of cannabis and focused on not doing it in her house and how she disliked the smell, rather than any other concern she felt about the substance use itself. In doing so is able to express personal disgust, for the smell of cannabis, alongside her own sadness at having to address asking her son to leave their house, without constructing her adolescent as unwanted or rejected, so remaining loving and concerned in line with an ideal parent whilst taking action she expresses as finding heartbreaking.

“Because I’m not having you sitting there smoking weed for hours and coming back smelling of it, I don’t want it in the house, [...] and I have to say I agreed with his dad, and it was heartbreak hotel”

The damaged character discourse constructs the past and present adolescent and parent. Adolescents are constructed as changing into a stranger because of substance use, and parents’ past selves are discursively framed as confused, betrayed, and powerless because of this change. Present parents are constructed as more informed, and sometimes reformed, at once articulating an expression of guilt but also resisting complete accountability, an ambivalence which is captured by Jane when she says,

“And I think, partly, I feel a bit like it must be a failing, partly, on my part”

This sense of moral failing emerges in constructions of, and maybe by association becomes attributed to, past parental relationships and conflicts. The moral failure discourse was drawn upon by Jane again as she structured her narrative in a way which by implication lends causality to a previous event. Here discursively Jane frames the moral failings in terms of the break-up of past relationship, and in doing so positions the narrator outside of it, an informed parent narrating past deviance. From this position, it is possible to make this confession, describe the failings of their past self and maintain a present position which is closer to the internalised ideal and maintain respectability. Shifting between these positions, and framing a confession in this way, this discourse reinforces the assumptions, values, and expectations which provoked the feelings of failure and reinforces the ideal.

“even if me and his dad were together and we were all happy families and everything was all hunky dory, would he have still done it I don’t know I think it’s just sort of the unknown I suppose you could say that about parenting full stop though can’t you, if this hadn’t happened would this have happened, you know erm, yeh I don’t know, I don’t know, I feel erm I don’t know I really don’t know”

This extract demonstrates another characteristic of use of this discourse in the narratives, in particular the reference to what cannot be said. The repetition of I don't know here serves to highlight that the speaker is struggling to put into words some aspect of their subject experience. The expert discourse of parenting is drawn upon but is resisted through irony and childlike speech; hunky dory, and all happy families perhaps functioning to subtly subvert the assumptions underpinning the ideal parent these discourses construct. The subtle challenge is shrouded in doubt and now knowing, and is spoken with hedging, and tentative repetition indicating thinking out loud, and prompts the question, what cannot be said from within these discursive resources?

The hierarchy of priorities was a discourse which produced a parent position from which relational priorities overwhelm social, moral, or even to some extent legal, responsibilities. It offers subject positions such as liberal parent and accepting parent which offer a qualitatively different emotional subjective experience to positions of enabling parent and not coping parent. These subject positions allow discussion about hypothetical alternative priorities, placing a parent's moral duty to prevent or intervene in substance use along a continuum of personal priorities. The discourse does not resist the underlying assumptions of parental moral responsibility inherent in the main three dominant discourses, but it does seem to produce positions which can sit alongside these responsibilities and relinquish some duties of surveillance or control without completely relinquishing all their internalised values or ideals. In doing so this discourse offers the opportunity for parents to shift positions to one in which they can express and experience themselves as loving parents without needing to experience or express as much guilt or shame. It also allows for exploration of other perspectives of substances and their use. But it seems an uncomfortable position to adopt, evidenced by how it is so tentatively expressed.

“I hate to say it ... it sounds crazy but he’s more fun to be around when he’s a bit you know, and yet, its wrong, but I am well past allowing it to come between me and him and our relationship”

This discourse offers other ways to talk about the ASM which does not prioritise it over other aspects of the adolescents and family life, tentatively re-ordering priorities to consider more complex or nuanced difficulties they may have been encountered, or indeed played a part in turning to substance use, and positions the parent-child relationship as more of a priority than unwanted substance use, as Susan hints at when she says;

“there’s been other things in his life that have been harder, that are harder for him, and make me sadder, so I have not allowed it to affect my relationship with him anymore”

This reprioritising the parent child relationship over the ASM may be a subtle subversion of the discourse which has produced difficult positions to occupy throughout the narrative. It may offer a narrative conclusion, a way of justifying tolerance and acceptance of something that is not legally tolerated or accepted socially. It may be a tentative compromise to enable the parent to return to a more acceptable position morally and it may function to alleviate the anxieties of not meeting internalised standards, as Susan says.

“On some levels his reality is his reality, and the fact he’s, he doesn’t hide any of it from me, allows us to still rub along very well together”

4.5.4 Moral Failure

The moral failure sub-discourse constructs substance use as both preventable and deviant, outside the norm of adolescent behaviours, and constructs parents as both physically and morally responsible for its prevention, monitoring, and cessation. This moral failure sub-discourse adds to the damaged character discourse by producing the position of failed parent, who has not prevented the character damage through sovereign control and discipline. The moral failure and damaged character sub-discourses are similar, but the failure inherent in this

sub-discourse is predominantly attributed to the parent as a person rather than the role, reinforcing and prioritising moral implications of failure over familial, personal, health, social or legal. There was evidence of a discursive performance of an ideal neoliberal self-responsible self-surveillance through framing the talk about ASM through the lens of a responsible reflecting citizen, taking time to contemplate the events and actions of their past self, as Eloise began her account with,

“And I was thinking about this the other day actually”

Together the discourses of moral failure, damaged character and shame and stigma interact to construct ASM as a moral crisis. These discourses contain and construct inherent assumptions and judgements which construct ASM as a moral failing on the part of the family as regulating institution. It produces the adolescent as a different person, and the parent as coping, who through their self-surveillance, confession, and acceptance of distress maintains the appearance of respectability and is saved from the only alternative, and intolerable position, of not coping. The intolerability of the positions available was often constructed in the narratives by parents prefacing their talk with phrases which demonstrates this anticipated universal judgement had been internalised completely as self-judgement.

“This sounds a really horrible thing to say, and I hate myself for allowing it”

The moral failure discourse constructs the family in terms of a morally guiding and regulating institution and produces a failed parent who is expressed through confession of self-surveillance, an emotional response of shame to demonstrate moral failure, and expression of an awareness of stigma. Susan describes how she fears how others might see her son, as just a substance user, and not see the other aspects of his character or value, and in doing so constructs an anticipated judgement from others.

“it’s almost like people’s perception I think, not everyone, but a significant amount of people would, would, label him as something I don’t think he is, erm, because of the rest of, who he, because of how he lives the rest of his life, you know, his responsibilities, his love, his capabilities, you know the way he’s, yeh, he’s such a good guy, he’s focused, he’s caring, he’s got so many good things about him that I think if you were very anti-this thing, you would brush to the side, and that would kill me if I ever saw anyone do that”

There was evidence that a confessional mode was used to enable ASM as a personal failure, not just a failed parent, but a deeply personal, emotional, subjective experience of guilt. Anticipated judgement is also found in the construction of the narrator as reflective parent, a position from which a process of self-surveillance against internalised social expectations can be confessed and also demonstrating how these values are intrinsic to and actively constructing the individual’s identity, not just the parental role. In this extract, Jane questions not just about what is or is not done, but about who she is.

So, I felt at the time, I’m not happy about this, I didn’t feel as you know like this is a serious problem and I didn’t feel I need to intervene sort of thing. Which now I’m saying it, and I’ve thought about it a lot afterwards and I thought am I stupid? Am I irresponsible?

Jane constructs a profound subjective experience of guilt alongside constructing a reflective and responsible parent, but she also emphasises that substance use is significantly different to other challenges parents may face, constructing ASM as a destructive force in their lives.

“I think as a parent you, if there’s substance misuse involved, I think it makes you feel like somewhere at some point you’ve done something wrong as a parent. Substance misuse it makes me feel that was it a reaction to something you know, if you know, me and his dad hadn’t had divorced, was that a trigger, I don’t know, I think it just makes you feel more guilt, it heaps guilt, you feel guilty I think more so than natural parent guilt”

The expression of guilt, as evidence of moral failure, is indicative of how these norms and expectations are internalised and not achieving them is experienced as an emotional

personal experience, the strength of which can be understood as being linked to the parent's perceived level of conflict with or failure to meet internalised values.

Jane draws on an understanding of motherhood assumed to be so widely shared, and in doing so, makes explicit an underlying assumption of anticipated universality of this experience of worry. She draws on legal expert discourse as well as parental control discourse to reinforce as assumption that parents are morally responsible for bringing up legally responsible future citizens, showing an awareness of legal classification of drugs. However, there is irony in this extract, as Jane later describes just how devastating the impact of cannabis use is upon her son's life, in particular as his bipolar escalates because of it. Jane is actively reconstructing her past self as naïve, for believing that 'class A' drugs were the 'nightmare' and that 'just cannabis' was not as worrying, and in doing so constructing her current self as more knowledgeable, more informed, and more responsible.

"of course, I worried that it would get excessive, and obviously every mother's nightmare of all the horror stories that you hear, and that it would escalate into you know, class A, and at first I didn't worry that it was just, just cannabis"

The moral failure discourse constructs all adolescent substance misuse itself as always a morally deviant behaviour, allowing for no other position, context, or classification. It constructs the adolescent user simultaneously as both a vulnerable child and a potential criminal or at least an excluded deviant from what is acceptable behaviour. From this discourse emerges a subject position for parents of protector parent, closely aligned with vigilant and authoritative parent, respectively. internalised values and responsabilisation cause an emotional subjective experience, particularly of guilt, confusion, and uncertainty, here described by Jane

"whereas the substance misuse I think there's a real and maybe this is why I don't talk about it much to people as well, because there's more of a stigma there, because if you have a child who is using drugs it just feels like, I think it feels like well you've done something wrong because why's your child using drugs, it is a stigma thing, maybe less so with weed, I don't know, I honestly don't know"

These positions allow for the narrator to express care and concern about the reputation and care of their child, and to describe their positive characteristics, enabling them to frame their child as a different person to the substance user that is simultaneously being constructed. This allows for the expression of protectiveness of their child whilst not condoning the substance user, as here Susan says.

“I’m a bit embarrassed by it and I don’t want people to think badly of him because he’s such a good lad. I would hate for someone to de-value him or think less of him, that makes, that worries me sometimes”

This discourse constructs the judgement as external, however, to take up one of the subject positions it makes available requires internalisation of the values and responsibilities inherent within, which confronted with differences in reality from these ideals, results in a subjective experience of worry or fear.

4.5.5 Parent subjective experiences; shame, stigma, and coping

A moral failure discourse also makes available a subject position of reformed character and informed parent. These positions offer the possibility of change, growth, or development for the parent, and are often constructed through expressions of guilt or shame about past inaction. This often referred to demonstrating a questioning of whether family dynamics, particularly parental relationship, or conflicts, may have contributed to the onset of substance use. In choosing to outwardly perform questioning this, Jane seems to anticipate judgement, criticism, or blame from others.

“Substance misuse it makes me feel that was it a reaction to something you know, if you know, me and his dad hadn’t had divorced, was that a trigger, I don’t know, I think it just makes you feel more guilt, it heaps guilt, you feel guilty I think more so than natural parent guilt”

Adopting the subject position reformed or informed parent allows the narrator to demonstrate self-reflection upon internalised values, expectations and responsibilities of this

subject position which result in the subjective experience of feelings of guilt. Reflecting on their past actions, and confessing feelings of shock, shame, or guilt are often framed by hedging, repetition or pausing before speaking, or prefacing aspects of the story with qualifying or anticipatory justifications. Jane construct her present self as a self-monitoring parent whilst describing her emotional thoughts about the past,

So, I felt at the time, I'm not happy about this, I didn't feel as you know like this is a serious problem and I didn't feel I need to intervene sort of thing. Which now I'm saying it, and I've thought about it a lot afterwards and I thought am I stupid? Am I irresponsible?

and Susan described how her own awareness of the substance use developed through her reaction to social systems and practices, for instance communication and interactions with her son's college,

"We had a couple more to-dos at college where I was called, parents, which was always me went in for a discussion, so it was definitely a thing by then, there's no point denying it"

A shame, stigma and blame sub-discourse within the wider moral crisis discourse is central to the construction of the subject positions coping parent and its opposition not-coping parent. Disciplinary power operates through the mechanism of shame, enabling a position of coping parent to be adopted, when confessing to deviance from the normalised ideal parent position. Enacting self-surveillance protects a position of informed neoliberal parent, implies change and insight, and prevents having to adopt the subject position of a not coping parent, an intolerable morally inadequate and powerless position which implies vulnerability to state intervention and social stigma. This makes only certain ways of being possible, withdrawing or adapting -either of which could be positioned as failing and not-coping, or coping. Eloise reflected back on her experiences with a sense of resignation.

"I suppose because what choice do I have you know, how do I not cope with it, there's literally nothing else I can do apart from cope with it"

From this coping position, it is possible to shift to a position where one can acknowledges distress as an expected and appropriate state for one who is not yet not coping but is produced by discourse as morally failed parent. Coping can then include not making changes but tolerating, accepting, adapting, or even withdrawing. Annie is not complacent about the positive changes her son has been able to make but holds a lingering fear for the future.

