A PHENOMENOLOGICAL STUDY OF PARENTS WITH ADOLESCENTS ABUSING *NYAOPE* IN MOKOPANE, SOUTH AFRICA

By

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DEDICATION

The current study is dedicated to all parents who are raising adolescents who abuse *nyaope* in South Africa.

DECLARATION

I declare that **A PHENOMENOLOGICAL STUDY OF PARENTS WITH ADOLESCENTS ABUSING *NYAOPE* IN MOKOPANE, SOUTH AFRICA** (thesis) hereby submitted to the University of Limpopo, for the degree of **Doctor of Philosophy** in Psychology, has not previously been submitted by me for a degree at this or any other university; that it is my work in design and in execution, and that all material contained herein has been duly acknowledged.

20/07/2024

Surname, Initials (Mr.) **Date**

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LIST OF ACRONYMS

Acronym	Explanation
AFM	Affected Family Members
AIDS	Acquired Immune Deficiency Syndrome
BPS	BioPsychosocial Model
BFST	Bowen Family Systems Theory
DSD	Department of Social Development
EVF	Efavirenz
HBS	Health Belief System
HIV	Human Immunodeficiency Virus
LOC	Locus of Control
SACENDU	South African Community Epidemiology Network on Drug Use
NDoH	National Department of Health
SAPS	South African Police Services
SSCS	Stress Strain and Coping Support Model

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ABSTRACT

Parenting an adolescent who abuses *nyaope* drug is a difficult task fraught with several difficulties. The present study explored the lived experiences of parents with adolescents who abuse *nyaope* with the aim of developing a research informed Help-Seeking Model around the rural areas of Mokopane in the Limpopo Province, South Africa. Parents' subjective experiences were gathered through the qualitative approach using the Hermeneutic phenomenological design. Data were analysed using the Interpretative Phenomenological Analysis (IPA). The study found *nyaope* to be a potent yet easily accessible drug of choice for teenagers in rural and township settings. *Nyaope* abuse risk factors were isolated and ranged from being of a psychosocial and spiritual nature. The deleterious nature of the condition meant parents' quality of life and well-being were compromised, including due to social stigma. Parents relied on religious, psychological, and social strategies for coping. It was discovered that several paths or trajectories, i.e., a combination of the medical, psychiatric, social-welfare, and spiritual services pathways, were necessary for the treatment of their affected youth. Based on the study findings, an adapted *nyaope* Help-Seeking Model is proposed for early identification and management of affected adolescents. The study also has several implications for clinical practice, further research, and policy development. It is concluded that *nyaope* abuse is a potent drug, which early identification of signs and symptoms indicative of use, is necessary towards sustainable interventions. Key in its management is addressing the risk as early as possible to lessen teenager vulnerability to the drug.

Keywords**:** *Nyaope* abuse, parents, help-seeking pathways, help-seeking model

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CHAPTER 1: INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 Introduction

This chapter presents the overview of the current study. The central objective of the study is to explore the lived experiences of parents living with adolescents who abuse *nyaope*. This lived experiences informs the developing of the Help-Seeking Model for parents in rural communities or townships. The current chapter comprises five sections. The first section encapsulates the background of the present study. The second section elucidates the problem statement. The third section entails the purpose of the study while the fourth section presents the provisional definition of the concepts that undergird the study. The fifth section provides the outline of the whole study.

1.2 Background to the study

Raising an adolescent child can generally be a daunting task for any parent (Hubert & Aujoulat, 2018; Mikolajczak & Roskam, 2018). The problem is further compounded by raising a child in low socioeconomic environment, which is perpetually prone to abuses of psychoactive substances (Choate, 2015; Groenewald & Bhana, 2016;). In South Africa, among the psychoactive substances of choice that such adolescents are likely to abuse is *nyaope* (Mabokela, 2018; Mahlangu & Geyer, 2018; Masombuka & Qalinge, 2020; Mokwena, 2015; Nkosi, 2017). *Nyaope*, also known as *whoongah*, is a highly addictive cocktail drug and has many different street names depending on the location. It is reported that *nyaope* is a drug of choice for adolescents from disadvantaged backgrounds (Mokwena, 2016; Mokwena & Huma, 2014; Mokwena & Morojele, 2014). Hence, it remains a "public health concern" and equally an area of scholarly interest (Mokwena & Huma, 2014, p. 353).

Nyaope is unmanageable mainly because of its nature: a cocktail of different drugs and poison (Mokwena, 2015; Mokwena & Huma, 2014). It is among the highly addictive and easily accessible illicit drugs which cause severe psychosomatic problems (Khine et al., 2015; Mokwena & Morojele, 2014). In essence, *nyaope* is a mixture of dagga, heroin, detergent powder, rat poison and an anti-retroviral drug

(Mokwena, 2015; Mokwena & Huma, 2014). Admittedly, the compositions of *nyaope* vary from one seller to the other and the location (Khine et al., 2015).

Generally, the factors that contribute to *nyaope* abuse are more or less similar to those that contribute to the abuse of other psychoactive substances, i.e. broken families, poverty, peer pressure, unemployment, drug accessibility and availability, difficult emotional situations such as the loss of a loved one or any other stressful circumstance (Dada et al., 2018; Groenewald & Bhana, 2018; Mokwena, 2015; Mokwena & Huma, 2014; Nevhutalu, 2017; Nkosi, 2017; Radebe & Pistorius, 2017). Mokwena and Fernandes (2016) add external locus of control and low self-esteem as contributory factors to the abuse of *nyaope*.

Parents of adolescents with substance abuse problems often "bear the burden of the child's substance abuse largely because the adolescent child is perceived as an extension of parents own identity" (Groenewald & Bhana, 2016, p. 14). Parental figures are believed to be the primary source of influence to their adolescents, which determines the later functioning (Choate, 2015). However, some theorists and scholars argue that the adolescence stage is characterised by a sense of independence and adolescents largely prefer the company of their peers over that of their parents, which leads to peer influence (Belsky, 2019; Orben et al., 2020; Rampee et al., 2020). Thus, parents bear the brunt of their children's behaviour (Choate, 2011; Mabokela, 2018).

Parents are perceived as being responsible for their children's behaviours, including criminal behaviour (at home and neighbourhood), dropping out of school and other risk-taking behaviours that make them susceptible to medical conditions (Choate, 2015; Kheswa & Tikimana, 2015). Consequently, parents experience severe emotional difficulties and physical conditions (Choate, 2015; Groenewald & Bhana, 2015; Ngantweni, 2018; Orford et al., 2013). The scourge of *nyaope* abuse is destroying the future and ambitions of South Africans, more specifically young people (Dada et al., 2018; Groenewald & Bhana, 2018). *Nyaope* is also associated with multiple negative health and psychosocial outcomes for its young victims, their families, and the society as a whole (Hlungwani et al., 2020; Mokwena & Huma, 2014; Mothibi, 2014).

Most parents who are faced with these challenges are mostly Africans who are also battling with socioeconomic challenges having to face an added challenge of adolescents who are addicted to *nyaope* (Dada et al., 2018; Mokwena, 2015). These parents are not only expected to cope with challenges of poverty, but also an additional burden of raising a child who abuses *nyaope* (Dada et al., 2018; Mokwena, 2015; Dada et al., 2016), limited psychosocial services for family members (particularly parents), inadequate intervention and/or prevention programmes against the problem (Groenewald & Bhana, 2015; Dada et al., 2018).

Studies have been suggesting that individuals of African descent do not utilise mental health services as compared to other races (Bojuwoye, 2005; Pretorius, 1999; Puckree et al., 2002). These studies also reveal that African people often first seek help from religious or traditional healers before considering western treatment (Berg, 2003). This is partly ascribable to the unavailability or restricted accessibility of mental health services and exorbitant financial costs often associated with the acquisition of mental health services in South Africa (Dada et al., 2016). Arguably, African people seek help based on consciousness and connectedness, which in their view, has no bearing on affordability and accessibility. There is enough evidence that suggests that families with substance abuse challenges tend to rely on social welfare services, rehabilitation services and medical services (Choate, 2011; Groenewald & Bhana, 2015; Khumalo, 2016; Mahlangu, 2016).

According to SACENDU, seeking help for substance abuse related problems in rural areas, particularly Limpopo Province, is accompanied by myriad of challenges. Part of the problem is that there are no official and effective inpatient facility in rural areas of Limpopo province (e.g., big city or small town) attended by the addict. Most residence of Limpopo relies on Gauteng province as a feeder with long waiting list for admission. Mokwena and Huma (2014) revealed that the rehabilitation centres in the South Africa's townships are ineffective, as reported by some participants who stated that centres did not help them at all. Hence, almost all the participants resumed *nyaope* smoking a few days after being discharged from rehabilitation centres. Some relapsed on the very same day on which they were discharged. These rehabilitation centres are reportedly expensive. It is against this background that a phenomenological account

of parents with adolescents who abuse nyaope were used to adapt a model from the works of previous scholars.

The problem of substance abuse by adolescents is not limited to South Africa. On the contrary, across the globe, it is reported that a significant number of adolescents abuse substances to a point of requiring professional intervention (Dada et al., 2016). In South Africa, substance abuse among adolescents is rapidly escalating (Audet et al., 2017; Dada et al., 2018; Groenewald & Bhana, 2018; Tshitangano & Tosin, 2016). The United Nations report affirms that South Africa is one of the drug capitals in the world (UNODC, 2016). Certainly, with *nyaope* being a relatively new drug in the South African context, the most appropriate interventions (i.e. rehabilitation programmes; family focused programmes; support groups) to help the adolescents who abuse *nyaope* and their families are not readily available (Dada et al., 2018; Groenewald & Bhana, 2018; Mokwena, 2015). Moreover, there is dearth of literature on *nyaope* abuse and its impact on family, despite there being a notable outcry about this phenomenon from the government and society at large. Against this background, it was imperative to investigate the lived experiences of parents with adolescents who abuse *nyaope*, with the intention of providing the most appropriate remedial interventions and help-seeking model for parents with adolescents who abuse *nyaope*.