“I mean I will never ever be as complacent to say it’s all gonna be fine, because it could all go horribly wrong tomorrow, and I accept that”

This discourse operates in combination with other wider discourses of parenting and development to construct a subject position of educated parent, an ideal who possesses knowledge of adolescent development, parental responsibilities, and parenting skills. The vigilant, coping, and educated, parent subject positions all carry the responsibilities of risk management, behavioural control, and moral guidance, delegated to families by these discourses, thereby reducing the expectation of external or state support to perform these moral duties. To be categorised not coping is inherently as shameful as it is irresponsible. This is thus a subtle technique of governance through disciplinary mechanisms of normalisation and subjectification, which result in the subjective experiences narrated of coping alone, limited opportunities to seek help, and parents disavowing the need for help at all, as Jane says.

“I suppose it didn’t occur to me to be honest to seek support, because I thought well he’s now an adult, what support am I going get, what am I going to get for him, and it didn’t occur to me to get support for me, it literally didn’t occur to me”

The coping parent must not only cope but demonstrate emotional regulation and containment, they can narrate distress within the limits of their own containment, even when the emotional distress is ongoing and significant. The feelings of doubt and exhaustion can

only be expressed within a wider frame of self-containment and coping, to do otherwise, to seek support or need help in some way is an impossible position, risking becoming the not coping parent which carries with it implied irresponsibility, weakness, and moral failure. In producing this position, this discourse silences support seeking behaviours and interventions which might address other external factors. It limits what can be said, and influences and shapes how emotional experiences are narrated and experienced. Ultimately to remain a good parent this position normalises a hidden endurance without any expectation of support.

4.5.6 Implications for Counselling Psychology

The use of these dominant discourses by parents reinforces and sustains ideals, norms, and expectations, which normalise coping with extreme levels of distress where there is ASM. For counselling psychologists working with individuals, it is likely that the shame and stigma associated and experienced by these individuals would be a barrier to their engagement not only in treatment programmes with their child, but in their own individual therapeutic process. Whilst there are significant implications for ASM family treatment programmes which involve parents, there are also significant implications for all counselling psychologists who's client may be a parent, whether they have sought therapy for any other presentation, such as depression or anxiety. The effects of ASM upon family members are vast and often not short term and evidence from this study suggests they become something that has to be 'coped' with, rather than something parents feel empowered or able to immediately change. Therefore, being aware of how the dominant discourses construct the shifting positions for parents and the ideals and norms they reinforce could be vital to engage with how ASM may show up in individual therapy sessions, and to be able to respond therapeutically without further reinforcing or sustaining those underlying assumptions and unintentionally adding further shame.

To summarise, three dominant discourses of risk management, moral crisis, expert science, and potential counter discourses of hierarchies were identified as constructing

adolescents, substance use, and parents roles, identities, and subjective experiences of ASM in the narrative accounts of the parents in this study. Each construct was explored in terms what values and ideals it normalised, and what limitations and possibilities were made possible. This was then explored in terms of implications for Counselling Psychologists working with individuals, and with families where there is ASM. The next chapter will explore these findings in the light of previous studies of parental experiences of ASM and considers how they may contribute to improving practice in Counselling Psychology and ASM treatment models..

Chapter 5. Discussion

In the previous chapter I considered how dominant discourses interacted to create key constructions of adolescents, substance use, and parents, and how these constructions offered subject positions which enabled parents to negotiate their experiences of parenting where there is ASM in the family, both resisting and reinforcing assumptions and implicit ideals inherent in those discourses being drawn upon. This chapter discusses these findings further in terms of the operation of power upon and through families, and in the light of previous research, and further consider implications for professional Counselling Psychology practice.

5.1 The Family as a regulatory institution

Taylor (2012) outlines how sovereign power is constitutional and often founded on a blood-right, a founding precedence in the past that justifies the sovereign's power. Parents' authority over their children is often a blood right (Taylor, 2012), and sovereign authority makes possible care and control practices such as boundary setting, discipline, and education. Although the role of parents has significantly transformed in the last century (Maltman, et al, 2020) with shifts in family compositions and dynamics (Kloep and Hendry 2010; Smith and Estefan 2014), the assumptions underpinning the dominant discourses found in the narratives suggests an assumption that a level of sovereign power is still operating through families. The analysis identified constructions of loss of sovereign power, usually framed in a demonstration of humour, sarcasm, or exasperation. This seem to demonstrate the presence of an "expectation of parental surveillance and control" (Haines-Saah, et al., 2019:133) and an underlying assumption of sovereign authority. Sovereign power most commonly was identified operating through the discourse of risk management and parental authority, particularly with regard to keeping the adolescent physically, mentally, and emotionally safe. This reinforces the concept of family as a regulatory institution and a sovereign expectation of parents to uphold the

delegated responsibility to maintain societal standards within the private sphere of the family. Parents lament a perceived loss of sovereign authority, assumed to be held by a responsible parent position, in their confession of failure to control, prevent, or intervene to stop ASM effectively. In using these discourses, parents can only occupy either responsible / authoritative or irresponsible / disempowered parent positions, as by resisting one position they constitute themselves as the other. This move to a disempowered position to highlight how authoritative parent practices were attempted but did not have an impact expected, seems significant and potentially reflects a level of anticipated blame, pre-empting judgement by giving evidence of attempting good practice. This gives the disempowered parent a position where authority has been taken away, rather than one where authority was never present, constituting a past self in the authoritative parent position, and framing the substance misuse itself, or possibly the substance user, as the trouble, rather than the parent. Flensburg et al., (2022) found that parents often give excuses or justifications demonstrating anticipation of such judgement. Explicitly sharing acknowledged good parenting practices, and shock at their ineffectiveness in the face of ASM, draws upon what is socially considered to be good parenting (Lind, et al., 2016; Flensburg, et al., 2022) enabling the narrator to retain a position of informed parent whilst narrating past (in)actions which may not be consistent with expectations of this position.

These discourses combine with those of expert health and neuroscience where governmentality is achieved through a parent feeling it is their concern, and their shared knowledge of delegated social responsibility. This is (re)constructed by the use of these discourses, which are drawn upon to explicitly construct a subjective emotional response to not meeting these responsibilities through recognised and socially approved appropriate parenting practices. It seems crucial for Counselling psychologists to recognise and acknowledge this regulatory position and the complex social, political, and cultural role that parents are designated, as this appears significantly and directly related to the experiences of shame and

stigma parents are experiencing. This implicit, taken-for-granted, shared assumption may not be spoken explicitly, but if these implicit cultural demands are ignored or remain unspoken, invisible, and unchallenged, they may be inadvertently reinforced, having the effect of adding further shame or blame, with detrimental effect upon therapeutic relationship, and outcomes of counselling psychology practice.

I have outlined how sovereign power may operate through the family as an institution of governmentality and identified the mechanisms through which disciplinary power operates both upon and within families. I will now explore further how disciplinary mechanisms of self-responsibilisation, self-surveillance and shame are demonstrated through confession and how dominant discourses interact to produce different subject positions from which parents negotiate the narration of their experience and constitute their past and present selves.

5.2 Parents identities, relationships, and parenting roles

Disciplinary power was identified as operating through the mechanisms of self-responsibilisation, self-surveillance, and confession (Foucault, 1976) in the analysis. The subject is not fixed but occupies positions which can shift, can be fluid, and sometimes contradictory (Arribas-Ayllon & Walkerdine, 2008). This was identified within the analysis, as parents used available discourses to shift subject positions in order to negotiate the often contradictory and conflicting experiences of parenting where there is ASM. Having to shift positions to mediate conflicting responsibilities and concerns, such as wanting to care for and nurture their child, protect their child, but also uphold legal and moral duties to put in place boundaries and uphold societies expectations. Shifting positions enables, and is accomplished through, confession. The confessions in the narratives show this dynamic, constant negotiation of positions, and also demonstrate how culture discursively gets inside individuals, shaping our “thoughts and feelings and producing our self and identity” (Riley, et al., 2021:289). The confessional mode is performative because it is not just a private confession of moral lapse,

but a public claim to moral legitimacy. (Dahlstedt & Frejes, 2014). Haines-Saah (2019) also found this, that when adopting a discourse of parental surveillance and control parents would self-blame, and by doing so claim moral legitimacy by recognising and acknowledging anticipated blame. There is evidence of this in the analysis, particularly in the use of damaged character and moral failure discourses. Haines-Saah, et al (2019) points out that individuals are not simply “discursive dupes” (Haines-Saah, et al., 2019:136) just inhabiting categories or identities, but actively construct their story, with agency, choice, and intent. The inclusion of excuses and justifications reveals parents felt they needed to legitimise or explain past (in)actions (Flensburg, et al., 2021). Confessions implicitly acknowledge a deviant choice by providing a rationale for the decision which aligns with other, perhaps conflicting, parental responsibilities such as risk management, or safety, and is therefore credible. Being able to confess this deviance, from a position of informed responsible parent, reproduces the parent in line with neoliberal qualities, demonstrating self-development and self-governing of behaviours. Although confessing demonstrates appropriate moderation of behaviour and serves to alleviate feelings of shame, it also reproduces the regime of truth upon which the shame is built.

Risk management, parental authority and control, and moral crisis discourses colluded to create this self-responsibilisation of parents. Self-responsibilisation is the taking up of inherent responsibilities of subject positions adopted and involves the internalisation of norms, which through self-surveillance governs and monitors behaviour (Foucault, 1976), by creating a desire within people to not deviate from the norm. the normalisation, “a core component in governmentality, the process by which governments create desire in people to “choose appropriately.” (Riley, Robson, Evans, 2021:289). These normalising judgements (Foucault, 1975) are intrinsically produced by the discourses which create these subject positions.. The process of normalisation is evidenced in the analysis, as parents narrate their adherence to

internalised ideals of parent, family, and adolescent, evidenced frequently through the use of expert discourses to present examples of good parenting practices (Bae, 2016) such as building their child's self-esteem or warning their child of dangers of substances. There is also evidence of the process of self-surveillance, reflection upon and moderating of individual choices of behaviour in the parents accounts. The risk management, parental authority and moral crisis discourses combine in this extract to construct a loss of parental authority which requires an alternative approach, and a reflecting responsible parent who is mediating between legal, social, and risk management which are 'taken-for-granted' internalised responsibilities. For Counselling Psychologists working with parents, these unspoken 'taken-for-granted' responsibilities may be so embedded and assumed within talk about family and within family practices, that without explicit exploration, therapeutic process is skimming the surface of socially constructed ideas, core beliefs about themselves, their identity, their experiences, rather than making the process and socially constructed natures of these beliefs transparent, and enabling a shift in perspective or change to occur.

Jager (1991) found that the order events are narrated can indicate significance to a preceding event. There was evidence of parents recounting ASM following parental conflict or separation,, implicitly connecting them and assigning responsibility to the latter. There is evidence of normative ideals of parents relationships inherent within expert developmental discourse, and assumptions about impact of parental conflict or separation, collude with contamination and risk management discourses in order to understand the significance of the need to confess the parental separation as a potential contributory factor in the ASM. These findings suggest that parents are inhabiting a shifting array of positions and having to negotiate conflicting responsibilities and norms, causing considerable stress at a time when parents are already experiencing heightened distress and loss of past norms in their relationships, home life, and sense of self. For counselling psychologists, understanding the requirement for these

shifting positions but also recognising and explicitly validating the difficulties inherent in these shifts for parents is vital, for parents to feel fully heard and seen in any therapeutic process undertaken.

5.3 Constructing the adolescent substance user as a stranger or an addict

*“And I thought, for a period, I just thought, you’re not who I thought
you were”*

Studies have identified that parents express a moment of “painful realisation” (Usher et al., 2007) following an often drawn out and confusing period of discovery, when parents “stopped seeing the child they had known before” (Choate, 2015:465). This included time taken to confirm suspicions, struggling to set limits whilst dealing with behavioural consequences of ASM at home, and living with blame and shame; all whilst “experiencing an overwhelming loss of the child as they once knew them” (Usher et al., 2005: 427). This experience of alienation from their once well-known child is constructed in the narratives and performs an essential function in the creation of the adolescent, and the substance using adolescent in particular, as a different person to their known child. This opens up a shift in subject positions for the parent, producing the narrator as an unrelated observer from where they are then able to describe concerning behaviours without blaming their child. These constructions of their adolescents serve to produce them as a transformation of their child into someone different and can be understood as a mechanism for managing the experience of shame, and one through which both biopower and disciplinary power is enacted. It also attributes the behaviours of substance misuse to this unknown substance user, protecting and maintaining the moral acceptability and character of their child. In constructing the adolescent as someone else, this offered the opportunity for the expression of betrayal, horror, disgust, or anger, towards this unknown substance user that would otherwise be difficult or unacceptable to express towards their child from the position of loving parent. Here biopower is producing the assumptions

necessary to make sense of these experiences from this subject position, working upon and through the parent.

In my analysis, a fear of risk sub-discourse in particular produced parents as agents of biopower, responsible for regulating, monitoring, surveilling and intervening in the health and physical safety of their children from within the family sphere. Parents become agents of biopower as they mediate between social expectations and their children's behaviours. This form of power continually interacts with operating sovereign and disciplinary power, as parents negotiate state requirements, family routines, and personal expectations. Haines-Saah et al (2019) found that many of the parents in their study referred to scientific studies in their answers, particularly around teenagers developmentally. They argue "in these instances the normal, healthy, and developing adolescent brain is viewed as at-risk" (135). Inherent in this regime of truth is that the "adolescent brain development is seen as a linear process, and parents protecting young brains ensures their productivity and longevity" (Haines-Saah, 2019:135), along with the idea parents were responsible for future generation and that "cannabis use may threaten the health and the potential of the future generation" (Haines-Saah, 2019:135) aligns with a biopolitical orientation. Haines-Saah et al., (2019) write about the "emerging governance of parents and their children within a medicalized model of adolescent cannabis prevention" (p135). They go on to highlight how biopower operates "under the guise of empowering people" (Haines-Saah, 2019:133). The operation of biopower can be identified through medicalisation of substance misuse, and use of health and treatment discourses which construct it in the narratives. Through the use of these discourses and practices, parents become agents of biopower, not just subject to it. The analysis found evidence of both biopower operating particularly through the constructions of the deviance associated with ASM, as an illness or a disease, rather than a crime. Parents take on responsibility for health risks and physical risks associated with ASM and this is evidenced in the analysis in the use of risk

management discourse as well as drawing on expert /science discourses. The expert discourse produces parents as releasing some responsibility to experts, for guidance, advice or potentially treatment, and framing confessions in medical / addiction terms.

“I don't know if I am enabling her, possibly I am, possibly I am this massive enabler”

For Counselling Psychologists, the operation of bio power is significant, as psychology is one of the expert discourses which may be drawn upon within the medicalisation of ASM and pathologisation of families (Bae, 2016) within ASM treatment discourse and practices. The medical model reinforced through addiction constructions of substance use, and developmental constructions of adolescence, are examples of bio power in operation. This positions parents as agents of bio power, with assumptions and shared understandings of ASM created by these discourses reinforced and sustained by their use. This produces yet another shift in subject position for parents to negotiate, which further conflicts with their internalised legal, moral, and social ideal roles. For Counselling Psychologists, being aware of the assumptions which underpin the medical, developmental, and therapeutic theories is essential as by using these discourses,, parents are reinforcing these assumptions which may be sustaining a perspective of parental blame, whether through inherited genes, early childhood unmet needs, or what has been constructed by these discourses as ineffective parenting. Making these explicit and challenging their legitimacy may be transformative in terms of the parents experience of support. Dominant discourses will position the Counselling Psychologist, along with other key practitioners, as experts, and this may have significant implications for the establishment of therapeutic relationship, collaboration, and therapists engagement empathically with parents (Bae, 2016).

5.4 Discourse of hierarchy: resistance, reinforcement, or negotiation?

Foucault also argued that all discourses necessarily produced their own counter discourses, Foucault “where there is power there is resistance” (1982:794). In this study, a fourth discourse was identified which appeared on the surface to fit the criteria of counter discourse, one that positioned substances, and legal and personal priorities, not within distinct categories, such as legal or illegal, but within hierarchies based on other concerns or characteristics, such as potential impact on life or health. Emerson (2015) states: “A problem is created in an interactional process which affects and moulds the definition of what is happening” (Emerson, 2015: 256). How the problem of ASM is defined is crucial to the potential roles available and opportunities for solutions (Bacchi, 2009). Research has identified that parents may minimize, deny or even normalize the substance use as part of the adolescent experience (Barton, 1991) in resistance to discourses which might otherwise construct ASM as pathologizing and stigmatising. This minimizing was identified in the analysis as in this example, where framing substance misuse as a lifestyle choice position both the user, and the parent, at least temporarily, differently. This construction of substance misuse in this extract attempts to subvert assumptions of developmental discourse and tentatively draws on a hierarchy discourse which places some substance misuse within the realm of acceptable lifestyle choices, as Susan recounts,

*“I realised that it wasn’t, that it was more a lifestyle choice than just a
‘let’s do it because we’re young and bored”*

Framing substance use in these terms is an example of how the hierarchy of substances sub-discourse which permits ASM as a lifestyle choice, a temporary alternative position to adopt to demonstrate a current position of having learnt from this experience. It also leans on nuanced understandings of expert / parenting discourses assumptions about adolescence which might suggest its ‘just’ a teenage solution to boredom. This temporary position shift enables

expression of something which might otherwise be pathologized by expert discourses. It produces a reflective, informed parent, a position which then re-aligns with and is re-established within the dominant expert and legal discourses. There is also evidence of how dominant and counter discourses colluded in the analysis to provide nuanced subject positions from which to speak a subjective reality which for many was not the life they had envisioned (Gruber & Taylor, 2006:11, Choate, 2015). Annie (re)constructs her subjective emotional experience of embarrassment and stigma, (re)constructing the parent as knowledgeable and reformed and also (re)positioning them within the realm of loving, caring, responsible parent for prioritising the strength of character of her child above their substance use, when she says,

“I’m a bit embarrassed by it and I don’t want people to think badly of him because he’s such a good lad”

This is an example of how the hierarchical discourse permitted this negotiation of positions to frame the experience as one from which a parent can emerge as morally acceptable, and still own conflicting perspectives. However, the counter discourse can only make sense, and hold authority, because of its relation to the initial discourse. In this case, the countering of the legal parameters of drug classification is only made possible because these are more widely legally and culturally contested, providing a culturally and historically situated argument upon which to rest the claim. Whilst on the surface the hierarchy discourses appear to defy or resist accepted truths, in actuality they appear to only, but crucially, function to make possible subtly distinct positions for parents to adopt to negotiate an otherwise intolerable position (Orford et al, 1998; Pearson, 2000). Their use may therefore ultimately function to reinforce the values which drove the necessity for its existence in the first place. Or, it *may* make possible reframing of ASM, and potentially offer a way to recognise strengths, resilience, and resources within and beyond the adolescent and family unit.

For Counselling psychologists, counter discourses offer a way in, in terms of how conflicting needs, responsibilities, and values, can be explored in therapeutic collaboration. Recognising when these are drawn upon in talk can provide points to catch and reflect with individual clients, and families, on potential ways to reframe meanings and understandings which may have been key to underlying individual core beliefs, or familial relational patterns, and which may continue to contribute to ongoing distress.

5.5 Moral failure; shame, stigma, and coping

“I think as a parent, if there’s substance misuse involved, I think it makes you feel like somewhere at some point you’ve done something wrong as a parent”

Here, Jane draws upon dominant discourses to demonstrate confession through a subject experience of guilt and captures the overwhelming weight of stigma and shame associated with ASM. This feeling is in line with previous studies which identified subjective experiences of feeling blamed, shame and anticipating being perceived as bad or neglectful parents (Usher et al, 2005; Jackson & Mannix, 2003). These feelings can be confessed, as a technology of the self, because the present self is constituted as one who is reflecting on this past deviance from ideal, with insight and improved understanding. Indeed, the narrative accounts themselves can be viewed as confessional accounts, each an act of constructing their actions, memories, reasoning, and subjective experience; each a practical technology “for speaking the truth (Hodge, 2002; Wetherell, 1998) and which constitutes both a past and a present self. Studies have identified the profound emotional impact, isolation, and considerable stress-related difficulties that parents experience when parenting with ASM, including insomnia, anxiety and depression, and suicidal ideation (Groenewold, 2016; Orford et al, 2010). These intense and profound emotional experiences can also be seen in terms of being socially constructed, “The ‘position’ we occupy in the world creates our sense of self and creates certain emotions” (Hedges, 2005:44). Feelings and emotions invoke moral values,

which we learn within our family, community, society, and culture (Averill 1982; Lutz 1988; Harre and Gillett 1994; Harre and Parrott 1996). Where there is conflict between these internalised values and ideals, it creates a perpetual, intense, and profound emotional subjective experience. Hoech & Van Hal (2012) argue that “the reluctance to seek support is related to feelings about what it means to be a good parent and the shame that the parent might feel it if was known outside the family” (Orford, et al., 2010:9) and this study identified the construction of expressions of experience of shame, stigma, and guilt, predominantly through the moral crisis sub-discourses of moral failure, damaged character and shame and stigma. Flensburg, et al., (2022) explored parents’ experience of courtesy stigma (Goffman, 1963) in parents’ narrative accounts, suggesting it emerges in their feelings of isolation. This study also found evidence of discourses constructing emotional experiences of isolation which was framed more by constructing anticipated judgements of others.

Narratives “often materialise when there has been a discrepancy between people’s experiences of ideal and real, or conflicts between self-society” (Rimmon-Kenon 2002:25). The narratives by these mothers appear to have materialised from a sense of conflict from their endeavours to meet an internalised ideal and actual experiences of parenting. It is interesting that only mothers came forward as participants in this study and this too seems significant. Mothers have traditionally been seen as central in family life, and often therefore held responsible for, and directly blamed for its problems (McGoldrick & Walsh, (1994). Overall, the narratives uphold the stigma, shame, and blame which has been normalised by dominant discourses colluding to construct parents as responsible for the onset of ASM and primary agents of recovery. Therefore, this and other dominant discourses used in the narratives upheld normative assumptions of what it means to be a good parent, (Haines-Saah, et al., 2019) creating feelings of shame and stigma for not meeting this internalised ideal.

Flensburg, et al., (2022) suggest that parents enact what they perceive as expected of them. In confessing guilt and shame, and the events which are constructed as provoking them, the discourse of moral failure in particular permits subject position of reformed or informed parent from which the confession makes sense due acknowledged shared assumptions of moral responsibility. By confessing to failing to meet these but recognising it, the parent is constituted as self-governing and therefore responsible. The confession is to a failure to produce healthy responsible future citizens. There are significant normative assumptions (re)produced by dominant expert discourses of education, parenting, health, and therapeutic, including being unable to help someone who doesn't want to help themselves for example, which underpin understanding of the position of disempowered parent. Discourses which produce helpless addict and vulnerable addict positions also produce these as significantly deviant from neoliberal ideal citizens. They limit ways of seeing adolescent substance misuse into the binary positions of non-user or addict along with inherent normative assumptions about behaviours, productivity, and characteristics, that to be held responsible for producing the latter is produced as a failed parent, and a subjective experience of shame.

Shame functions here as a mechanism of disciplinary power. Parker and Aggleton's (2003) article on stigma and HIV links stigma and the production of power, asserting stigma is "central to the establishment and maintenance of the social order". (Parker & Aggleton, 2003:17). The expression of the experience of shame, is performative, a social act which performs recognition of a socially, culturally, and historically situated acceptable emotional response. Expression of shame in particular reflects how one's identity is so intricately linked to the internalised expectations of the self; not meeting these is not simply a failing of responsibility, but a failing in the self, linked intrinsically to the identity of the narrator. Guilt reflects deviance in actions, shame reflects deviance of character, someone who is not acceptable. Where this sense of conflict between internalised ideals and real experiences

perpetuates, dominant discourses collude in producing two noticeably clear binary positions for parents to adopt, that of coping or not coping parent.

Maltman, et al, (2020) identified two primary coping styles available to parents, holding on, and letting go. The first enables some to maintain a sense of control, the second, though a source of grief, enables some sense of moving on to focus on their own wellbeing. Choate (2011) found that parents moved between positions within their narratives, from enabling, ignoring, to confronting the substance use. This negotiation of subject positions is also identified within the narratives of this study, including positions of authoritative parent, to informed parent, produced by parental authority and therapeutic expert discourses, to vigilant and helpless parent produced by risk management and moral crisis discourses. Maltman, et al., (2020) suggests that parents moved repeatedly between these two positions when parenting with ASM, an exhausting dance of survival between only just caring for oneself and only just holding on to one's child. The discourses of parental authority, risk management only offer these binary positions and limit other possibilities for action making this shifting of positions necessary.

The implications of not coping are constituted from legal, social, and political discourses which hold within them implicit assumptions of state intervention upon the family if it is deemed necessary. This is not directly spoken which implies a shared knowledge about the not coping subject position which is almost intolerable to adopt as demonstrated by this extract. This implicit knowledge reduces options for intervention or parenting practices as an understanding of a good parent is produced as one who endures and manages. This in turn reinforces an internalised responsibility to manage and cope without seeking support, and a subjective experiences of shame for wanting or needing support and fear of being seen as not coping. It also reinforces the shared underlying taken for granted understanding of a good coping parent as enduring and managing therefore not requiring help or support, as Eliose said,

“I suppose because what choice do I have you know, how do I not cope with it, there’s literally nothing else I can do apart from cope with it”

5.6 implications for counselling psychology: working with individuals

Post modern thinking, and the theory of social constructionism has had an influence upon many different therapeutic models with which Counselling Psychologists may be working, in particular paying closer attention on the “here-and-now of the therapist-client relationship” Boscolo & Bertrando, 2021: 35). Villegas (1994) has pointed out that, between the 1980s and the 1990s, social constructionism influenced even cognitive therapy where the therapy process began to be considered as the creation of shared narratives, a collaborative story, which allows the client to create new ideas and images of themselves.