1.3 Research problem

When children are born in a healthy environment and family set up, they are likely to lead a healthy lifestyle that is free from a plethora of social ills, including substance abuse (Haefner, 2014). Such an environment becomes more crucial during adolescence, which is a critical stage in human development because it is characterised by search for independence, clarity of one's identity and preparation for adulthood (Barret & Turner, 2006). The successful completion of this critical stage essentially contributes to a successful individual with a relatively well functioning family, which may lead to a better community (Steinberg & Morris, 2001). Therefore, a failure to manage this stage may yield confusion in terms of roles and responsibilities, which ultimately affects families negatively and other important institutions (Christie & Viner, 2005).

According to the Lachman et al. (2016), stable and healthy families are the epicentre of well-developed individuals and strong societies. The White Paper on Families (2021) concurs that it is within the family environment that an individual's physical, emotional and psychological development occurs. This implies that in family, individuals learn unconditional love, understand right from wrong, and gain empathy, respect and self-regulation (Gould & Ward, 2015). These qualities enable individuals to engage positively at school, at work and in society in general. The absence of a stable and nurturing family environment has a profound impact on the individual, which often leads to behaviours that are detrimental to society (Gould & Ward, 2015; Lachman et al., 2016).

An adolescent whose social and emotional needs are catered for within the family structure rarely associates with deviant peers in search of a sense of fulfilment (Barret & Turner, 2006). Therefore, good role models in the family context, be they caregivers, parents, siblings or any other person worth emulating pertaining to responsible living, have been found to play a role in the development of an internal locus of control that assists in resisting external pressures (Choate, 2011; Christie & Viner, 2005). Parents are central to the overall development of their children (Steinberg & Morris, 2001). Parents create, or at least are supposed to create families that ultimately contribute to societies that are free from teenage pregnancy, criminal activities, and substance abuse. This, however, cannot be said of numerous South African societies, which have been grappling with the scourge of *nyaope* abuse for almost two decades, resulting in the nation dubbed the drug capital by the United Nations (UNODC, 2016). *Nyaope* abuse prevails amongst adolescents from low socio-economic areas such as rural areas and townships (Dintwe, 2017; Fernandes & Mokwena, 2016; Mokwena & Huma, 2014). *Nyaope* continues to destroy the future prospects of successful and healthy lives among young people as it leads to school dropouts, criminal behaviour, shattered dreams, poor hygiene, broken families and impulsive sexual behaviour (Dintwe, 2017; Jackson et al., 2005; Mokwena & Huma, 2014).

Social workers who have studied adolescents' abuse of *nyaope* have found that the adolescents' parents and their families are negatively impacted by the abuse and subsequently require rehabilitation (Mafa & Makhubele, 2020; Masombuka & Qalinge, 2020; Radebe & Pistorius, 2017). A family is generally a system in which the behaviour

(positive or negative) of one family member automatically affects other family members that comprise it (Choete, 2015). Therefore, when a family has an adolescent who abuses *nyaope*, his/her addiction not only disrupts, but also alters the ultimate functioning of the entire family (Brown, 1999).

Society often blames the parents of an adolescent who abuses *nyaope*, for instance, for failing to inculcate positive behaviour in their child or children (Brown, 1999; Choate, 2011). The parents are blamed mainly because children who abuse *nyaope* are highly likely to drop out of school, engage in criminal activities and become community nuisance (Groenewald & Bhana, 2016; Kalam & Mthembu, 2018). Suffice it to say that parents as primary caregivers are automatically affected when their children abuse drugs (Mahlangu, 2016; Masombuka, 2013; Mathibela, 2017). Further compounding the problem is that most of these parents are from poor backgrounds and rarely afford the treatment costs required by their children (Masombuka & Qalinge, 2020). Hence, the parents might exhibit poor emotional health, often characterised by depression, irritability, or unstable emotional behaviour (Groenewald & Bhana, 2017). Consequently, their emotional state might culminate in poor parenting.

Given the historical background of South Africa, which includes social and economic exclusion, the protracted effects of this history are still evident among some parents in rural areas. These parents rarely have formal education and thus have fewer employment opportunities (Magoro, 2021; Tambe et al., 2023). Such a socioeconomic background may compel some adolescents to abuse *nyaope* as a coping mechanism, especially among those adolescents whose parents work far from home (Hansen & Chen, 2016; Magoro, 2021; Mokwena & Huma, 2014). Consequently, most families in rural areas end up being child-headed for the most part, resulting in poor parental care (Hansen & Chen, 2016).

In South Africa, there is ongoing challenges of limited access and unavailability of mental health services in rural areas (Kohn et al., 2003). In instances where there is access, the budget allocated for mental health is often insufficient and compromising the quality of service sought. According to Docrat et al. (2019), South Africa's public mental health expenditure represented 5.0% of the total public health budget, with wide disparities between provinces. Inpatient care represented 86% of mental

healthcare expenditure, with nearly half of the total expenditure on mental health occurring at the psychiatric hospital-level. Almost one-quarter (24%) of mental health inpatients are readmitted to hospitalisation within 3 months of a previous discharge, costing the public health system 18.2% of the total mental health expenditure (Dada et al., 2016; 2018). This insufficient budget caters to substance related problems, including *nyaope* abuse.

Overall, there is a dearth of formal studies, precisely from a clinical psychology perspective that focuses on parents' emotional needs, treatment sought and as well as help-seeking pathways followed by parents with adolescents who abuse *nyaope*. In addition, studies that attempted to document the lived experiences of parents with adolescents who abuse *nyaope* do not provide comprehensive and applicable information on help-seeking pathways for parents and their children, especially those in previously disadvantaged rural communities. Furthermore, proposed coping mechanisms are not tailor-made for parents in rural provinces and more specifically, the Waterberg District, as it has its own unique socio-economic challenges. Tjale et al., (2022) found that the Waterberg District lacks economic opportunities and poor infrastructure as indices of its low socio-economic status. This status ultimately places adolescents in the district at risk to abuse substances and subsequently *nyaope* abuse.

There have been numerous calls for research with a view to curb the impact of *nyaope* at multiple levels, chief among them being the family level in South Africa (Mokwena & Huma, 2014). The present study therefore sought to respond to this call and employ a family-oriented approach through the lens of clinical psychology by investigating the lived experiences of parents with adolescents who abuse *nyaope* in the selected villages of Mokopane (Limpopo Province). It documented the contributory factors to *nyaope* abuse by adolescents in the study area. The study further sought to provide knowledge on how adolescents' abuse of *nyaope* affects their parents and how the parents cope with the attendant challenges. The study proposed solutions in relation to treatment and help-seeking pathways model for both the adolescents, parents and communities at large. Overall, the study's findings informed the researcher's proposal of family-oriented interventions against the prevalence of *nyaope* abuse among the affected adolescents and their parents.

1.4 Purpose of the study

1.4.1 Aim of the study

- The aim of the study was to explore the lived experiences and develop a help seeking model for parents with adolescents who abuse *nyaope* in Mokopane area, South Africa.

1.4.2 Objectives of the study

The present study advanced the following objectives:

- To ascertain the parents' understanding of the contributory factors to *nyaope* abuse problems.
- To determine the psychological impact of the adolescents' *nyaope* abuse on their parents and the overall functioning of their families.
- To identify and describe the strategies used by parents to cope with the problems emanating from *nyaope* abuse by their adolescent children.
- To document parents' views regarding the treatment that their adolescent child was receiving or should have received.
- To document the help-seeking pathways that parents followed in the management of adolescent child's *nyaope* abuse problems.
- Based on the phenomenological account, develop a contextually relevant help-seeking model for parents with adolescents who abuse *nyaope* in townships and rural areas.

1.5 Significance of the study

This study contributes significantly to the body of knowledge on substance abuse, particularly *nyaope* abuse, which remains a grave concern to South Africa's public health. The current study zoomed into the lived experiences of parents raising adolescents who abuse *nyaope*. Since the emergence of *nyaope* post millennium, there remains a dearth of literature on the lived experiences of the parents of adolescents who abuse *nyaope*.

Through its proposal of a family-oriented treatment approach, the study provided remedial interventions that can combat the prevalence of substance abuse among adolescents as well as provide treatment for their affected parents from the perspective of clinical psychology. Hence, the study did not only elucidate the challenges faced by the adolescents, but also drew into critical focus their parents' lived experiences – an aspect thus far under-researched in South African scholarship. The study will assist tailoring policy direction and research for Psychologist, Researchers, Social Workers and other mental health professionals with regards to *nyaope* abuse

The study was grounded on hermeneutic phenomenological design, which allowed the researcher to generate in-depth perspectives and insights regarding the phenomenon under investigation. The findings may provide valuable insights regarding the experiences of parents with adolescents who abuse *nyaope* and contributes to research informed Help-Seeking Model. The family-orientated approach recommended in this study as a strategic intervention against the scourge of *nyaope* abuse among adolescents, represents a novel perspective, which uniquely applies to the context within which the study was conducted.

1.6 Operational definition of concepts

Parent: refers to a primary helper, monitor, coordinator, observer, record keeper and decision maker for the child (Govindaraj & Anusudha, 2014). According to Oxford Dictionary (2005), the word 'parent' refers to a person who is one of the progenitors of a child; a father or mother. Also, in extended use; a man or woman who takes on parental responsibilities of a child, e.g. a stepfather or adopter father. In the context of this study, a parent would refer to a primary care giver either a mother, father or guardian who is responsible for coordinating, observing and monitoring the overall wellbeing of the children.

Parenting: refers to the rearing of a child or children, in particular the care, love, and guidance given by a parent (Putra et al., 2023). According to Virasiri et al., (2011) parenting can be defined as the act or process of functioning as parents and of raising children using skills or activity of looking after children. Parenting is a process of raising

and educating a child from birth until adulthood, which is carried out in a child's family by the mother and father or guardian.

Adolescent: According to Menkiti (2009), adolescent refers to a young person between the age of 10-24years who has outgrown the social status of a child but has not yet been accorded the social and mature privilege of an adult. The World Health Organisation (2010) defines an adolescent as a young person between 10-19 years of age, who is undergoing physical, psychological and social change. For the purpose of this study, adolescent will refer to young persons between the age of 10-19 who is in the border between childhood and adulthood undergoing physical, psychological and social change.

1.6.4 Family: A societal group that is related by blood (kinship), adoption, foster care or ties of marriage (civil, customary or religion), civil union or cohabitation, and goes beyond a particular residence (Lachman et al., 2016; White Paper on Family, 2021, p. 180). The same definition will apply in the current study.

***1.6.5 Nyaope*:** is a street mixture of drugs with the most common substances including heroin and cannabis. *Nyaope* (heroin part) is sprinkled on cannabis and smoked as a cocktail. On its own it is also injected or 'chased' off foil without cannabis – the active ingredients are mainly heroin and other opioids to give a heroin-like effect. The other substances, such as some small amounts of stimulants are to enhance the initial perception of a high through dopamine activity (which is not primarily linked to heroin use) and as 'bulking' agents (Drug Master Plan, 2019, p. 8). Mokwena (2016) refers to *nyaope* as a relatively new designer drug, highly addictive and consisting of dagga, heroin and different kinds of chemicals.

1.6.6 Nyaope abuse: is defined as an excessive use of *nyaope*, and such use is without medical justification (Drug Master Plan, 2019). In the context of this study, *nyaope* abuse would refer to the excessive use of *nyaope* without medical justification and such use continues despite clear evidence of impairment in significant areas of functioning.

1.6.7 Help-seeking pathways: According to Zartaloudi and Madianos (2010) help-seeking pathways refers to the "active search for resources that are relevant for the resolution of that problem". Unrau and Grinnell (2005) defined help-seeking pathways as a pathways followed in order to seek for assistance from informal supports or formalized services for the purpose of resolving emotion, behavioural, or health problems. Barker (2007, p. 2) defined it as "Any action or activity carried out by an adolescent who perceives herself/himself as needing personal, psychological, affective assistance or health or social services, with the purpose of meeting this need in a positive way. This includes seeking help from formal services – for example, clinic services, counsellors, psychologists, medical staff, traditional healers, religious leaders or youth programmers – as well as informal sources, which includes peer groups and friends, family members or kinship groups and/or other adults in the community".

1.6.8 Treatment: refers to the process that begins when people who use drugs come into contact with a health provider or any other community service and may continue through a succession of specific interventions until the highest attainable level of health and well-being is reached (Drug Master Plan, 2019, p. 10). Treatment can be defined in general terms as the provision of one or more structured interventions designed to manage health and other problems as a consequence of drug abuse and to improve or maximize personal and social functioning.

1.6.9 Rehabilitation: refers to a process by which a service user is enabled to reach and maintain his or her own optimal physical, psychological, intellectual, mental, psychiatric or social functional levels, and includes measures to restore functions or compensate for the loss or absence of a function. Rehabilitation refers to interventions designed to optimize functioning and reduce disability in individuals with health conditions in their interactions with their environment. It addresses the needs of a broad range of people across the lifespan (WHO, 2019).

1.7 Outline of the thesis

This thesis consists of seven chapters. Chapter one outlined the background, the research problem, the aim and objectives of the present study. Chapter two is a critical

review of literature followed by chapter three which includes psychological models and theories. The fourth chapter entails the rationale for the chosen methodology and details regarding the procedures followed when conducting this study. In the fourth chapter, the study methodology that was followed is presented. Aspects such as the selected research paradigm, study design, data-analysis strategy employed, ethical considerations and quality criteria form the core of Chapter four. Chapter five gives a detailed presentation of the research findings. The first part of this chapter provides the demographic information of the participants, whilst the second part of the chapter gives the core of qualitative findings. Chapter six presents the discussion of the findings in relation to key literature and psychological theory. A presentation of the conclusions, limitations and recommendations for practice and future research was presented in Chapter seven.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The purpose of this chapter is to review the existing literature within the area under investigation. This chapter begins with a general overview of substance abuse and addiction to provide context to the phenomenon under investigation. Thereafter, a synopsis of *nyaope* abuse, which includes the description, route of administration, pharmacological composition, prevalence as well as its impact on the users. The third part of the review focuses on the contributory factors to *nyaope* abuse among adolescents, followed by a reflection on the psychosocial impact of *nyaope* abuse on parents and their coping strategies. Subsequently, the treatment and prevention methods available to those who are having substance abuse problems in general and *nyaope* abuse in particular are discussed. Lastly, the chapter focuses on help-seeking pathways followed by the parents affected by the problem of substance abuse.

2.2 Substance abuse and addiction in Sub-Saharan Africa

The most reported drugs of abuse include heroin, cannabis, nicotine, alcohol, cocaine, mandrax, and ecstacy (Tali, 2024). Substance abuse includes the use of licit (legal) and illicit (illegal) drugs as well as other chemicals (Possi, 2018; Tshitangano & Tosin, 2016). Substance use, misuse and abuse remain one of the greatest concerns globally with far-reaching consequences on individuals, workplace, schools and most significantly families and communities (Mbandwa & Dorasamy, 2020; Mothibi, 2014). South Africa like other countries has developed legislations, guidelines, and policies to curb the rapid escalation of substance abuse in country (Dada et al., 2018; Groenewald & Bhana, 2018). These legislations include amongst others Prevention of and Treatment for Substance Abuse Act 30 of 2008, Pharmacy Act 53 of 1974 as well as South African Institute for Drug Free Sports Act 14 of 1997 (Dada et al., 2018). Policies relevant include White Paper on Families and the latest version of National Drug Master Plan 2019-2024 (Dada et al., 2018; Groenewald & Bhana, 2018). These legislations and policies have been ineffective in addressing some of the key contributing factors to substance abuse such as poverty, inequality, and unemployment among young South Africans (Mothibi, 2014). This is evident in that

the problem has escalated to sophisticated levels where young people especially from township and rural settings mix all kinds of substances to produce cheap drugs like *nyaope* (Mokwena & Setshego, 2021; Tshitangano & Tosin, 2016).

The trend of cheap but toxic drugs such as *nyaope* has been observed in other regions outside South Africa. In recent years, there has been increasing literature on the new spectrum of substance use problems that are commonly referred to as 'cocktail drug abuse' or 'designer drug abuse' (Levine & Lovecchio, 2021). This is the novel phenomenon where mostly young people in Americas design their own drug by creating a mixture of different drugs and toxic substances to produce a unique mental effect (Almaghrabi, 2021; Levine & Lovecchio, 2021). Sub-Saharan Africa has not been spared from this scourge since 2015 (Olawole et al., 2018). A systematic study by Olawole and colleagues clearly illustrates that Nigeria, South Africa, and Botswana have a high prevalence of this type of designer drug. Such drugs have a unique physical health and mental effects ranging from problems such as hallucinations, aggressive behaviour and death in some cases (Almaghrabi, 2021; Olawole et al., 2018). Substance abuse can simply be understood as a combination of cognitive, behavioural, and physiological symptoms following the prolonged use of a particular drug (Kaplan & Saddock, 2013). This prolonged use continues despite the visible evidence of deterioration and impairment in significant areas of function (APA, 2013). Possi (2018) adds that this deliberate use of substances/drugs is aimed at inducing physiological and or psychological effects for non-therapeutic purposes.

Over decades, South Africa has experienced a significant increase in the scourge of substance abuse in the general population and more significantly among adolescents (Dada et al., 2016). This scourge continues to perpetuate poverty and ravage the future prospects of young people (Audet et al., 2017). Findings in a study by Morejele et al. (2009) indicate that substance abuse accounts to a number of challenges which include, amongst others, high dropout rates from school and unemployability. Substance abuse also contributes to a high rate of criminal activities and contracting contagious diseases (Baloyi, 2018; Dintwe, 2017; Groenewald & Essack, 2019). Findings from other studies indicate that most young people who are victims of substance abuse are mostly from low socio-economic backgrounds and are said to

prefer alcohol, cigarettes, glue and dagga due to their availability and easy access (Dada et al., 2016).

Studies have further associated substance abuse with several mental health-related problems, such as conduct disorder and attention deficit-hyperactivity disorder (ADHD) (Maluleke, 2010; Morejele et al., 2009). According to Heru et al. (2021), the impacts resulting from such problems include behavioural disorders and substance use disorder, which affect not only the addict, but also the caregivers and/or family members. Substance abuse leads to addiction, which is a brain disease that involves the altering of brain mechanisms leading to the modification of mood, memory, perception and emotional state (Hlungwani et al., 2020; Ramlagan et al., 2010). Addiction is described as a chronic and recurrent illness with brain changes that are responsible for compulsive and uncontrollable use of substances (Leshner, 2001). The distinction between addiction and other brain disease is its onset, it always begins with a voluntary behaviour that is the initial decision to use drugs (Thompson, 2013).

Biological factors are reportedly the predisposing factor to addictions while environmental factors contribute as precipitating factors (Steinberg & Morris, 2001). This argument explains why some users may use the same substance and yet not all of them experience addiction. Studies estimated that between 0 to 70 percent of the susceptibility to becoming addicted could be better accounted for by genetic factors (Kelly et al., 2017; Ramlagan et al., 2010). This brings a conclusive argument that addiction is a biopsychosocial condition and therefore, the solution should adopt the biopsychosocial model.

The treatment and help-seeking pathways of substance abuse has always been in the spotlight given the numerous challenges such as insufficient treatment centres, high relapse rate which is at times attributed to lack of integration between clinical services and spiritual services (Mafa et al., 2022; Morgan et al., 2019). These assertions are supported by the previous national drug master plan which acknowledged that there is no clear strategy on demand reduction, supply reduction as well as harm reduction. It was also found that the implementation plan was not aligned with the funding requirements. Lastly, the intervention strategies to reduce supply had limited effect and lacked a balanced approach (National Drug Master Plan, 2019). Studies by Mokwena et al. (2014; 2015; 2016; 2019; 2021; 2022) identified that the pre-existing challenges on substance abuse have become significantly worse with the introduction of *nyaope* abuse.