Evidence suggests these feelings of shame may prevent parents from seeking or engaging in treatment (Orford et al., 2010:9; Pearson, 2000), and this and other findings in this research have significant implications for Counselling Psychologists working therapeutically with individuals, and for those working with adolescents, and families, in the field of ASM. If parents have internalised an ‘ideal,’ they are positioned relative to this in their coping parent role, and may be unlikely to seek support, or feel able to engage with treatment which they experience as further reinforcing a sense of shame and blame for ASM. It seems likely Counselling Psychologists working with individuals may come across ASM working with a client who is also a parent and may be seeking support for other mental health concerns, perhaps for depression or anxiety. Due to stigma, and anticipated judgement, ASM may not emerge in initial assessments, making the establishment of a strong and attuned therapeutic relationship essential for this aspect of an individual’s story to emerge and be addressed. Internalised expectations and responsibilities will feel like, and will be expressed often, as individual beliefs and values. For counselling psychologists working across a variety of therapeutic modalities, recognising how these values and beliefs may have been constructed

and are maintained through social language and practices offers an alternative opportunity for insight and perspective taking which can provoke change, and supports the integration of narrative and discursive forms of therapy. Integrating a critical awareness of the social construction of ideals which individuals can take on board as an individual belief provides a way for intervention at a cognitive and behavioural level to have impact but also permits deeper exploration of how a client may be interpreting or attempting to adopt unrealistic norms or ideals.

Whilst the findings of this study supports the use of narrative therapeutic approaches, it would benefit the counselling psychologist working with many other modalities to critically reflect on the norms, ideals, and assumptions, inherent in the language used and practices of assessment, formulation, and therapy sessions. For instance, how do our questions shape and reinforce those unspoken expectations or ideals, and when formulating how much do we challenge underlying culturally or socially accepted norms. Evidence from this study demonstrates the dominance of particular discourses and the knowledge they construct is given privileged status, for example expert discourses from health, science, or psychology. How then, does this impact our therapeutic relationship, our ability to adopt a collaborative stance, and what is able to be shared, heard, reflected upon, and valued in our sessions. It seems critically important for counselling psychologists to be aware how those privileged forms of knowledge and underlying assumptions which they are grounded within may marginalise, silence, or subjugate other forms of knowledge, and may create the feelings of shame, blame, and stigma that these parents describe. It seems crucial that Counselling Psychologists have an awareness of how the dominant discourses collude to position the client constructing these experiences and may be contributing to their subjective experiences of shame, disillusionment, or pain. This may show up in individual sessions by exploring how clients distress is linked to unspoken expectations about their role as a parent or reflecting on the social interactions through which

these expectations are sustained. Vittorio Guidano (1991) suggests a technique of ‘zooming in and ‘slowing down’,’ to focus on small details of periods of their life to develop better awareness of their own internal narrative. Listening in to the discourse which emerge in our client’s stories can help counselling psychologists to collaboratively explore how these expectations and ideals are showing up for them. The findings also reinforce a need for Counselling Psychologists to practice with cultural sensitivity and to attend to the intersectionality of social factors such as race, class, or gender, and reinforces a need for robust self-reflexivity, to critically reflect and examine their own internalised norms and values and what each individual counselling psychologist is bringing to the assessment, formulation, or therapeutic relationship.

5.7 Implications for counselling psychology: working with families

Research literature tends to agree that there is a necessity for treatment to include family members and parents (Usher, et al., 2007). However, in order to actively engage in treatment, what seems to be needed in practice is potential for a position for parents from which they can seek help and a construction of ASM which considers that the impact of ASM on families is mediated by factors such as social class, age, gender, family position, place, and culture (Orford, 2017). Many counselling Psychologists work within drug and alcohol services, working with adolescents using predominantly psychosocial and cognitive behavioural approaches (NICE, 2007), and adopting a systemic approach to work with families where there is ASM. The findings of this study are relevant to two key models of systemic treatment for ASM: Behaviour exchange and Systems Therapy, and Multi-Dimensional Family Therapy. (Lewis, 2020; Liddle, 2010). The findings of this study support criticisms that normative assumptions and privileged forms of knowledge may shape treatment policies and may impact family therapy practices with families. This may have the effect of potentially creating therapeutic practice which risks dismissing other solutions to ASM which may be found outside

the family unit (Devaney, 2017). Whilst parents are constructed as coping or not coping, these positions limit and constrain viability of understanding, recognition and support for families which may inhibit their ability to engage with treatment programmes or to proactively seek support for, or to proactively intervene in a meaningful way to respond to their adolescent's substance misuse. In the context of the findings of this study, this would suggest that a way of accommodating or constructing multiple parent positions which are more complex and multi-faceted than the binary coping/not coping could be a meaningful and constructive consideration for treatment and support pathways. These findings align with Cottam & Espie's (2014) suggestion that policies which focus on quality of life, resilience, loving family relationships and relationships may empower parents to focus on inherent strengths of the child and the family in terms of adversity. This in turn may reduce discursive reliance on expert understandings which disempower and invalidate the parental experience, identity, knowledge, and strengths. It also suggests that there may be a role for Counselling Psychologists outside of individual or family treatment processes, and within a wider community policy development, to be part of beginning to address other factors which contribute to ASM.

5.8 Limitations of study

It is recognised that all participants were recruited from similar locations (geographically and socio-economically) in England, and that all participants were mothers.

5.9 Contribution to the field of Counselling Psychology

Counselling Psychology has a long tradition of supporting and advocating for social justice in UK and around the world (Winter & Hanley, 2015; Cutts, 2013; Kennedy & Arthur, 2014). Potentially, psychological research itself has also contributed to a poor perception of parents whose children use drugs, by historically referring to parents as inadequate in their parenting or blaming parents for perceived failures and dysfunctions that have contributed to their child's drug use (Orford, et al., 2010b), even when other studies have highlighted the

influence of peers, school socialisation and engagement, neighbourhood structure and social processes all influence the onset of ASM (Trucco, 2020). Counselling Psychology prioritises a commitment to empathic and collaborative engagement with clients based on humanistic values (Rogers, 1951) and as a profession is built on a foundation of “a humanistic and relational value system, which aims at the exploration, clarification, and understanding of clients’ world-views, underlying assumptions, and emotional difficulties that emerge out of our interaction with the world and others” (BPS, 2014:15-16). As Counselling Psychologists, the findings from this study highlight the role our own professional discourse of expertise plays in the constructions of identities, behaviours, thoughts, and subjective emotional experiences of individuals, and in the case of ASM, potentially contributing to the shame and stigma that parents and families may be experiencing. Counselling Psychologists therefore have a significant responsibility in their use of psychological language, educational and therapeutic practices, to attempt to disrupt or at the very least avoid sustaining normative ideals which may be perpetuating factors in emotional and psychological difficulties experienced by individuals, and families. Having a rich awareness of the role of discourse and practices in constructing ASM, Counselling Psychologists and other professionals in the field also have a rationale for becoming involved at a policy and community level, to begin to explore and address other potential factors which may be contributing to ASM.

Foucauldian theory suggests that “the “job” of psychology is to explore what “truths” are constructed in language, and their consequences for how people can understand themselves or others” (Riley, Robson & Evans, 2021:290). Counselling psychologists in particular “have a distinct role to play in providing much needed support and therapeutic services to parents and siblings focused on the myriad aspects in the relationship that have become distorted as a result of the substance abuse of the adolescent” Dykes & Casker (2021:233).

Devaney (2017) suggested that further study exploring the lived effects of the discourses which emerged in her policy analysis would be useful. It is hoped the findings in this study contribute to understanding “the constructed and political nature of the familial institution and its abiding and shifting investments in power struggles” (Taylor, 2012:215). Sugarman (2015) concludes, it is only by “interrogating neoliberalism, psychologists’ relationship to it, how it affects what persons are and might become, and whether it is good for human well-being that we can understand the ethics of psychological disciplinary and professional practices [...] and if we are living up to our social responsibility” (Sugarman, 2015:103). To do so, “we have to remember the importance of listening to our clients. Their voices should receive equal, if not greater, respect than the experts’ voices and should be listened to with care by all professional workers” (Boscolo & Bertrando, 2021: 40). It is hoped that the findings of this study will be disseminated through publication in the *Journal of Child and Adolescent Substance Use*, where it is hoped it will reach Counselling Psychologists and other practitioners working in this field. Please see Appendix G for the Journal Article.

5.10 Future research

Future research might consider recruitment of adolescents, fathers, siblings, and other family members to explore which discourses construct their accounts. These interviews might also take place pre and post therapy. Further insight might also be gained by interviewing the therapist working with the family, again to explore the shared and conflicting discourses of each, perhaps through using a case study approach.

Chapter 6. Conclusion and Evaluation

This study sought to identify the discourses available to parents, and the subject positions therein, with which to characterise and construct their narrative accounts of parenting an adolescent who has misused substances. It explored how different forms of power operate through and within families, as parents enact disciplinary power through processes of subjectification, internalisation of norms, and through mechanisms such as (self)surveillance, confession, and other technologies of the self, and become active agents in bio power through monitoring, surveillance and self-responsibilisation. It mapped the discursive constructions of adolescence, substance use, and parental subjective experiences of shame, and coping, and highlighted how parents negotiated dominant discourses and a hierarchy discourses to shift positions to maintain social respectability, whilst challenging stigma, but ultimately sustained an internalised ideal, and expectation of coping which normalises extreme levels of distress and prevents support seeking.

The British Psychological Society (BPS) asserts that psychologists have a role to play in the development of policy and decision-making processes at government level (BPS, 2013). The findings from this study would suggest that there is a need to move towards policies and practices and therapeutic intervention, with individuals, and in family-based treatment of ASM, which focus on quality of life, resilience, and loving family relationships that “may empower parents to focus on inherent strengths of the child and the family in times of adversity (Cottam & Espie, 2014). It is hoped that the evidence from this study may encourage Counselling Psychology practice to reflect critically on privileged forms of knowledge that shape policy and therapeutic practices. It is further hoped that these reflections may support the development of practices which empower parents and families and perhaps open up opportunities for consideration of wider political, socio economic and gender inequalities that may also shape experiences of ASM.

References

- Aarsand, L.A. (2011). Parents, expertise, and identity work: the media conceptualised as a lifelong learning practice. *Pedagogy, Culture and Society*. 19 (3), 435-455
- Aarsand, L.A. & Aarsand, P. (2011). How to be good: Media representations of parenting. *Studies in the Education of Adults*. 43 (1), 78-92
- Ackard D.M., Neumark-Sztainer D., Story, M., & Perry, C. (2006). Parent–child connectedness and behavioural and emotional health among adolescents. *Does J Prevent Med*, 30, 59–66.
- American Psychiatric Association (APA), (2013). Diagnostic and Statistics Manual of Mental Disorders, 5th edition. Washington-DC.
- Andersen, T. (1987). The reflecting team: Dialogue and meta-dialogue in clinical work. *Family Process*, 26(4), 415–428.
- Azrin, N. H., Donohue, B., Besalel, V. A., Kogan, E. S., & Acierno, R. (1994). Youth drug abuse treatment: A controlled outcome study. *Journal of Child & Adolescent Substance Abuse*, 3(3), 1–16. https://doi.org/10.1300/J029v03n03_01
- Arribas- Ayllon, M. & Walkerdine, V. (2008). Foucauldian Discourse Analysis. In Willig, C., & Stanton-Rogers, W. (Eds) *The Sage Handbook of qualitative Research in Psychology*. Sage Publications. Pp91-108
- Asante, K. O. & Lento or, A. G. (2017). Use of crystal methamphetamine among male adolescents in Cape Town, South Africa: Caregivers’ experiences. *Substance Abuse Treatment, Prevention, and Policy*, 12(18), 1-7.
- Averill, J. (1982). *Anger and Aggression: An Essay on Emotion*. New York, NY: Springer-Verlag. <https://doi.org/10.1007/978-1-4612-5743-1>
- Baigent, M. (2003). Physical complications of substance abuse; What the psychiatrist needs to know. *Current Option in psychiatry*, 16(3), 291-296
- Bacchi, C., & Goodwin, S. (2016). *Post-Structural policy analysis: A guide to practice*. New York: Palgrave MacMillan.
- Bacchi, Carol. (2009). *Analysing Policy: What's the Problem Represented to Be?*. Pearson Education.
- Bae, S. (2016). Incredible years as a tool of Governmentality: A Foucauldian analysis of an Early year’s parenting programme. In M.A. Peters (ed.), *Encyclopaedia of Educational Philosophy and Theory*.
- Ball. S. (1990). *Politics and policy making in education*. Routledge.