2.3 *Nyaope* as a drug of choice

2.3.1 The drug 'Nyaope' and its prevalence

The current study focused on *nyaope* as a substance abused mainly by the young South African population. Unlike other substances, *nyaope* has multi-layered consequences for its users and their families. *Nyaope* is a Setswana coinage, which means '*mishmash'*, referring to how it is made from a muddled collection or mixture of potent substances and materials. Nevertheless, *nyaope* is a novel 'cocktail' or 'mixture' drug, making it a unique phenomenon to the South African population (Mokwena & Huma, 2014; Monyakane, 2018). Geographically, studies trace this drug from the City of Tswane in the Gauteng Province of South Africa (Masombuka, 2013; Monyakane, 2018). Users of this potent and cheap drug are young people predominately from townships and a low socioeconomic status (Fernandes & Mokwena, 2014; Khine & Mokwena, 2016; Mokwena & Huma, 2014; Monyakane, 2018).

Nyaope emerged in the early 2000s and has been responsible for destroying aspirations and careers of young people (Mokwena, 2015). Since its inception, it has spread across the country while assuming different street names in the different parts of the country, including '*Whoongah*' in Kwa-Zulu Natal Province, '*Pinch*' in Limpopo and Mpumalanga provinces, and '*Kataza*' in Johannesburg (Dintwe, 2017; Mokwena

& Huma, 2014). These diverse linguistic terms used to identify the drug reflect the affected regions' attempts at making sense of the 'cocktail' or 'mixture' drug. The drug is in the form of powder and is usually rolled with cannabis (dagga) for use. The current study adopted the name "*nyaope"*, as it is the most used name for this type of cocktail drug across the country.

The use of *nyaope* has been found to be common between 12- and 15-year-olds (Dintwe, 2017; Mokwena, 2015). The reports support earlier statistics by Dada et al. (2016) that found that 75% of patients treated for drug abuse in their clinics were between the ages 14 and 16 years. Although there are increasing reports of females who are abusing *nyaope*, the significant percentage of *nyaope* abusers are males including those identifying as gays, lesbians, and transgender (Fernandes & Mokwena, 2020). Dintwe (2017) proffers that adolescents who are not keen in educational activities are likely to use *nyaope* as compared to those who are keen on pursuing their academic activities.

2.3.2 Pharmacological composition of the drug

Determining the pharmacological composition of *nyaope* has been viewed as one of the difficult exercises due to the fact that its mixtures differ according to locations and that sellers are always experimenting, continuously adding new chemicals and materials. There are few studies conducted to help determine the mixtures in different regions (Fernandes & Mokwena, 2020; Khine & Mokwena, 2015). It is also reported that laboratory analyses of different drugs are costly and that the exorbitant costs are responsible for the significant scarcity of studies (Khine et al., 2015).Existing studies agree on cannabis and heroin as the main ingredients of the mixture (Dintwe, 2017; Mokwena & Huma, 2014; Mokwena & Fernandes, 2014). In addition to cannabis and heroin, other mixtures include detergents, crystal meth, rat poison, bicarbonate of soda, detergent powder, crushed anti-retroviral medication (ARV medication), battery acid, milk powder and chlorine (Khine & Mokwena, 2016).

In a study by Khine et al. (2015), samples of *nyaope* were purchased around the Johannesburg area and taken for laboratory analysis. Results show that *nyaope* is composed of cafeine, opiates, codeine, morphine, methyl-dioxy amphetamine (MDA)

and heroin. Some samples contained antibiotics (citrofex) and antretroviral drugs (zidovudine). In other samples, the results revealed that phenobarbitone and benzodiazepines, benzitramide, moramide intermediates and thiofentanyl and stmulants, such as Pipradol, and fenethyline were also constituents of *nyaope*. Based on these findings, it is evident that the pharmachological properties of the drug will always prove difficult to establish. For instance, a qualitative study by Nevhutalu (2017) conducted around Thohoyandou to determine the user of the drug in the Limpopo Province reported on some unique ingredients. Some of the reported ingredients included vinegar, bath soap, powder soap, rat poison, multi-purpose cleaner, chalk, HIV/AIDS pills, cough syrup, powder from a plasma flat screen, pain relief tablets, ethanol spirit and eye-drop medicine.

Bearing in mind the fluid nature of *nyaope*, treatment of the addicts to the drug is likely to be difficult. Still, it is important to determine the pharmacological composition of *nyaope* to assist with the treatment of withdrawal symptoms as well as the criminalisation of *nyaope*. Firstly, when an adolescent presents with certain withdrawal symptoms of using a particular drug, it informs the type of antidote that should be prescribed (Khine et al., 2019; Khine & Mokwena, 2016). Secondly, this determination is also likely to inform the criminalisation of *nyaope* trade (Dintwe, 2017).

2.3.3 Physiological effects of nyaope on adolescents

The devastating impact of *nyaope* is its ability to cause its user to be addicted to it within a short space of time. Mokwena and Huma (2014) report that *nyaope* has the most devastating effects that are cumulative in nature ranging from the initial effects that are calming and peaceful to a highly addictive usage with harsh withdrawal symptoms. The initial pleasant effect convinces the users that they are stress-free and that the drug will enable them to sleep and wake up to face another day (Masombuka, 2013; Mokwena & Huma, 2014). Therefore, adolescents who abuse *nyaope* initially take the drug as a form of self-medication against difficult life situations or problems (Mokwena & Huma, 2014). However, the initial calming effect that *nyaope* produces is followed by the highly addictive phase (Mokwena, 2015, Mokwena & Huma, 2014). Mokwena and Huma (2014) found that *nyaope* has certain addictive effects that cannot be produced by any other drug. For instance, the cravings it causes are

reported to be unbearable and accompanied by stomach cramps, joint pain and other harsh physiological changes (Mahlangu, 2016; Mokwena, 2015; Radebe, 2017).

2.3.4 Impact of nyaope abuse on the users

This section will discuss the studies that have documented several impact that *nyaope* has on its users. This impact includes physical symptoms, neuropsychiatric symptoms, infectious conditions and criminal behaviour. These impact are notably distinct from other substances/drugs of choice and have been described as severe. This section presents the symptoms and challenges associated with *nyaope* to highlight its severity and disruptive nature. The unique challenges emanating from *nyaope* abuse are also a burden to the parents who are expected to raise the addicted adolescents, mostly without the efficient skills on how to deal with such a distressing situation.

2.3.4.1 Physical health impacts

Khine et al. (2019) conducted a qualitative study with the aim to assess the body organ (liver, kidney, endocrine function and haematological parameter) dysfunction among chronic *nyaope* users. The laboratory results revealed that 86.7 percent of the users had organ abnormalities. A study conducted by Van Wormer and Davis (2008) confirmed that *nyaope* destroys the body's organs and causes poor nutrition and a poor personal hygiene. These abnormalities could be associated with severe chest and abdominal pain, excessive drowsiness, yawning, restlessness, vomiting, and diarrhoea with excessive weight loss. Studies added that these organ abnormalities are also responsible for severe withdrawal symptoms, skin rashes, pimples and sores that itch constantly.

Short tempers, uncontrollable tears, tiredness, drowsiness and mood swings are also listed as common physical effects on *nyaope* users. The results from previous studies showed that if a *nyaope* user stays without it (*nyaope*)*,* they feel sick and their "whole system is dead; [only] *nyaope* brings [them] back to life" (Mokwena & Huma, 2014, p. 353). Other studies add that physical changes are evident in *nyaope* users, i.e. among those who do not bath or wear clean clothes (Khine & Mokwena, 2016; Khumalo, 2016; Mokwena & Huma, 2014; Nevhutalu, 2017). The foregoing researchers confirmed

nyaope users were often poorly groomed and recurrently cited reasons such as not having the time to clean themselves as they spend most of their time using *nyaope*.

2.3.4.2 Neuropsychiatric conditions

There are neuropsychiatric conditions that are associated with *nyaope* abuse due to the use of efavirenz (EFV) as part of *nyaope* constituency (Moller et al., 2018). This drug that is commonly used for HIV and AIDS patients is an antiretroviral therapy which has been found to be a constituent of *nyaope* (Khine et al., 2015; Khine & Mokwena, 2016). Fourie (2018) found that EFV have mind-altering and addictive-like properties found to induce a number of neuropsychiatric effects such as dizziness, anhedonia, hallucinations, sleep disturbances, anxiety, depression, impaired concentration, aggression, paranoia and acute psychosis.

2.3.4.3 Infectious conditions

Nyaope abuse, just like any other substance, is associated with risk-taking behaviour such as unprotected sex and 'bluetoothing' (this is the process of using an syringe to draw blood of an individual who is intoxicated and inject on the next person with the aim to achieve the similar effect of intoxication), which predispose users to HIV, hepatitis and Turberculosis (TB) (Thomas & Velaphi, 2014; Nevhutalu, 2017). There has been a concern that people with HIV who smoke *nyaope* may develop mutant strains of the virus that are resistant to medication (Khumalo, 2016; Moller et al., 2018). Users seem to not care about "adhering to treatment and a good diet as they replace these with drugs, which subsequently leads to further health complications" (Goldman & Smith, 2002). The World Health Organisation (WHO) (2014) reported that there is a causal relationship between the use of cocktail drugs (*nyaope*) and illnesses like TB and cancer.

In addition, it is also evident from the study conducted by Nevhutalu (2017) that the use of *nyaope* and mainly because of the way it is used, i.e., users injecting themselves, exposes the users to various physiological health risks that leave them with wounds on their skins, thus making them vulnerable to HIV and other infections. As they share injections, an exchange of blood and even of saliva might also contribute

to the transfer of infections from one user to the other (Baloyi, 2018; Groenewald & Essack, 2019; Meel, 2018).

2.3.4.4 Criminal behaviour

Substance abuse in general has been linked to a high rate of crimes (National Drug Master Plan, 2016). Literature on *nyaope* abuse has added more weight on the association between chronic *nyaope* users and criminal activities (Dintwe, 2018; Khanyi & Malesa, 2022; Mahlangu, 2016; Radebe, 2017). Furthermore, rural areas have experience a significant decline in communities that were free from criminal activities and this was attributed to substance abuse (Mdhluli, 2018; Taylor et al., 2012). Gravitations to criminal behaviour are a result of the irresistible craving and withdrawal symptoms, which compel *nyaope* users to steal whatever they can sell, including costly assets, to buy the drug (Mokwena, 2015; Mokwena & Huma, 2014; Nevhutalu, 2017). A study by Mokwena and Huma (2014) confirmed the notion that most *nyaope* abusers engage in criminal activities. Poverty, unemployment and the addictive nature of *nyaope* are cited frequently as contributory factors to the user's committing crime, mostly petty theft, sustain their habits (Fernandes & Mokwena, 2016; Mahlangu, 2016; Masombuka, 2013; Mokwena, 2015; Mokwena & Huma, 2014).

Nyaope users reported that they steal anything that they come across with, including shoes, blankets, DVDs, kettles and meat from their families (Groenewald & Bhana, 2016; Mokwena, 2015; Nevhutalu, 2017). One user recalled how they would steal school bags from their classmates, throw out the books and sell the bags (Mahlangu, 2016). In almost all the discussions, the participants referred to experiences in prison, after being arrested for the theft of various items in their community or in shops (Nevhutalu, 2017). Apparently, some parents discover that their children are using *nyaope* after they start stealing things from home (Radebe, 2017). On the other hand, some parents noticed that their child was (ab)using *nyaope* when they realised that money was being stolen from their bank accounts. One parent attested that she used to send her child to school with her bank card to withdraw money for them after school. However, the child started withdrawing more than the money than was required, which raised the mother's suspicions.

2.4 Contributory factors to adolescent *nyaope* abuse

This section elucidates the factors that contribute to or precipitate the use of *nyaope* among adolescents. These factors resonate with those attributable to general substance abuse. The section focuses mainly on peer pressure, availability of *nyaope*; easy access to substances, social problems, the need to experiment and spirituality.

2.4.1 Peer pressure

Studies have found peer pressure to be a driving force of certain behaviours and habits, including substance abuse (Kahan, 2019; Morojele & Ramsoomar, 2016; Weybright et al., 2015). Peers conform to each other's norms and values to fulfil their need for belonging and acceptance. This pressure rises during adolescent stage, which is characterised by the need to identify with peers (Baron et al., 2007). It is believed that human beings in general conform, to a certain degree, to social group standards whereas adolescents in particular mostly conform to deviant behaviour to derive a sense of belonging. Thus, adolescents whose peers abuse drugs or are addicted to a certain drug, are more likely to also abuse drugs as opposed to those with friends who do not use drugs or have a drug addiction (Mahlangu, 2016).

Mokwena and Fernandes (2014) in a qualitative study with young *nyaope* abusers found that the main contributory factor is the influence of friends and associates. This was supported by Dintwe (2017) who also found that some young *nyaope* addicts were influenced by their friends who were using the drug at high school. They used the drug in an attempt to gain acceptance and respect among their addicted peers (Dintwe, 2017; Mahlangu, 2016). Nevhutalu (2017) found that peer pressure had a significant contribution to *nyaope* abuse as most users reported that their friends told them the drug reduces stress. Some users reported feeling sick and actually vomiting the first time they smoked *nyaope* (Mahlangu, 2016; Mokwena & Huma, 2014), but nevertheless persisted in using the drug.

Masombuka (2013) found that parents were able to notice that their children were abusing *nyaope* when they started relating with suspicious strangers who were allegedly using *nyaope*. Peer pressure is not a standalone factor as children coming

from broken families, who are abused and/or suffering some mental health-related problems are easily influenced by their peers and start using drugs as a stress reliever. This was also echoed by Nevhutalu (2017) who reported that new *nyaope* users were recruited by their friends who recommended *nyaope* for self-medicating purposes and to escape life difficulties. This is because the drug elicits the most 'euphoric' feeling; hence, peers, especially those with life problems, fall for it (Khumalo, 2016).

Studies found that young people whose peers were abusing drugs or addicts were more likely to use drugs themselves when compared to those with friends who did not smoke or have addictions (Dintwe, 2017; Nevhutalu, 2017). Part of the reasons provided for using *nyaope* was to fit in within the group and gain respect amongst their peers (Dintwe, 2017). These findings were supported by studies that presented the concept of Locus of Control (LOC) (Fernandes & Mokwena, 2014; Mokwena & Fernandes, 2014). LOC refers to the degree to which people get influenced to behave in a particular way by circumstances around or within them. Authors found that external LOC contributes to the use of *nyaope* and further acts as a predictive indicator of the recovery process. Adolescents with external LOC will therefore be easily influenced by external factors such as friends who abuse *nyaope* and have welcoming attitudes towards substances (Fernandes & Mokwena, 2014; Mokwena & Fernandes, 2014).

2.4.2 Social problems

Disruption of family structure has been found to be amongst the significant contributing factors to drug problems, including *nyaope* abuse among adolescents. Nevhutalu (2017) noted family breakdown as a major contributor towards *nyaope* abuse. Family breakdown, according to Nevhutalu (2017) was caused by factors such as divorce, parents working away from home, poor relationships between parents and single parent homes, as well as deaths of parents. Nkosi (2017) found that some participants were single and consequently felt lonely, further resorting to *nyaope* abuse as a coping mechanism. Thus, most *nyaope* users reported that they use the drug to escape from family problems such as the loss of a loved one, divorce, anger towards an absent father and family conflicts (Khumalo, 2016; Nkosi, 2017; Radebe, 2017). In addition, family risk factors, such as domestic violence, parents who use drugs, parents who

are involved in criminal activities, marital conflicts, child maltreatment, poor parenting style, disrupted parent-child relationships, and weak family structures, all had the potential to predispose adolescents to the use of substances (Choate, 2015; Groenewald & Bhana, 2016).

Poverty-stricken and unemployed adolescents have been found to be the most prone to *nyaope* abuse. *Nyaope* addicts largely view life as unfair to them in lieu of their unemployed parents who cannot provide for them and thus opt for drug abuse to forget their impoverishment (Nevhutalu, 2017). Most addicts believe that had they been from affluent backgrounds or working, they would not have involved themselves in *nyaope* abuse (Khumalo, 2016; Mahlangu, 2016). This reiterates the notion that individuals from a low socioeconomic status and are unemployed are more susceptible to *nyaope* abuse (Dintwe, 2017; Fernandes & Mokwena, 2016; Mokwena, 2016; Radebe, 2017). According to Madinga and Mokwena (2015) *nyaope* is unique challenge to South African population and is mostly prevalent among young and unemployed black people who live in socio-economically disadvantaged areas. In fact, there is a significant correlation between socioeconomic status and mental health-related challenges (Davstad et al., 2013; Hadidi et al., 2009; Mossakowski, 2008).

Although it is true that individuals from both affluent families can also be addicted to drugs, this study foregrounds a low socioeconomic status as a far much more contributory factor to *nyaope* abuse or addiction than affluence. This is not to negate the idea that contributory factors to substance abuse or addiction can be understood from a multi-faceted perspective, which amongst others, includes biological predisposition, peer pressure, and high levels of stress. Studies that explored *nyaope* abuse actually established a direct link between the social and economic status of the users (Dintwe, 2017; Fernandes & Mokwena, 2016; Mahlangu, 2016; Mokwena, 2016; Mokwena & Huma, 2014; Nevhutalu, 2017; Radebe, 2017).

2.4.3 Availability, easy access and need to experiment

The availability and accessibility of drugs of drugs contribute to the proliferation of drug abuse in the recent decades. When there is easy access to drugs, chances of trying them out and consequently being addicted to drugs are quite high (Tam & Foo, 2012).

Mokwena (2015) adds that *nyaope* is easily available and very cheap, i.e. approximately R26 and R40 per joint and this motivate a large number of adolescents to use it. Amplifying the problem is that some users can make their own *nyaope* by crushing HIV medication and mixing it with other readily available drugs such as dagga and other chemicals.

Nevhutalu (2017) affirms that *nyaope* is cheap and readily available. Ramlagan et al. (2010) reported that most of their participants mentioned the prices of the drug and the availability of drug dealers as contributory factors to drug abuse. Mokwena (2015) asserts that communities struggle with the mushrooming of dealers on their doorsteps and an increasing number of young people who are addicted to the drug and find it very difficult to stop the use. It was found that *nyaope* dealers could be easily located with little effort whenever one wanted to buy the drug from them (Dintwe, 2017; Monyakane, 2018; Nevhutalu, 2017).

Ramlagan et al. (2010) reported that most participants used drugs mainly because of its affordability and ease of access in communities. Mokwena and Fernandes (2014) hold that in recent times, South African communities have been struggling with the mushrooming of drug dealers and an increasing number of young people who are addicted to drugs. Dintwe (2017) found that *nyaope* dealers could easily be located by users unlike with other more expensive drugs such as cocaine and heroin. In Dintwe's study, some users mentioned that they could not afford such drugs which they said they "belonged" to "cheese boys" – the latter is a slang used to refer to peers from affluent families. It is evident that, ease of access to nyaope in by its users is an issue requiring immediate attention. This is important so that actions could be carried out to minimise or eliminate the drug's effect on young people.

Dintwe's (2017) results, which classified *nyaope* as a township drug used by those who belong to a low socioeconomic class indicated that users had easy access and could afford *nyaope* as compared to heroin and other drugs that are regarded as expensive and difficult to access. Mokwena (2015) adds that easy access to *nyaope* has been one of the current situations among the South African youth and when accessibility of drugs is easy, chances of people trying out and consequently being addicted to drugs is increased.

Regarding the contributory factors, it can be deduced that socio-economic status and social problems are the main contributors to *nyaope* abuse. Other contributory factors include peer pressure, availability, easy access and need to experiment. Notwithstanding that these studies were conducted with the *nyaope* users, the current study sought to investigate the understanding of parents with regards to their children's problems. This study explored the understanding of parents' views regarding the contributory factors to their children abusing drugs to further inform the treatment and prevention strategies. Previous studies' findings were derived mainly from qualitative studies (phenomenological design) whereas the current study employed the hermeneutic phenomenological design.