Bamberg, J.H.; Tombourou, J.W., Marks, R. (2008). Including the siblings of youth substance abusers in a parent-focused intervention: A pilot test of the Best Plus program. *J. Psychoact. Drugs*, 40, 281–291.

Bandura, A., 1977. *Social Learning Theory*. Prentice-Hall, Englewood Cliffs, NJ

Banister, P., Burman, E., Parker, I., Taylor, M., & Tindall, C. (1994). *Qualitative methods in psychology: A research guide*. Open University Press.

Barker, J., & Hunt, G. (2004). Representations of family: A review of the alcohol and drug literature. *International Journal of Drug Policy*, 15(5–6), 347–356.

Barton J. A. (1991). Parental adaptation to adolescent drug abuse: an ethnographic study of role formulation in response to courtesy stigma. *Public health nursing (Boston, Mass.)*, 8(1), 39–45. <https://doi.org/10.1111/j.1525-1446.1991.tb00741.x>

Bateson G. (1935). *Culture Contact and Schizogenesis*. Man. 178–83.

Bateson, G. (1972). *Steps to an ecology of mind: Collected essays in anthropology, psychiatry, evolution, and epistemology*. Jason Aronson

Berger, R. (2013). Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research*, 15(2), 219–234. <https://doi.org/10.1177/1468794112468475>

Bertrand, K., Richer, I., Brunelle, N., Beaudoin, I., Lemieux, A., & Ménard, J-M, (2013). Substance Abuse Treatment for Adolescents: How are Family Factors Related to Substance Use Change? *Journal of Psychoactive Drugs*, 45(1), 28–38. DOI: [10.1080/02791072.2013.763560](https://doi.org/10.1080/02791072.2013.763560)

Besley, T. & Peters, M.A. (2007). *Subjectivity and Truth; Foucault, Education, and the culture of self*. Peter Lang.

Bessant, J., and Watts, R. (2012). The mismeasurement of youth: Why adolescent brain science is bad science. *Contemporary Social Science* 7(2): 181–196.

Biehl, J. (2013). The judicialization of biopolitics: Claiming the right to pharmaceuticals in Brazilian courts. *American Ethnologist*. 40(3) 419–436.

Blair, L. (2010). A critical review of the scientist-practitioner model for counselling psychology. *Counselling Psychology Review*, 25(4), 19–30.

Bowlby J. (1940). The influence of early environment in the development of neurosis and neurotic character. *Int J Psycho-Anal.* 21,154–78.

Bonomo, Y. & Bowes, G. (2001). Putting harm reduction into an adolescent context. *Journal of Paediatrics and Child Health*, 37, 5–11.

Boscolo, L. & Bertrando, P. (1996). *Systemic Therapy with Individuals*. Routledge.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101. doi:10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. SAGE Publications.

Breakwell, G.M., Smith, J.A., Wright, D.B., (2012). *Research Methods in Psychology*. Sage.

British Psychological Society. (2014). *BPS Code of Human Research Ethics* (2nd ed.). <https://www.bps.org.uk/news-and-policy/bps-code-human-research-ethics-2nd-edition-2014> [accessed 17/4/2023]

Bruner, A. B. & Fishman, M. (1998). Adolescents and illicit drug abuse. *Journal of the American Medical Association*, 280, 597–598.

Burn, K., & Szoeke, C. (2016). Boomerang families and failure-to-launch: commentary on adult children living at home. *Maturitas*. 83, 9–12.

Butler, R. & Bauld, L. (2005). The parents' experience: coping with drug use in the family. *Drugs: Education, Prevention and Policy*, 12(1) 35-45 DOI: [10.1080/0968763042000275308](https://doi.org/10.1080/0968763042000275308)

Burr, V. (2003). *Social Constructionism*. Routledge.

Byng-Hall J. (2002). Relieving parentified children's burdens in families with insecure attachment patterns. *Family Process*. 41(3):375–88. doi: 10.1111/j.1545 5300.2002.41307.x

Byng-Hall J. (2008). The crucial roles of attachment in family therapy. *Journal of Family Therapy*. 30(2),129–146. doi: 10.1111/j.1467-6427.2008. 00422.x

Catalano, R.F., Hawkins, J.D., (1996). The social development model: a theory of antisocial behaviour. In: Hawkins, J.D. (Ed.), *Delinquency and Crime: Current Theories*

Choate, P.W. (2011). Adolescent Addiction: What parents' need. *Procedia: Social and Behavioural Sciences* 30, 1359-1364.

Choate, P.W. (2015). Adolescent Alcoholism and Drug Addiction: The Experience of Parents. *Behavioural Sciences*, 5(4), 461-476. <https://doi.org/10.3390/bs5040461>

Clarke, V., & Braun, V. (2017). Thematic Analysis. *The Journal of Positive Psychology*, 12, 297-298. <https://doi.org/10.1080/17439760.2016.1262613>

Conrad, P. (1975) The discovery of hyperkinesis, *Social Problems*, 12, 1, 12–21.

Constantinou, C. S., Georgiou, M., & Perdikogianni, M. (2017). A comparative method for themes saturation (CoMeTS) in qualitative interviews. *Qualitative Research*, 17(4), 146879411668665. <https://doi.org/10.1177/1468794116686650>

Cook, L.S. (2001). Adolescent addiction and delinquency in the family system. *Issues Mental Health Nurs.* 22, 151–157.

- Copello, A., Templeton, L., Orford, J., & Velleman, R. (2010a). The 5-step method: evidence of gains for affected family members. *Drugs Educ Prev Policy*. 17(sup 1), 100–112.
- Copello, A., Templeton, L., & Powell, J. (2010b). The impact of addiction on the family: Estimates of prevalence and costs. *Drugs Educ Prev Policy*. 17(sup 1), 63–74.
- Corrigan, P.W., Watson, A.C., & Miller, F.E. (2006). Blame, shame, and contamination: the impact of mental illness and drug dependence stigma on family members. *J Fam Psychol*. 20(2), 239.
- Cottam, S. & Espie, J., (2014). Discourses underpinning parenting training programmes: Positioning and Power. *Children and Society*, 28, 465-477
- Corrigan, P.W., Watson, A.C., & Miller, F. E. (2006). Blame, shame and contamination: The impact of mental illness and drug dependence stigma on family members. *Journal of Family Psychology*. 20 (2), 239-246
- Couture, S., Strong, T. (2006). Turning differences into possibilities: Using discourse analysis to investigate change in therapy with adolescents and their families. *Counselling and Psychotherapy Research* vol 4(1) pp90-101 <https://doi.org/10.1080/14733140412331384098>
- Cowan, S., & McLeod, J. (2004). Research methods: Discourse analysis. *Counselling and Psychotherapy Research*, 4(1), 102. <https://doi.org/10.1080/14733140412331384108>
- Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). SAGE Publications.
- Cutts, L. A. (2013). Considering a social justice agenda for counselling psychology in the UK. *Counselling Psychology Review*, 28(2), 8–16.
- Cooper, M., & McLeod, W. (2015). *The Handbook of Counselling and Psychotherapy*. Sage.
- Dahlstedt, M. and Fejes, A. (2014). Family Makeover: coaching, confession and parental responsabilisation. *Pedagogy, Culture & Society*, 2014, 22 (2), 169–188,
- Dallos, R., & Draper, R., (2010) *An Introduction to Family Therapy*. Open University Press.
- Dallos, R. & Vetere, A. (2021). *Systemic Therapy and Attachment Narratives* Routledge.
- Davies, B. & Harre, R. (1999). Positioning and Personhood. In R. Harre and L. Van Langenhove (eds), *Positioning Theory*. Blackwell
- Dempsey, I. (2018). Disciplining psychology education – a Foucauldian discourse analysis. *Psychology Teaching Review*, 24(2), 12-23
- Dennis C.L. (2003). Peer support within a health care context: a concept analysis. *Int J Nurs Stud*, 40, 321–332.

Devaney, E. (2017). The emergence of the affected adult family member in drug policy discourse: A Foucauldian perspective. *Drugs: Education, Prevention and Policy*, 24(4), 359–367. <https://doi.org/10.1080/09687637.2017.1340433>

Dion, K. (2014). That's what I mean by a hundred little, a thousand little deaths...': a case study of the grief experienced by the mother of a substance abusing child. *MedSurg Nursing*. 23(6), 397–403.

Dobson, P. J. (2012). Critical Realism and IS Research: Some Methodological Implications . In Mora, M., Gelman, O., Steenkamp, A. L., & Raisinghani, M. (Eds.). *Research Methodologies, Innovations and Philosophies in Software Systems Engineering and Information Systems* (pp. 63-81)

Douglas, B. (2010). 'Disorder and its discontents' in R. Woolfe, S. Strawbridge, B. And W. Dryden (eds). *Handbook of Counselling Psychology*. Sage. Pp23-43

Duschinsky & L. A. Rocha (Eds.), *Foucault, the Family and Politics* (Palgrave Macmillan Studies in Family and Intimate Life, pp. ...). Palgrave Macmillan.
https://doi.org/10.1057/9781137291288_5

Dwyer, H. (2010). *Curriculum Connections Psychology: History of Psychology* (1st ed.). Brown Bear Books Ltd.
<https://search.credoreference.com/articles/Qm9va0FydGljbGU6MzE0MjE1Mw==?aid=279767>

Dykes, G., & Casker, R. (2021). Adolescents and substance abuse: the effects of substance abuse on parents and siblings. *International Journal of Adolescence and Youth*, 26(1), 224-237. DOI: 10.1080/02673843.2021.1908376

Ebersole, D. S., Miller-Day, M., & Raup-Krieger, J. (2014). Do Actions Speak Louder Than Words?: Adolescent Interpretations of Parental Substance Use. *Journal of family communication*, 14(4), 328–351. <https://doi.org/10.1080/15267431.2014.945699>

Egeland, B, Weinfield, N.S., Bosquet, M., Cheng, V.K., (2000). Remembering, repeating, and working through lessons from attachment-based interventions. *WAIMH Handb Infant Ment Health* 4, 35–89.

Emerson, R. M. (2015). *Everyday troubles. The micro-politics of interpersonal conflict*. The University of Chicago Press.

Erikson, E. H. (1963). *Childhood and society* (2nd ed.). Norton

Erikson, E. H. (1968). *Identity: Youth and crisis*. Norton

Esteban, J., Suarez-Relique, C., & Jimenez, T., (2023). Effects of family therapy for substance use: A systematic review of recent research. *Family Process*. 62:49–73.

Ewick, P., & Silbey, S. S. (1995). Subversive Stories and Hegemonic Tales: Toward a Sociology of Narrative. *Law & Society Review*, 29(2), 197–226. doi:10.2307/3054010

Fairbairn CE, Briley DA, Kang D, Fraley RC, Hankin BL, Ariss T. (2018). A meta-analysis of longitudinal associations between substance use and interpersonal attachment security. *Psychol Bull.* 144(5), 532–55.

Farrugia, A., Fraser, S. (2017). Young brains at risk: Co-constituting youth and addiction in neuroscience-informed Australian drug education. *BioSocieties* 12, 588–610.
<https://doi.org/10.1057/s41292-017-0047-2>

Feder, E. K. (1997). Discipling the family: The case of gender identity disorder. *Philosophical Studies* 85 (2-3), 195-211

Feder, E.K. (2007a). The dangerous individual's mother: Biopower, family, and the production office.. *Hypatia* 22 (2): 60-78.

Flensburg, O., Johnson, B., Nordgren, J., Richert, T., & Svensson, B. (2022). 'Something wasn't right': parents of children with drug problems looking back at how the troubles first began.' *Drugs: Education, Prevention and Policy*, 29(3), 255-264. DOI: 10.1080/09687637.2021.1897525

Fonagy, P., Gergely, G., Jurist, E., Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. Other Press

Foucault, M. (1972). *The Archaeology of Knowledge, and the Discourse on Language* (A. M. Sheridan Smith, Trans.). New York: Pantheon Books.

Foucault, M. (1976). *History of Sexuality, Volume 1: An Introduction* (R. Hurley, Trans.) Pantheon Books. (Original work published 1976)

Foucault, M. (1977). *Discipline and punish: The birth of the prison*. Pantheon Books.

Foucault, M. (1978). *The History of Sexuality*. New York, NY: Pantheon Books.

Foucault, M. (1980). *Power/Knowledge: Selected Interviews and Other Writings, 1972 1977*. New York, NY: Pantheon.

Foucault, M. (1980b). Two Lectures. In C. Gordon (Ed.), *Power/Knowledge: Selected Interviews and Other Writings 1972-1977* (pp. 78-108). Pantheon Books

Foucault, M. (1981). *The Order of Discourse*. (R. J. Goldstein, Trans.). In *Language and Politics* (pp. 108-131). Oxford: Basil Blackwell

Foucault, M. (1982). The subject and power. *Critical Inquiry*, 8(4), 777–795.

Foucault, M. (1984a). *The History of Sexuality. Vol 2: The Use of Pleasure*. London: Penguin.

Foucault, M. (1984b). Polemics, politics, and problematizations. In P. Rabinow (Ed.), *The Foucault Reader: An Introduction to Foucault's Thought* (pp. 381–390). London: Penguin Books.