2.4.4 Spiritual causal factors

There is no literature that directly associate spiritual attacks with *nyaope* abuse or substance abuse in general. However, studies have focused on mental illness and other mental health related conditions (Bojuwoye, 2005; Bojuwoye & Sodi, 2010; Campbell-Hall et al., 2010; Mufamadi & Sodi, 2010; Patel, 1995; Shange & Ross, 2022). Mufamadi and Sodi (2010) supported these findings by stating that witchcraft, sorcery, spirit possession and disregard for cultural norms is a causal factor for mental illness. In essence, what is viewed as a spiritual attack has been a concern, particularly with reference to mental illness and rarely associated with substance abuse. A possible explanation for these results could be that *nyaope* abuse is so extremely devastating that parents would associate it with a supernatural explanation. This literature was supported by Shange and Ross (2022) whose findings highlighted supernatural/spiritual (ancestral calling and witchcraft) and breach of customs as a causal factor to mental illness.

2.5 Psycho-social impacts of adolescent *nyaope* abuse on parents

This section provides an account of the lived experiences of the parents whose adolescent children abuse substances. It also reflects on the psychosocial impact that *nyaope* abuse has on these parents.

2.5.1 Psychological effects on parents

Studies that explored substance abuse and its impact on parents generally focused on substances such as cannabis, alcohol, heroin and cocaine, amongst others (Choete, 2015; Groenewald & Bhana, 2016; Jackson, et al., 2005). Only in the recent years have researcher's foregrounded *nyaope* as a preferred substance of abuse and its impact on parents (Khumalo, 2016; Mahlangu, 2016; Masombuka, 2013; Masombuka & Qalinge, 2020; Mokwena & Huma, 2014; Nkosi, 2017; Radebe, 2016). The psycho-social impact of *nyaope* on the parents is traceable through the following symptoms:

2.5.1.1 Emotional symptoms

Most parents who have adolescents with substance abuse problems tend to experience emotions ranging from anxiety, despair, anger, shame, humiliation and frustration (Choete, 2015; Groenewald & Bhana, 2016). These parents are reported to experience shame and humiliation as a result of their adolescents' substance abuse (Groenewald & Bhana, 2016). The community largely perceives these parents as incapable of parenting and this compounds the emotional trauma they already deal with on a daily basis (Choate, 2015; Khumalo, 2016; Mahlangu, 2016; Masombuka, 2013; Mokwena, 2015, Mokwena & Huma, 2014; Nevhutalu, 2017; Radebe, 2016).

Mokwena and Huma (2014) reported that parents often display high levels of distress, worry and frustration when their adolescent child stays out later than what the parents had permitted or without the knowledge of the adolescent's whereabouts. They are often worried about the safety of their adolescents, which also triggers insomnia (Choate, 2015; Groenewald & Bhana, 2016). Dykes and Casker (2021) conducted an interview with parents who are raising teenagers who abuse substances and reported that the parents cry recurrently and are usually overwhelmed by a sense of helplessness. Orford et al. (2010) add that these emotional problems on the part of the parents are likely to cause unhappiness in the entire family system (Groenewald & Bhana, 2016).

2.5.1.2 Behavioural symptoms

Parents whose adolescents abuse substances often exhibit behavioural symptoms such as drinking problems, interpersonal problems, withdrawal, poor work performance, insomnia and/or hypersomnia; either loss of or increased appetite, and loss of interest in previously enjoyed activities (Ngantweni, 2018; Choate, 2015; Groenewald & Bhana, 2015; Orford et al., 2013; Smith & Estefan, 2014). Furthermore, they find it difficult to initiate or maintain interpersonal relationships with their partners, other children, family members, colleagues and community members due to their children addiction to substances (Choate, 2015; Jackson et al., 2007). In addition to interpersonal problems, conflicts between parents and adolescents mostly occur when parents attempt to control the adolescents' drug abuse (Groenewald & Bhana, 2017). This mainly involved verbal confrontations and physical displays of anger, including the adolescents insulting their parents. Other parents reported that their adolescents would become more destructive, i.e. banging doors and destroying properties, when denied money for buying substances (Choate, 2015). Groenewald and Bhana (2017) report that some parents become embarrassed by their children's behaviour and eventually isolate themselves from the child, although this withdrawal could be related to self-blaming.

2.5.1.3 Cognitive symptoms

Groenewald and Bhana (2017) proffer some parents reported having suicidal thoughts or actually attempting suicide, after they felt like they could no longer cope with their adolescent child's drug abuse. These suicidal thoughts and attempts could perhaps be understood (Choate, 2015; Groenewald & Bhana, 2017; Kalam & Mthembu, 2018), as a desperate cry for help (Choate, 2015; Groenewald & Bhana, 2017; Masombuka, 2013). Some parents blame each other for the adolescents' substance abuse (Groenewald & Bhana, 2017), citing examples such as the other parent's physical and/or emotional absence or his or her passivity towards the child's drug abuse (Choate, 2015; Khumalo, 2016; Masombuka, 2013). Choate (2015) found that mothers with children who abuse substances battled with self-blame and guilt because they feel responsible and guilty for not preventing the adolescent's substance abuse

problem. Most parents went to an extent of doubting their own parenting style and discipline methods (Choate, 2015; Khumalo, 2016; Radebe, 2017).

2.5.2 Stigmatisation

The noun 'stigma' originates from ancient Greece and represents a visible mark placed or branded on members of tainted groups such as traitors or slaves (Stuart, 2018). Stigma can be understood as an attribute, attitude, behaviour, or condition that is socially discrediting. This behaviour aims to blame and portray the person in a particular situation as substandard and strips them of their dignity (Hinshaw, 2005). Until recently, the discipline of mental health has been grappling the issue of stigma. This challenge has been considered a major obstacle to well-being among people with mental health-related problems.

There is paucity of literature regarding the stigma experienced by parents of adolescents who abuse *nyaope*. However, Radebe (2017) found that parents with children who abuse *nyaope* experienced rejection and were assigned derogatory names by their family members and communities. This culminated in a sense of shame and indignity. Mathibela (2017) found that parents became frustrated due to community members who not only ostracise them, but also accuse them of condoning their adolescent children's behaviour. Indeed, mothers with children who abuse different kinds of substances often blame themselves for their children drug addictions and the community reinforces this feeling either by overtly or covertly judging their parenting as poor.

2.5.3 Financial burden

Studies on general substance abuse have found that this scourge is associated with enormous financial burdens on the users, parents and other family members (Choate, 2015; Groenewald & Bhana, 2018; Kalam & Mthembu, 2018; Mahlangu, 2016). Parents with children who abuse substances highlighted financial difficulties due to costs of rehabilitation centres, transport fares, payment of accommodation such as hotels and lodges when facilitating access to treatment for their children (Groenewald & Bhana, 2018).

For parents with children who abuse *nyaope*, Dykes and Casker (2021) found that some children would steal money for drugs from home and nearby houses with the full knowledge that their parents were already struggling financially. What compounds the problem is the fact that the parents are expected to recover whatever damage caused by the children. Authors also found that some children incurred debts with relatives and neighbours in pretence of buying food and household items. The borrowed money was used for buying drugs and sadly becomes the responsibility of the parents to repay. Mathibela (2018) found that the parents were frustrated with their children because they would steal from home and community to maintain the addiction.

For some parents, they incurred severe financial costs due to rehabilitation services aimed at assisting their children (Groenewald & Bhana, 2018; Khumalo, 2016; Nevhutalu, 2017). These are inclusive of transport fares during visits and payments of accommodations such as hotels and lodges for treatment. Choate (2015) notes that, for some parents, their financial burdens emanated from their adolescents' thieving behaviours and damage to property, which required finances to repair or replace (Mahlangu, 2016; Radebe, 2017). Khumalo (2016) states that all these efforts still yield very minimal positive results because of the high rate of relapse among *nyaope* users.

2.5.4 Physical impact on parents

Parents with adolescents who abuse substances also bear the brunt of caring for an adolescent who abuse substances and this takes a toll on them physically. Although there is scarcity of literature on physical impact of *nyaope* abuse on parents, Dykes and Casker (2021) found that some parents would be so stressed that it would even trigger pre-existing medical conditions like asthmatic attacks and high blood pressure. Hlungwani et al. (2020) confirms that parents can suffer health problems because of their child's abuse of substances. These studies were all qualitative and investigated the lived experiences of parents with adolescents who abuse substances in general, but a few studies focused on the parents whose adolescents are *nyaope* abusers. Furthermore, these studies were conducted from the perspective of public health and social work and rarely from the perspective of clinical psychology. Furthermore, these

studies did not employ the hermeneutic phenomenology as the research design, as the current study did (Orford et al., 2013).

Ngantweni (2018) found that there are health-related problems associated with living with adolescents who abuse substances. Nkosi (2017) adds that parents experience medically related problems such as heart problems and high blood pressure. Mathibela (2017) further found that some of the parents who presented with physical symptoms were put on depression medication by medical officers while others verbalised that they were struggling with hypertension, stress and other stress-related diseases. These parents indicated that every time they consulted with medical officers, they would be told that there was no other medical basis to their condition, but stress.

2.6 Parental coping strategies

Parenting children who abuse *nyaope* comes with huge responsibility and the demand to develop dependable coping strategies become a priority. This difficult task arises in a country where little support is available for parent with adolescents who abuse *nyaope*. South Africa does not have adequate services that are designed or tailor-made for parents with children who abuse *nyaope* (Groenewald & Bhana, 2017; Nevhutalu, 2017). Mafa and Makhubele (2020) reported that most parents found it difficult to cope with their children's addiction to substances, as these parents struggled to access formal treatment and support services (Groenewald & Bhana, 2016). Nevertheless, the parents resorted to different coping mechanisms such as reliance on social support, talking honestly about emotional problems while some opted for what may be termed 'supernatural powers' in search of help. These coping mechanisms are discussed in the subsequent sections.

2.6.1 Social support

Orford et al. (2010) conceptualise social support as services that are provided by both formal (professional) and informal networks. Professional support includes the provision of relevant information and emotional support from qualified professionals whereas informal networks refer to support from friends and family, which comprise emotional and material support. Affected family members, most importantly parents,

recognise social support networks as helpful to them in coping with the difficulties caused by their children's addiction to and abuse of substances. Parents resorting to networks for help are reflective of their implicit and explicit acknowledgement of their need for help in dealing with the problem (Choate, 2011).

Nkosi (2017) found that parents received social support from the community policing forum, community social worker and centre for youth and community development, which helped them to cope with the difficulties of parenting an adolescent who abuses substances. Mafa and Makhubele (2020) add that part of the social support received by the parents includes emotional support from family and friends with the potential to promote long-term sobriety to the substance user. Masombuka and Qalinge (2020) further state that parents with children who abuse *nyaope* need professional programmes which includes formal support structure designed to support them. These structures are believed to assist those who are reluctant to approach fellow parents for assistance in the form of information sharing or support, notwithstanding the fact that they all experienced similar emotions.

Choate (2015) concurs that some parents despite there being the need of support, some parents are still reluctant to seek the support. Felker et al. (2019) report that the parents of the adolescents who abuse substances perceived support groups as important in the treatment process of the adolescents. In these support groups, rehabilitated adolescents share their experiences on how they overcame their addictions, which encourages those in search of treatment. The support systems required by the parents of the adolescents who abuse *nyaope* can be categorised into support from family, friends, professionals and the community at large. All these systems have the potential to promote long-term sobriety for the substance users (Mafa & Makhubele, 2020; Masombuka & Qalinge, 2020).

2.6.2 Engaged and withdrawn

Parents adopted varied coping approaches when faced with difficulties in coping their children substance abuse problem (Mathibela, 2019). The first strategy is described as engaged coping or enduring the addiction. This involves being actively involved in the progress of the child's condition and ensuring that there are rules set to monitor

the child, punishment to restrain the child, and also talking to the child about his problem. The second strategy is described as 'Standing up' which involves active participation in assisting the adolescent to seek help from all possible external sources including rehabilitation. The third strategy is described as withdrawal (giving up), this involves the parents' disengagement from the adolescents who abuse substances as a last and desperate resort to cope (Choete, 2015; Groenewald & Bhana, 2015; Jackson et al., 2007). Findings reveal that parents who are faced with the burden of raising adolescents who abuse substances find it difficult to cope with their adolescents' emotional and financial demands (Choete, 2015; Groenewald & Bhana, 2015; Jackson et al., 2007). Notwithstanding the human beings' resilient and ability to adapt, parents experience difficulty in managing their day-to-day functioning.

2.6.3 Spiritual reliance

Spirituality can be understood to mean a sense of connection to higher powers or belief to powers that guides the universe (Lucchetti & Koenig, 2021; Kao et al., 2020). According to Kao et al., (2020) spiritual nuances that are found to be nurturing during difficult times are gratitude, forgiveness, and humility. These virtues are believed to draw individuals beyond themselves. No wonder empirical research seems to suggest that there's some positive correlation between spirituality and improved mental health wellbeing (Pardini et al., 2000). Also, there are noticeable collaborative research efforts between some religious groups and professional mental health practitioners (Lucchetti & Koenig, 2021; Koenig, 2009).

Mathibela (2017) found that parents utilise spiritual services which include praying and going to church to cope with difficulties in their lives. According to Mathibela, parents believed that prayer and going to church will assist them in coping with their children who abuse substances. Mathibela and Skhosana (2019) adds that when parents realised that their children's addiction problem was persisting despite talking to them, they tried to get religious help from faith-based organisations, which also assisted them to cope. Reliance on their spirituality gives them (parents) hope and faith, which helps them to cope with their children's abuse of *nyaope* (Koenig, 2009; Matheba, 2020). Thus, "religion plays a vital role in people's lives as it brings hope; hence, the parents turn to their religion as they seek to understand their children's problems"

(Mafa & Makhubele, 2020, p. 1934). The findings of these studies revealed that parents often relied on religion and spirituality to cope with their challenges (Masombuka 2013).

2.7 Treatment of *nyaope* abuse

This section reviews literature on the kind of treatment that is provided to adolescents who abuse *nyaope*. It conceptualises drug addiction as a chronic disease because of its effects on the human brain. Addiction to *Nyaope* results in severe withdrawal symptoms compared to other common drugs in South Africa which makes it difficult to quit. *Nyaope* treatment is complicated, hence the need for a holistic approach towards helping the addict.

There are reports of high relapses and school dropout rates amongst adolescents who undergo treatment of *nyaope* abuse at rehabilitation centres. Part of the problem is the type of facility (in- or outpatient) and facility location (e.g. big city or small town) attended by the addict. Some facilities had the drop-out rate ranging from 2 - 8% while other facilities reported 40% and higher. Higher dropout rates were noted at outpatient-based facilities, as abusers have a higher chance of being influenced towards a relapse before they complete the treatment. The relapse rates often approximate 50% for cannabis, 33% for alcohol and 65% for harder drugs, such as cocaine and heroin (Dada et al., 2016; 2018).

The high relapse rates are attributable to the nature of care in terms of outpatient rather than inpatient care (Kabisa, 2021; Nagy, 2022). For outpatients, the facility has little control over their patients and this contributes immensely to the patients' relapse (Nagy, 2022; Ramlagan et al., 2010). Perhaps this is why Masombuka and Qalinge (2020) emphasise that the family members of the addict participate in the preparatory groups prior to treatment and post-treatment. The treatment of *nyaope* addicts should include their parents or primary care givers in order to foster compliance on the part of adolescents and to guide the parents on how to support their children (Mzolo, 2015). This section therefore reviews literature on the treatment available to parents with adolescents who abuse *nyaope*, with a specific focus on rehabilitation programmes, social services, medical services and spiritual services.

2.7.1 Rehabilitation programmes

Rehabilitation programmes are among the most dependable treatment approaches to substance-related problems. Rehabilitation services are provided to support an individual with an illness, injury, or physical or mental disability, disorder, or impairment. For substance abusers, a rehabilitation programme is typically a customised treatment that seeks to meet the specific needs of each individual. It is mainly offered on the basis of inpatient and outpatient categories. Dada et al.2016 reports that there is no official inpatient rehabilitation centre in Limpopo Province. However, the province has outpatient treatment centres that have been proven to be effective as an aftercare facility (Dada et al.; 2016; Mafa et al., 2022). Mokwena (2015) conducted a study in three different townships situated in three different provinces and found that there is a lack of drug rehabilitation services that deal with specific drug addictions, i.e. *nyaope*, in South Africa. Khumalo (2016) adds that most drug treatment centres in South Africa are situated in upmarket areas in Gauteng and Western Cape Province. Khumalo also found that Kwazulu-Natal Province has a limited number of treatment centres, with the three common centres catering for outpatients only.

The inpatient treatment centres which are mainly based in Gauteng province and a serve as a referral point for Mpumalanga province and Limpopo province had a long waiting list for admission between 2016 and 2019 (Dada et al., 2019). Nevhutalu (2017) conducted a study in the Limpopo Province (Vhembe District) and found a rise in *nyaope* abuse in the district. Surprisingly, there is no rehabilitation centre in the Thulamela municipality (Nevhutalu, 2017). Mokwena and Huma (2014) revealed that the rehabilitation centres in the South Africa's townships are ineffective. Participants in their study appraised the centres unfavourably, that is, the centres were found to be unhelpful. Hence, almost all the participants were found to have relapsed a few days after being discharged from rehabilitation centres. Some relapsed on the very same day on which they were discharged. The foregoing findings show that there is not only minimal access to rehabilitation facilities, but also where these centres exist, there are no programmes to assist the affected family members (Choate, 2015; Department of Social Development, 2015; Koenig, 2009; Mothibi, 2014).

2.7.2 Social services

Social services are social welfare services that are provided by Social Workers. Social Workers have the statutory obligation to deliver social services that aim at strengthening and building capacity, the self-reliance and resilience of service users (Chavalala, 2016). These services focus on early detection of potential risks and symptoms that could negatively affect the social well-being of young individuals (Chavalala, 2016; Mamabolo, 2021). Mathibela (2017; 2019) argues that services rendered by Social Workers or members of a multidisciplinary team on parenthood can be utilised to improve the skills of parents who raise adolescents. The programmes can result in improved childrearing practices and enhance support for the adolescents during their transitional challenges (Hlungwani et al., 2020; Mathibela 2019).

In a study conducted with 21 parents from a long-term, family-based adolescent rehabilitation programme in Canada, it was revealed that parents felt unsupported by Social Workers and other social service professionals (Choate, 2015). These parents felt that Social Workers and other professionals do not disclose the information that could assist in supporting the young members who are struggling with addiction. Thus, most parents highlighted their need for information on how best they could address problems of substance abuse in their children's lives (Choate, 2015). Therefore, Social Workers should consider extending their remedial interventions to parents (Mafa & Makhubele, 2020). According to Orford et al. (2010), parents expressed the need for Social Workers and the government to come up with programmes that protect them from their children who abuse substances. Implied here is that these parents always live at the risk of being assaulted by their adolescents who often demand money from them to buy drugs.

Qualitative studies conducted with parents who have children with *nyaope* abuse problem, it was reported that parents needed to be empowered to cope with their situation (Khumalo, 2016; Mahlangu, 2016). Emotional support, good information and material dissemination were identified as essential for family members who are affected by substance-abuse problem (Khumalo, 2016; Mahlangu, 2016; Radebe,

2017; Orford et al., 2010). Social Work services also receive criticism for not abiding by the standards provided in the policies that guide their practice. Parents also raised concerns regarding unsatisfactory services that they received from social services, which included little or no contact with the adolescents after they are released from rehabilitation and the lack of community involvement to help the adolescents (Chavalala, 2016; Mahlangu, 2016). Another criticism levelled against Social Work services relates to the confidentiality clause that completely excludes parents from knowing about their adolescent's treatment programme. This confidentiality persists despite there being recommendations of adopting the family-oriented approach in dealing with substance abuse (Dykes & Casker, 2021).