- Foucault, M. (1982). The subject and power. *Critical Inquiry*, 8(4), 777–795.
- Foucault, M. (1984). The ethics of the concern of the self as a practice of freedom. In P. Rabinow, & N. Rose (Eds.), *The essential Foucault: 96 Selections from essential works of Foucault, 1954-1984* (pp. 24-42). New York, The United States of America: The New Press
- Foucault, M. 1988. “Technologies of the Self.” In *Technologies of the Self*, edited by L. H. Martin, H. Gutman, and P. H. Hutton, 16–49. London: Tavistock.
- Foucault, M. 1998. *The Will to Knowledge*. London: Penguin Books.
- Foucault, M. (1990). The history of sexuality, Volume 1: An introduction (R. Hurley, Trans.). New York: Vintage Book
- Foucault, M. (1991). Governmentality. In G. Burchell, C. Gordon, & P. Miller (Eds.), *The Foucault Effects: Studies in Governmentality* (pp. 87-104). London: Harvester Wheatsheaf.
- Foucault, M. (1994). *The order of things: An archaeology of the human sciences*. Vintage Book
- Foucault, M. 2003. “Technologies of the Self.” In *The Essential Foucault*, edited by P. Rabinow and N. Rose, 145–169. New York: The New Press.
- Foucault, M. (2008). *The Birth of Biopolitics: Lectures at the Collège de France, 1978–9*. Basingstoke: Palgrave.
- Foucault M. (2013). *Archaeology of knowledge*. Routledge
- Francis, A. (2012). The dynamics of family trouble: Middle-class parents whose children have problems. *Journal of Contemporary Ethnography*, 41(4), 371–401.
<https://doi.org/10.1177/0891241611426142>
- Frank, A. W. (1995). *The wounded storyteller: Body, illness, and ethics*. University of Chicago Press.
- Fraser, S., Piernaar, K. Dilkes-Frayne, E., Moore, D., Kokanovic, R., Treloar, C., & Dunlop, A. (2017). Addiction stigma and the biopolitics of modernity: a qualitative analysis. *International Journal of Drug Policy* 44, 192-201
- Furedi, F. 2004. *Therapy Culture*. London: Routledge.
- Gall, F. J. and Spurzheim, J.C. (1835). *On the Functions of the Brain and Each of its Parts*. (W. Lewis Jr., Trans.) (Vols. 1–6.) Boston, MA: Marsh, Capen and Lyon. (Original work published 1822–1825)
- Geijer-Simpson, E., Kipping, R. R., White, J., MacArthur, G. J., & Hickman, M. (2023). A systematic review and meta-analysis of family-involved interventions for reducing co-occurring alcohol use and mental health problems in young people aged 12–17. *International Journal of Environmental Research and Public Health*, 20(19), 6890.
<https://doi.org/10.3390/ijerph20196890>

- Gergen, K. J. (1999). *An invitation to social construction*. Sage.
- Glaser, B., & Strauss, A. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Mill Valley, CA: Sociology Press.
- Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability, *Field Methods*, 18, 59-82. <http://dx.doi.org/10.1177/1525822X05279903>
- González, A., & García, M. (2019). Storytelling as a therapeutic tool for family support in bulimia nervosa. In *Bulimia Nervosa*, 1–14. IntechOpen
- Goffman, E. (1973/1963). *Stigma: Notes on the management of spoiled identity*. Harmondsworth and Ringwood: Penguin.
- Goodman, S. (2017). How to conduct a psychological discourse analysis. Critical approaches to discourse analysis across disciplines. www.cadaadjournal.com. 9(2), 142-153
- GOV.UK. (2023). Drug Misuse in England and Wales: Year ending June 2022. Published December 2022. (2022). <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/drugmisuseinenglandandwales/yearendingjune2022#overall-trends-in-drug-misuse> [Accessed 23/3/23]
- GOV.UK (2025) Office for Health Improvement and Disparities. Children and young people substance misuse statistics 23-24 report. [Children and young people's substance misuse treatment statistics 2023 to 2024: report - GOV.UK](#)
- GOV.UK (2004). Children's Act. [Children Act 2004](#)
- GOV.uk (2024). Every Child Matters. [Every child matters - GOV.UK](#)
- GOV.UK (2018). GDPR Data Protection Act. [Data protection: The UK's data protection legislation - GOV.UK](#)
- Greenwood, J. D. (2015). Frontmatter. In *A Conceptual History of Psychology: Exploring the Tangled Web* (pp. i–iv). frontmatter, Cambridge: Cambridge University Press.
- Groenewald, C. & Bhana, A. (2017). Mothers' experiences of coping with adolescents' substance abuse. *Contemporary Nursing*, 53(4), 421-435.
- Gruber, K.J.; Taylor, M.F. (2006). A family perspective for substance abuse: Implications from the literature. *J. Soc. Work Pract. Addict.* 6, 1–29.
- Haines-Saah, R.J., Mitchell, S, Slemon, A., Jenkins, E.K. (2019). Parents are the best prevention?' Troubling assumptions in cannabis policy and prevention discourses in the context of legislation in Canada. *International Journal of Drug Policy*, 68, 132-138.

- Haley, T. (2002). The fit between reflecting teams and a social constructionist approach. *Journal of Systemic Therapies*, 21(1), 20–40. <https://doi.org/10.1521/jsyt.21.1.20.23095>
- Hall, S. (2001). Foucault: Power, knowledge, and discourse. In M. Wetherell, S. Taylor, & S. J. Yates (Eds.), *Discourse theory, and practice: A reader* (pp. 72-81). London, England: Sage Publications Ltd.
- Hammersley, R. (2017). How and why addiction is socially constructed. Available at: [Final-How and Why Addiction is Socially Constructed-libre.pdf](#)
- Harkins, G. (2012). Foucault, the Family, and the Cold Monster of Neoliberalism. In: Duschinsky, R., Rocha, L.A. (eds) *Foucault, the Family and Politics*. Palgrave Macmillan Studies in Family and Intimate Life. Palgrave Macmillan, London. https://doi.org/10.1057/9781137291288_5
- Harper, D. J. (2011). Choosing a qualitative research method. In Harper, D. J. & Thompson, A. R. (eds) *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners* pp83-97. Wiley-Blackwell.
- Harré, R., & Gillett, G. (1994). *The discursive mind*. London, England: Sage.
- Harré, R., & Parrott, W.G. (1996). *The Emotions, Social, Cultural and Biological Dimensions*. Sage
- Hearnshaw, L. S. (1989). *The Shaping of Modern Psychology: An Historical Introduction*. London: Routledge.
- Hedges, F. (2005). *An Introduction to systemic therapy with individuals*. Palgrave. Macmillan.
- Henderson, C.E., Greenbaum, P.E., Dakoff, G.A., & Liddle, H.A. (2010). Effective of multidimensional family therapy with higher severity substance-abusing adolescents: report from two randomised controlled trials. *Journal of clinical and consulting psychology*. 78(6), 885-897
- Higham, J.E. Friedlander, M.L., Escudero, V., & Diamond, G. (2011). Engaging reluctant adolescents in family therapy; an exploratory study of in-session processes of change. *Journal of Family Therapy*. 34, 24-52
- Hodge, I. (2002). Moving beyond words: therapeutic discourse and ethical problematization. *Discourse Studies*. 4(4), 455-479
- Hoeck, S., & Van Hal, G. (2012). Experiences of parents of substance-abusing young people attending support groups. *Arch Public Health*, 70, 11.
- Hoffman, D.M. (2010). Risky investments: Parenting and the production of the resilient child. *Health, Risk and Society* 12(4), 385-394.

Hook, D. (2007). Foucault, psychology, and the analytics of power. Basingstoke: Palgrave Macmillan.

Henriques, J. (1984). *Changing the subject*. Methuen.

Jackson, J. H. (1931). Selected Writings of Hughlings Jackson. (J. Taylor, Ed.) (Vols. 1–2.) London: Hodder and Stoughton.

Jackson, D., Usher, K., & O'Brien, L. (2007). Fractured families: Parental perspectives of the effects of adolescent drug abuse on family life, *Contemporary Nurse*, 23(2), 321-330.

Jackson, D. & Mannix, J. (2003). 'Then suddenly he went right off the rails': Mothers' stories of adolescent cannabis use. *Contemporary Nurse*, 14, 169–179.

Jager, B., (1991). Psychology in a Postmodern Era, *Journal of Phenomenological Psychology*, 22 (1) (Spring) 60-71

Karver, M.S., Nadai, A.S., Monahan, M., & Shirk, S.R. (2018). Meta-analysis of the prospective relation between alliance and outcome in child and adolescent psychotherapy. *Science for the Advancement of psychotherapy*. 55(4), 341-355

Kelly, P. (2012). The brain in the jar: A critique of discourses of adolescent brain development. *Journal of Youth Studies* 15(7), 944–959.

Kennedy, B. A., & Arthur, N. (2014). Social Justice and Counselling Psychology: Recommitment Through Action. *Canadian Journal of Counselling and Psychotherapy*, 48(3). Retrieved from <https://cjc-rcc.ucalgary.ca/article/view/61013>

Kloep, M., & Hendry, L.B. (2010). Letting go or holding on? Parents' perceptions of their relationships with their children during emerging adulthood. *Brit J Dev Psychol*. 28(4), 817–834.

Kuusisto, K., Evilampi, S., Ekqvist, E., & Juhila, K. (2023) Discourses of behavioural addiction, normalisation, and techniques of governmentality in inpatient substance abuse treatment, *Nordic Social Work Research*, 13 (2), 217-230, DOI: 10.1080/2156857X.2021.1950038

Kumpfer, K.L. & Alvarado, R. (2003). Family Strengthening Approaches for the Prevention of Youth Problem Behaviours. *American Psychologist* 58 (6/7), 457-465

Kvale, S., & Brinkmann, S. (2009). *Interviews: Learning the craft of qualitative research interviewing*. Sage Publications Ltd.

Lesko, N.. (2001). *Act your age!: a cultural construction of adolescence*. Routledge Falmer,

Levitt, H.M., Bamberg, M. Cresswell, J.M., Frost, D.M., Josselson, R., & Suárez-Orozco, C. (2018). Journal Article Reporting Standards for Qualitative Primary, Qualitative Meta-Analytic, and Mixed Methods Research in Psychology: The APA Publications and Communications Board Task Force Report. *American Psychologist* 73(1) 26-46

Lewis AJ, Bertino MD, Robertson N, Knight T, Toumbourou, JW. (2012) Consumer feedback following participation in a family-based intervention for youth mental health. *Depression Res Treat.* doi: 10.1155/2012/235646

Lewis, A.J. (2020). Attachment based Family therapy for adolescent substance use: A move to the level of systems. *Frontiers in psychiatry*, 10. 1-10.

Liddle, H. (2010). Treating Adolescent Substance Abuse Using Multi-Dimensional Family Therapy in J. Weisz & A. Kazdin (Eds.) (2010), *Evidence-based psychotherapies for children and adolescents* (Second Edition). N.Y.: Guilford.

Liddle, H.A., Dakof, G.A., Guy P., Diamond, S., Barrett, K. & Tejada, M. (2001). Multidimensional family therapy for adolescent drug abuse: results of a randomized clinical trial. *The American Journal of Drug and Alcohol Abuse*, 27(4), 651-688. DOI: [10.1081/ADA-100107661](https://doi.org/10.1081/ADA-100107661)

Liddle, H.A., Rowe, C.L., Dakoff, G.A. (2009). Multidimensional family therapy for young adolescent substance use; Twelve-month outcomes of a randomized controlled trial. *Journal of consulting and clinical psychology*. 77(1), 12-25

Lincoln, Y.S., & Guba. E.G. (1985). *Naturalistic Inquiry* Sage.

Lind, A., Westerling, A., Sparrman, A., & Dannesboe, K. I. (2016). Introduction: Doing good parenthood. In A. Sparrman, A. Westerling, J. Lind, & K. I. Dannesboe (Eds.), *Doing good parenthood* (pp. 1–16). Palgrave Macmillan Studies in Family and Intimate Life.

London Metropolitan University. (2025). Research Guidelines. [Research Policies and Regulations - Student Zone](#)

Lutz, C. A. (1988). *Unnatural emotions: Everyday sentiments on a Micronesian atoll & their challenge to Western theory*. University of Chicago Press.

Lyons-Ruth K, Yellin C, Melnick S, Atwood G. (2005). Expanding the concept of unresolved mental states: hostile/helpless states of mind on the adult attachment interview are associated with disrupted mother–infant communication and infant disorganization. *Dev Psychopathol.* 17, (1),1–23. doi: 10.1017/S0954579405050017

Maher, W. B. and Maher, B. E. (1985b). Psychopathology: II. From the 18th century to modern times. In G. A. Kimble and K. Schlesinger (Eds.), *Topics in the History of Psychology*. (Vol. 2.) Hillsdale, NJ: Erlbaum.

Maltman, K., Savic, M., Lubman, D.I., Manning, V., Dilkes-Frayne, E., & Carter, A. (2020). ‘Holding on’ and ‘letting go’: a thematic analysis of Australian parent’s styles of coping with their adult child’s methamphetamine use. *Addiction Research & Theory*. 28 (4), 345-353 <https://doi.org/10.1080/16066359.2019.1655547>

Martin, J., Sugarman, J., & Slaney, K. L. (Eds.). (2015). *The Wiley handbook of theoretical and philosophical psychology: Methods, approaches, and new directions for social sciences*. John Wiley & Sons, Incorporated.

- Maruyama, M. (1968). *Systemic Family Therapy and the influence of post-modernism*. Cambridge University Press.
- Mathiebela, F., & Skhosana, R.M. (2021). "I just knew something was not right!" Coping strategies of parents living with adolescent misusing substances. *Journal of Substance Abuse Treatment*, 120, 108-178.
- Miller, A., & Cook J.M., (2017). The Adolescent Substance Use Risk Continuum: A Cultural Strengths-based Approach to Case conceptualisation. *The Professional Counsellor* 7(1), 1-14
- MacNaughton, G. (2005). *Doing Foucault in early childhood studies: Applying post structural ideas*. London: Routledge.
- Mason, M. (2010). Sample Size and Saturation in PhD Studies Using Qualitative Interviews, *Forum, Qualitative Social Research*, 11, 3, pp. 1-20.
- Mayes, R., and Horwitz, A. V. (2005). DSM-III and the revolution in the classification of mental illness. *Journal of the History of the Behavioral Sciences*, 41, 249–267.
- McArdle, P., Wieggersma, A., Gilvarry, E., Kolte, B., McCarthy, S., Fitzgerald, M., Brinkley, A., Blom, M., Stoeckel, I., Pierolini, A., Michels, I., Johnson, R., & Quensel, S. (2002). European adolescent substance use: the roles of family structure, function, and gender. *Addiction* 97, 329–336.
- McCann, T.V., & Lubman, D.I. (2018). Stigma experience of families supporting an adult member with substance misuse. *Int J Mental Health Nurs*. 27(2), 693–701.
- McGhee, P. (2001). *Thinking Psychologically*. Palgrave MacMillan.
- McHoul, A. & Grace, W. (1997). *The Foucault Primer*. New York University Press.
- Morojele, N. & Ramsoomar, L. (2016). Addressing adolescent alcohol use in South Africa. *South African Medical Journal*. 106. 551. 10.7196/SAMJ. 2016.v106i6.10944.
- Moustakas, C. (1994). *Phenomenological research methods*. SAGE Publications.
- Myles, J. & Willner, P. (1999). Substance misuse and psychiatric comorbidity in children and adolescents. *Current Opinion in Psychiatry*, 12, 287–290.
- Neimeyer, R. A. (1998). Social constructionism in the counselling context. *Counselling Psychology Quarterly*, 11(2), 135–149
- Newman, K., Harrison, L., Dashiff, C., & Davies, S. (2008). Relationships between parenting styles and risk behaviours in adolescent health: an integrative literature review. *Rev Lat Am Enferm* 16, 142–150.
- NEURO_QUAL. (2025).** (n.d.). *Unit 3: Sampling in qualitative research*. In *NEURO_QUAL: An open-access qualitative resource for neurosurgeons and neurosurgery*. University of Cambridge. Retrieved June 11, 2025, from <https://neuroqual.org/v2/unit3>

- Nightingale, D.J. & Cromby, J. (1999). *Social Constructionist Psychology: A Critical Analysis of theory and practice*. Open University Press.
- Noble, D. (1853). *Elements of Psychological Medicine*. London: Churchill.
- Office for National Statistics. (ONS) (2023). [Estimates of the population for the UK, England, Wales, and Northern Ireland - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk/population/estimates). [Accessed 4/4/23]
- Office for National Statistics Crime Survey for England and Wales. (CSEW) (2025). [Drug misuse in England and Wales - Office for National Statistics](https://ons.gov.uk/crime) [Accessed 7/3/26]
- Onwuegbuzie, A. J., Dickinson, W. B., Leech, N. L., & Zoran, A. G. (2009). A qualitative framework for collecting and analysing data in focus group research. *International Journal of Qualitative Methods*, 8(3), 1–21. <https://doi.org/10.1177/160940690900800301>
- Onwuegbuzie, A. J., Frels, R. K., & Hwang, E. (2016). Mapping Saldaña's coding methods onto the literature review process. *Journal of Educational Issues*, 2(1), 130–150. <https://doi.org/10.5296/jei.v2i1.8931>
- Oreo, A., & Ozgul, S. (2007). Grief experiences of parents coping with an adult child with problem substance use. *Addict Res Theory*, 15(1), 71–83.
- Orford, J., Natera, G., Davies, J., Nava, A., Mora, J., Rigby, K. (1998). Tolerate, engage, or withdraw: A study of the structure of families coping with alcohol and drug problems in southwest England and Mexico City. *Addiction*, 93(12), 1799–1813.
- Orford, J., Velleman, R., Copello, A., Templeton, L., & Ibanga, A. (2010). The experiences of affected family members: A summary of two decades of qualitative research. *Drugs: Education Prevention and Policy*, 17(1), 44–62. <https://doi.org/10.3109/09687637.2010.514192>
- Orford J. (2017). How does the common core to the harm experienced by affected family members vary by relationship, social and cultural factors? *Drugs Educ Prev Policy*, 24(1):9–16.
- Oxford University Press. (1991). *The Compact Oxford English Dictionary* (2nd ed.). Oxford University Press.
- Ozechowski, T. J., & Liddle, H. A. (2000). Family-based therapy for adolescent drug abuse: Knowns and unknowns. *Clinical Child and Family Psychology Review*, 3, 269–298.
- Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. *Social science & medicine* (1982), 57(1), 13–24. [https://doi.org/10.1016/s0277-9536\(02\)00304-0](https://doi.org/10.1016/s0277-9536(02)00304-0)
- Parker, H., Aldridge, J., & Measham, F. (1998). *Illegal Leisure: the normalisation of adolescent recreational drug use*. Routledge. <https://doi.org/10.1093/her/14.5.707>

- Papathomas, A., Smith, B., & Lavalley, D. (2015). Family experiences of living with an eating disorder: A narrative analysis. *Journal of Health Psychology*, 20(3), 313–325.
- Patrika, P. & Tseliou, E. (2015). Blame, responsibility and systemic neutrality; a discourse analysis methodology to the study of family therapy problem talk. *Journal of Family Therapy*, 38 (4), 467-490
- Pitts, J. (1968). Social control. In [D.L. Sills](#) (Ed.), [International encyclopaedia of the social sciences](#) 14, 381-396
- Prado, C. G. (1995). *Starting with Foucault: an introduction to genealogy*. Boulder, Westview Press
- Priory Group. (2019). Available at: <https://www.priorygroup.com/addiction-treatment/drug-rehab/drug-abuse-statistics-uk> [accessed 25/3/23]
- Paul, G.M., Smith, S.M., Whitford, D.L., O'Shea, E., O'Kelly, F., & O'Dowd, T. (2007). Peer support in type 2 diabetes: a randomised controlled trial in primary care with parallel economic and qualitative analyses: pilot study and protocol. *BMC Fam Pract*, 8:45.
- Pearson, G. (2000). Substance abuse and the family. *Current Opinion in Psychiatry*. 13, 305–308.
- Potter, J., & Hepburn, (2005). Qualitative interviews in psychology: problems and possibilities. *Qualitative Research in Psychology*, 2, 38-55.
- Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviours*. Sage Publications Ltd.
- Rabinow, P. (1997). (ed) “Sex, Power and the Politics of Identity” in *Ethics, Subjectivity and Truth*. New Press.
- Rorty, R. (ed), (1967). *The linguistic turn: Recent essays in philosophical method*. University of Chicago press.
- Rose, N. (1979). The psychological complex: mental measurement and social administration. *Ideology & consciousness*. 5, 5-68.
- Rose, N. (1999). *Governing the Soul: The Shaping of the Private Self*. London: Free Association Books.
- Riley, S. & Wiggins, S. (2018). Discourse analysis. In C. Sullivan & M. Forrester, (Eds.), *Doing Qualitative Research in Psychology: A Practical Guide* (pp. 233–256). London: Sage. Youtube video www.youtube.com/watch?v=iYKuTHdFMPw.
- Riley, S., Robson, M., Evans, A. (2021). Foucauldian-informed Discourse analysis. <https://doi.org/10.1017/9781108755146.016> Published online by Cambridge University Press

Rimmon-Kenan, S. (2002). The Story of “I”: Illness and Narrative Identity. *Narrative*, 10(1), 9–27. <http://www.jstor.org/stable/20107270>

Rogers, C. (1951). *Client-Centred Therapy: Its Current Practice, Implications and Theory*. London: Constable.

Saunders, J. & Young, R. (2002). Assessment and diagnosis. In: G. Hulse, J. White & G. Cape (Eds). *Management of Alcohol and Drug Problems* (pp. 229–238). Melbourne: Oxford University Press.

Segrott, J., Rothwell, H., Hewitt, G., Wight, D., & Moore, L. (2019). Preventing substance misuse: Evaluating the Kids, Adults Together (KAT) Programme—A multi-level, community-based intervention. *Public Health Research*, 7(6).

Schirato, A. Danaher, G. & Webb, J. (2012). *Understanding Foucault: A Critical Introduction*. Sage Publications.

Simons-Morton, B. (2007). Social Influences on Adolescent Substance Use. *American journal of health behaviour*. 31. 672-84

Sims-Schouten, W., Riley, S. C. E., & Willig, C. (2007). Critical realism in discourse analysis: A presentation of a systematic method of analysis using 115 women’s talk of motherhood, childcare, and female employment as an example. *Theory & Psychology*, 17, 101-124.

Silverman, D. (1993). *Interpreting Qualitative Data*. Available at: [\(PDF\) Interpreting Qualitative Data. A Guide to the Principles of Qualitative Research](#)

Smith, J., Flowers, P. & Larkin, M. (2022). *Interpretative Phenomenological Analysis: Theory, Method, and Research*. Sage.

Smith, B., & Sparkes, A. C. (2005). Men, sport, spinal cord injury, and narratives of hope. *Social Science & Medicine*, 61(5), 1095–1105.

Smith, B., & Sparkes, A. C. (2006). Becoming disabled through sport: Multiple responses to an embodied chaos narrative. In B. Sparkes & B. Smith (Eds.), *Narrative, and memory: Selected proceedings of the 4th International Conference* (pp. 91–101). University of Huddersfield.

Smith, J.M., & Estefan, A. (2014). Families parenting adolescents with substance abuse—recovering the mother’s voice: a narrative literature review. *J Fam Nurs*. 20(4), 415–441.

Speer, S.A. (2000). Let’s get real: Feminism, constructionism, and the realism/Relativism debate. *Feminism and Psychology*, 10(4), 519-530

Stainton-Rogers W. 2009. Promoting better childhoods. In *An Introduction to Childhood Studies*, 2nd edn. Kehily MJ (ed.). Open University Press: Maidenhead; 1–17.

Stedmon, J., & Dallos, R. (2009). *Reflective practice in psychotherapy and counselling*. McGraw-Hill Education.

- Sugarman, J. (2015). Neoliberalism and psychological ethics. *Journal of theoretical and philosophical psychology*. 25(2), 103-116
- Tambling, R.R., Russell, B. & D'Aniello, C. (2022). Where is the Family in Young Adult Substance Use Treatment? The Case for Systemic Family Therapy for Young Adults with Substance Use Disorders. *Int J Ment Health Addiction* 20, 1659–1670
<https://doi.org/10.1007/s11469-020-00471-1>
- Taylor, C. (2012). Foucault and Familial Power. *Hypatia*. 27(1) 201-218
- Touzard, R.S. (2011). A critical constructionist view of "at-risk" youth in alternative education. *Dissertation Abstracts International Section A: Humanities and Social Sciences*, 71(7A), p2414
- Toumbourou, J.W., Blyth, A., Bamberg, J., and Forer, D. (2001). Early impact of the BEST intervention for parents stressed by adolescent substance abuse. *J. Community. Appl. Soc. Psychol.* 11. 291-304. <https://doi.org/10.1002/casp.632>
- Trucco, E.M. (2020). A review of psychosocial factors linked to adolescent substance use. *Pharmacology, Biochemistry and Behaviour*; 196,1-14.
<https://doi.org/10.1016/j.pbb.2020.172969>
- Usher, K., Jackson, D., & O'Brien, L. (2005). 'Shattered dreams: Parental experiences of adolescent substance abuse.' *International Journal Mental Health Nursing*. 16, 422–430.
- Usher, K., Jackson, D., & O'Brien, L. (2005). Adolescent drug abuse: Helping families survive. *Int. J. Mental Health Nurs.* 14, 209–214. 13
- United Nations Office on Drugs and Crime (UNODC), (2025) Available at: [World Drug Report 2025](#) [Accessed 7/3/26]
- von Krafft-Ebing, R. (1879). *Lehrbuch der Psychiatric auf klinischer grundlage* [Textbook of Psychiatry on a Clinical Foundation]. Stuttgart: Erike.
- Van Schoor, E.P., & Beach, R. (1993). Pseudo-independence in adolescent drug abuse: A family systems perspective. *Family Therapy*, 20 (3)
- Velleman, R.; Templeton, L. (2003). Alcohol, drugs, and the family: Results from a long-running research programme within the UK. *Eur. Addict. Res*, 9, 103–112.
- Waldran, H.B., Slesnick, N, & Brody, J.L. (2001). Treatment outcomes for adolescent substance use at 4- and 7- month assessment. *Journal of consulting and clinical psychology*. 69(5), 802-813
- Walkerdine, V. (1998). *Developmental psychology and the Child-centred pedagogy: the insertion of Piaget into early education*. Routledge.

- Watts, W. D. (1989) "Reducing Adolescent Drug Abuse: Sociological Strategies for Community Practice," *Clinical Sociology Review: Vol. 7* (1), Article 16. Available at: <http://digitalcommons.wayne.edu/csr/vol7/iss1/16>
- Wetherell, M. (1998). Positioning and interpretative repertoires: Conversation analysis and poststructuralism in dialogue. *Discourse and Society*. 9(3), 387-412.
- Wilson, S.R., Rodda, S., Lubman, D.I., Manning, V., & Yap, M.B.H. (2017). How online counselling can support partners of individuals with problem alcohol or other drug use. *J Subst Abuse Treat*. 78, 56–62.
- Wilson, M. (1993). DSM and the transformation of America psychiatry: a history. *American Journal of Psychiatry*, 150, 399–410.
- Wiggins, S. (2017). *Discursive Psychology: Theory, Method, and Applications*. London: Sage.
- Willig, C. (2001). 4th Edition. *Introducing Qualitative Research in Psychology*. Open University Press.
- Winter, L. & Hanley, T. (2015). “Unless everyone’s covert guerilla-like social justice practitioners...”: A preliminary study exploring social justice in UK counselling psychology. *Counselling Psychology Review* 30 (2), 32-46
- Wittgenstein, L. (1953). *Philosophical Investigations*. Blackwell.
- Woods, P., & Sikes, P. (2022). *Successful Writing for Qualitative Researchers* (3rd ed.). Routledge. <https://doi.org/10.4324/9781003143406>
- World Health Organization (WHO). (2016). School health and youth health. <http://goo.gL/91Dz3>.
- Yip, J.W.C. (2024). Discourse Analysis: Theory and Practice. In: *Discourse of Online Social Support*. Springer. https://doi.org/10.1007/978-981-99-9569-1_2
- Youniss, J. (1983). Social construction of adolescence by adolescents and parents. *New Directions for Child Development*, 22, 93–109. <https://doi.org/10.1002/cd.23219832208>
- Zola, I. (1972) Medicine as an institution of social control, *Sociological Review*, 20, 4, 487–504.

Appendices

Appendix A. Flyer for recruitment

Counselling Psychology Doctoral Research Project:

Parenting an adolescent who has engaged in substance misuse

Are you a parent who has had past experience of parenting an adolescent who engaged in substance misuse?

Would you be prepared to share your story anonymously?

I am a trainee counselling psychologist at London Metropolitan University, and I am carrying out research for my Professional Doctorate in Counselling Psychology project into the experiences of parents who have had past experience of parenting an adolescent child who had misused substances

Interviews will be carried out on Zoom and would last no more than 60 minutes. To ensure confidentiality, participants will be requested to undertake the interview in a private space where they cannot be overheard.

All data will be anonymised.

Whilst this is an academic doctoral project, it is hoped that findings from this research may have much wider benefits and potentially inform future practice within Counselling Psychology, Adolescent substance misuse, and other family support services.

If you would be interested in taking part in this study, please email:
shw0391@my.londonmet.ac.uk

Thank you for reading. I do hope you will consider taking part.

Appendix B. Information for participants

Research Project: Parenting an adolescent who engaged in substance misuse.

Dear volunteer

I am a trainee counselling psychologist at London Metropolitan University, and I am carrying out a research project for my Professional Doctorate in Counselling Psychology. With over 11,000 adolescents seeking treatment for substance misuse in the UK in 2021-2022, it is actually estimated that adolescent substance misuse is actually far more prevalent, perhaps as much as 2 in 10 adolescents, and so may have affected far more parents than those involved in substance misuse treatment programmes. I am particularly interested in your experiences if you have parented an adolescent who has misused substances whether or not they had accessed treatment programmes.

I am hoping to complete this research as my doctoral thesis. For this study I am looking for parents who have parented an adolescent through a period of substance misuse. Participation would involve an online interview lasting no more than 60 mins. The interview would be audio recorded, and transcribed. Transcriptions will be amended to remove any identifying names, places, or descriptions to ensure anonymity. Anonymised illustrative quotes may be included in written results / discussion. Participation is entirely voluntary, and participants have a right to withdraw up to one month after data collection without question. Your name or any identifying information will be removed from the data and will not be quoted in the study. The consent forms will be kept separately from the data and will only serve to verify that proper consent has been obtained.

Recordings will be kept secure, password protected and encrypted, data will be anonymised upon transcription. All recordings will be destroyed once the project is submitted. Please note that my director of studies or the external examiner may request access to the raw data for verification purposes. Please note the interview will be discussing a difficult and potentially traumatic period in your life and as such may bring up distressing or difficult feelings for participants. There will be a distress protocol in place, however it is important that participants feel ready and able to discuss this period in their lives safely. There will be an opportunity for a full debrief following the interview and resources for further support for parents and for adolescents will be signposted if needed. To ensure confidentiality, participants will be requested to undertake the interview in a private space where they cannot be overheard.

Also, I am intending to submit the completed study for publication with a renowned journal. Successful publication would require me to retain all data for a certain length of time which could be around 5 years depending on the journal. *Please* note findings from this study may be written up and published in journals or presented at conferences. If any individual data are presented, the data will be totally anonymous, without any means of identifying the individuals involved. All interviewees are invited to request a copy of the final study after completion of the project. This will be available in Jan 2026.

This study has been approved by the Research Ethics Review Panel at London Metropolitan University and will be conducted in accordance with the ethical guidelines provided by the British Psychological Society. If you have any questions, comments or complaints about this study please get in touch with me, either in person, via phone or email. Alternatively, you can contact my director of studies, Dr Angie Cucchi, a.cucchi@londonmet.ac.uk

Thank you very much for your time and interest. Should you decide you would be willing to take part in this study, please do email: shw0391@my.londonmet.ac.uk

Yours sincerely

Appendix C. Fully informed Consent Form

Research Project: Parenting an adolescent who engaged in substance misuse.

Researcher: Sharon Walker

I confirm that I have read and fully understand the information sheet for the above study and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any time until 31st July 2024. I do not have to give any reasons for why I no longer want to take part and there will be no adverse consequences if I choose to withdraw. I understand that interviews will be confidential, however there may be rare exceptional circumstances where confidentiality cannot be guaranteed. Where possible these will be discussed with you before any breach of confidentiality takes place.

These are:

Where there is a risk of harm to others relating to serious crime (e.g. child abuse, drug trafficking, money laundering, terrorism, female genital mutilation, forced marriage).

Where there is an imminent risk of your causing serious harm to yourself or others

I understand that the interview will be audio-recorded and transcribed anonymously - transcriptions will be amended to remove any identifying names, places, or descriptions. The recording will be stored in a protected encrypted cloud to then be transcribed and anonymised for analysis. I understand these recordings will be completely destroyed once transcribed.

I understand that the anonymised results of the study may be included in written articles for publication and stored in the university repository for access for future researchers. I understand that confidential anonymised brief extracts from my interview (minus explicit identifying information) may be used within the study.

I understand that I may find this interview upsetting and that it may evoke a number of difficult and distressing feelings for me. I understand that the researcher will be able to provide information on further support available if required.

I understand that I have the right to obtain information about the findings of the study and details of how to obtain this information will be given in the debriefing form.

I understand that the data will be destroyed once the study has been assessed.

I understand my personal details such as name, phone number, address, and email address etc. will not be revealed to people outside the project.

I understand and agree that this researcher may use my data in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form

I understand and agree that my words may be quoted in publications, reports, web pages, and other research outputs. I understand that I will not be named in these outputs unless I specifically request this.

To ensure confidentiality, I agree to carry out the interview in a private room, where I cannot be overheard by others.

I understand and agree that other authorised researchers may use my data in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.

I give permission for the thesis written including anonymised transcript extracts and analysis of data from the interview that I provide to be deposited in London Metropolitan University repository so it can be used for future research and learning

So that the information can be used legally by the researchers, I agree to assign the copyright I hold in any materials generated as part of this project to London Metropolitan University.

I agree to take part in the above study.

Please initial box. ☐

.....		
Name of Participant	Date	Signature
.....		
Name of Researcher	Date	Signature

Appendix D: De-brief Form

Thank you for taking part in this research study.

This is part of a Doctoral project that the researcher is conducting. If you are interested in the results of the study, or if you have any questions about this study, or if you wish to withdraw, please contact the researcher on the following email address: shw0391@my.londonmet.ac.uk

Emails will be checked regularly.

Please remember that if you wish to withdraw your date from this study it should be done by 31st July 2024, as it may not be possible at a later stage.

Equally, if you have any questions or concerns you are more than welcome to address them now. If you have any complaints regarding any aspect of the way you have been treated during the course of the study please contact my research supervisor Dr Angie Cucchi, Email: a.cucchi@londonmet.ac.uk

If participation has raised any concerns or issues that you wish to discuss further, a number of agencies can provide advice and support in confidence.

YOUNG MINDS Drug and Alcohol: www.youngminds.org.uk

CATCH 22: Surrey Young People's Substance misuse service: www.catch-22.org.uk: Out of hours helpline: 0800 622 6662

The Mix: Essential Support for Under 25's: www.themix.org.uk

MIND: Alcohol, drugs, and addiction: www.mind.org.uk

FRANK: Honest information about drugs: www.talktofrank.com

Helpline: 0300 1236600

NHS: SABP i-access drug & alcohol service: www.surreydrugandalcohol.com

Helpline: 0300 222 5932

Appendix E: Distress protocol

Protocol to follow if participants become distressed during participation

This protocol has been devised to deal with the possibility that some participants may become distressed and/or agitated during their involvement in the present research study on parents' experiences of parenting an adolescent who has misused substances. Participants may have experienced some form of psychological trauma from these experiences.

There follows below a three-step protocol detailing signs of distress that the researcher will look out for, as well as action to take at each stage. The researcher also recognises that participants may find the topic of the interview somewhat distressing but may wish to continue talking. The researcher will trust the participants to be aware of their own emotional wellbeing and be led by the participants wishes to stop or continue, unless extreme distress is evident.

It is expected that researcher will be aware of and monitor any outward signs of distress during the interview. It is not expected that extreme distress will occur, nor that the relevant action will become necessary, but it is included in the protocol, in case of emergencies where such professionals cannot be reached in time.

Mild distress:

Researcher to be aware of any sign of tearfulness, hesitancy to speak or finding it difficult to speak, or becoming distracted or restless.

Action:

Research to pause and allow time for participant to recover.

Researcher to remind participant of their right to withdraw at any time and can offer short break if needed.

Researcher to ask participant if they are okay to continue and agree a signal or phrase to stop if distress returns.

Moderate distress:

Researcher to look out for signs of dysregulation, such as crying, raised voice, physical motor movements, getting up, shouting, lost in thought, silence, signs of panic attack, laboured breathing, sweating, shaking

Actions:

Researcher to reflect back to participant they have noticed their distress and intervene to stop the interview.

Immediate debrief if participant is able. If not, allow time for recovery. Potentially, suggest techniques to relax, re-regulate physically and emotionally.

Reassure participant that topic is emotionally sensitive, and it is normal to feel strong feelings after traumatic events involving those we care about.

Have details of crisis support services, helplines, and counselling services available to offer to participants.

Participants will be reminded to let the researcher know if at any time they are feeling distressed by the questions or their responses, and of their right to withdraw or pause the interview at any time for any, and no, reason. They do not have to give a reason to the researcher, their wish to stop will be unquestioned and the interview will stop.

Appendix F: Interview Schedule (45 mins)

(Adapted from Choate 2011, Dykes & Casker, 2021; Groenewold & Bhana (2017), Pearson (2000),

How did you first become aware that your adolescent son/daughter was misusing substances?

How did you react at first?

Can you describe how the substance misuse progressed and the impact on you?

What were your concerns? Did they change over time?

How did substance misuse affect your adolescent's life?

How did their substance misuse affect your life?

What support did you have at the time? Now?

How are things now?

What would you say to other parents going through the same thing?

Is there anything you were expecting me to ask that I haven't? Or anything else you would like to add about your experience of parenting an adolescent who engaged in substance misuse?

Follow up questions can include

Tell me more about that?

Can you say more about that?

How did that feel for you?

How do you feel about that now?