2.7.3 Medical services

Medical services have been the epicentre in the treatment of substance abuse for their role in the reduction of the physical pain associated with withdrawal symptoms. Fernandes and Mokwena (2020) submit that there is a need to understand the constituencies of *nyaope* in order to develop the tailor-made medication to help treat the users' withdrawal symptoms. There is still a need to identify the generic composition of *nyaope*, as the constituents differ from one region to the other (Fernandes & Mokwena, 2020; Khine et al., 2015). Without a definite understanding of what precisely comprises *nyaope,* the treatment of *nyaope* addicts will remain not only complicated, but also costly (Mothibi, 2016). Presently, adolescents who abuse *nyaope* are reported to prefer Methadone as a reliever of their withdrawal symptoms and has to some extent been proven to be effective for others (Khumalo, 2016; Thomas & Velaphi, 2014). However, Methadone has been found to be a *nyaope* constituent and thus could be ineffective in reducing the withdrawal symptoms caused by the drug itself (Khine et al., 2019).

2.7.4 Spiritual services

Mahlangu (2016) highlighted the significance of actively involving spiritual elements in the treatment and aftercare of *nyaope* addicts. Mahlangu (2016) further asserts that communion with a higher power often gives one a sense of peace, hope, motivation and courage to deal with the harsh withdrawal symptoms and ultimately fight

temptations to relapse. Appeals to a higher power, especially in the rural areas, seem to fill the void left by the limited services offered by the Social Workers and the clinics that provide further treatment (Mahlangu, 2016; Mokwena & Morejele, 2016).

The findings of these studies revealed that parents often relied on religion and spirituality to cope with their challenges (Karaca and Konuk-Sener, 2021; Masombuka 2013). Dykes and Casker (2021) added that some parents consulted spiritual healers who believed that their children were possessed by an evil spirit, which is responsible for their children's conduct. These evil spirits are associated to jealous people who do not want to see the adolescents prospering in life. Hence, the parents seek religious assistance and prayer after realising that other avenues of assistance are ineffective, especially in rural areas (Groenewald & Bhana, 2017; Masombuka, 2013). Rural areas do not have facilities and capabilities to manage the scourge of *nyaope* abuse.

2.8 Prevention of *nyaope* abuse

The Department of Social Development (2015) oversees and implements prevention and treatment programmes for substance use disorders, while the National Department of Health (NDoH) manages acute consequences, emergencies and psychiatric conditions as per their legislative mandate. Awareness campaigns on preventing substance abuse within the domain of the Department of Social Development and a study by Masombuka (2013) indicated that there are significant hurdles encountered when rendering adequate services such as awareness campaigns.

Primordial Prevention: This is the prevention strategy by WHO which consists of risk factor reduction targeted towards an entire population through a focus on social and environmental conditions (Brown, 2022). Such measures typically get promoted through laws and national policy. Due to the fact that primordial prevention is the earliest prevention modality, it is often aimed at children to decrease as much risk exposure as possible (Kumpfer, 2014; Lynch et al., 2004). Primordial prevention targets the underlying stage of natural disease by targeting the underlying social conditions that promote disease onset (Kumpfer, 2014; Mishra & Huber, 2019).

Primary Prevention: According to Mishra and Huber (2019), primary prevention aims to assist population or individuals at risk of a particular condition before they could be affected by such condition/s. The purpose of primary prevention is to prevent a disease from ever occurring (Kisling & Das, 2022). Thus, primary prevention targets a healthy individuals or population. Kisling and Das (2022) further indicates that primary prevention activities that "limit risk exposure or increase the immunity of individuals at risk to prevent a disease from progressing in a susceptible individual to subclinical disease" (p. 4).

According to WHO (2021), the effective prevention strategy for substance abuse should entail a comprehensive, holistic and coordinated approach across a range of organisations and agencies. Given the fact that substance-related health and social problems are multifaceted, requiring complex and dynamic responses, the responsibility for such actions cannot rest with a single agency or organisation (Kisling & Das, 2022). It therefore requires the combined efforts of a number of organisations and institutions, and all sectors of civil society to begin to address these issues. In addition, it is critical to include young people amongst others to the planning, implementation and evaluation of strategies and approaches (Kisling & Das, 2022). The involvement of young people in all these stages helps to ensure that their health needs are comprehensively and sensitively addressed.

According to the report by the United Nations Report (UNODC) (2016), drug abuse prevention campaigns in South Africa have used different approaches. These programmes were initially based on opinions rather than evidence. Scare tactics were often used to reinforce the message that drugs were dangerous, which did not work. A later approach involved information dissemination (Mabokela, 2018). This was based on the assumption that once people become aware of negative consequences of drug abuse, they would choose not to use drugs. In recent years, a greater emphasis has been placed on information-based programmes which are complemented by a life-skills approach, which deals with a wide range of social skills.

2.8.1 Awareness programs

The underlying assumption is that drug use is at least partly due to poor social coping strategies, undeveloped decision-making skills, low self-esteem, inadequate peer pressure resistance skills, et cetera. When applied sensibly, these strategies have yielded positive results in the South African experience (UNODC, 2016). Continuous awareness programmes at schools and communities that focus on preventing young people from using or abusing substances have been found to have a significant impact in reducing the scourge of substance abuse (Mokwena & Morejele, 2016).

2.8.2 Spirituality

Mahlangu (2016) highlighted the significance of spirituality in the prevention of substance abuse, specifically *nyaope*. Religion and spirituality work as a form of social control and provide guidelines for behaviours (Department of Social Development, 2013; Koenig, 2009). In this context, symptoms such as delusions and hallucinations are often to evil spirits, thus implying the need for religious and spiritual intervention (Mahlangu, 2016; Nevhutalu, 2017). Witchcraft and possession by evil spirits is usually cited by faith healers as the cause of *nyaope* use (Mafa & Makhubele, 2020; Nevhutalu, 2017). This typifies the belief that there are other explanations for substance abuse could be substantiated by findings in Choate (2015) where parents were looking for other explanations beyond substance abuse.

2.8.3 Economic and social change

Nyaope is predominantly abused by young people from low socioeconomic backgrounds and townships (Khumalo, 2016; Mahlangu, 2016; Mokwena, 2015; Mokwena & Huma, 2014; Mokwena & Fernandes, 2016; Nevhutalu, 2017; Radebe, 2017). In the afore-cited studies, the participants reported that being employed and having access to other opportunities could keep them away from drugs. Admittedly, there are other factors that contribute to *nyaope* abuse such as dropping out of school, poverty, absent parents and deaths of loved ones (Mokwena & Huma; Mahlangu, 2016). Nonetheless, *nyaope* abusers from low socioeconomic backgrounds are generally classified as ‘at risk populations’ (Ramlagan et al., 2010). Therefore,

preventive and remedial interventions against *nyaope* abuse should target the youth in townships and rural areas.

Mahlangu and Geyer (2018) argue that in order for government to assist in preventing the escalation of *nyaope* abuse, there should be efforts to create employment for young people. For those who are in school going age, government should help by building recreational facilities and sporting grounds. The National Drug Master Plan 2013-2017 (NDMP) makes the point that demand reduction should focus on preventing the onset of drug usage and eliminate all conditions/factors that may tempt an individual to use substances (Department of Social Development, 2013). Hence, the participants stressed the importance of having recreational activities in their communities, which they felt were lacking in the Hammanskraal community.

2.9 Help-seeking pathways followed by parents of adolescent with *nyaope* abuse

According to Gulliver et al. (2012), help-seeking pathways in mental health has been found to be an essential element for early detection, prevention and prompt treatment mental health related problems. Scholars made several attempts to define help-seeking pathways. Cornally & McCarthy (2011) defined help-seeking pathways as a "problem focused, planned behaviour involving an interpersonal interaction with a selected health care professional" (p. 286). Barker (2007) added that help-seeking pathways could be understood as any actions or activities that are followed by an individual affected by a particular challenge or health concern. These pathways include informal (friends, kinship, relatives, etc) and formal (psychologist, counsellors, social workers, traditional healers, religious leaders, medical doctors, etc).

Help-seeking within mental health related problems has received little attention in South African scholarly fraternity. Few studies attempted to unpack help seeking pathways, however they did not produce or adapted a help seeking model for certain conditions (Shai & Sodi, 2012; Sodi & Phethi, 2017; Zondo, 2008). This critical aspect in mental health has further received little attention in rural areas where there are myriad of challenges not limited to scarcity of mental health services, limited access to mental health services and poverty (Lynch et al., 2018; Nagai, 2015; Srebnik et al.,

1996). It is therefore significant to traverse the area of help-seeking in mental health in rural areas with specific focus on *nyaope* abuse in order to develop a tailor-made model for parents in rural areas.

Godoy et al. (2014) indicate that an understanding of help-seeking pathways by parents with children who have mental health-related challenges is likely to place them in a good position to effectively assist their children. Studies reveal that a lack of knowledge regarding early signs and symptoms (Cloutterbuck & Mahoney, 2003), uncertainty about significance of symptoms (Parker et al. , 2020; Teel & Carson, 2003), and lack of awareness that symptoms were signs of a particular condition (Rimmer et al., 2005), contribute to difficulties in providing the required help. Help-seeking within mental health context is more dynamic and sophisticated process that is dependent on multiple factors, including culture and mental health literacy (which is an understanding of the specific conditions that have a bearing on diagnosis and treatment) (Rickwood et al., 2002; Scott & Walter, 2010).

2.9.1 Help-seeking pathways and culture

Socio cultural factors are critical determinant of whether individual will seek help from which source (Cauce et al., 2002; Rickwood & Thomas, 2012). This is due to the fact that culture influences the conceptualisation of different conditions within mental health which later informs the sources of help. This was supported by Shai and Sodi (2012) who found that individuals who entered the mental healthcare system as their initial treatment point were informed by the knowledge they had about the illness and severity of symptoms, e.g., manifestation of aggressive behaviour. It was further revealed that utilising mental health care system as an initial point of contact did not limit the individuals from exploring other treatment modalities after their discharge from the mental health-care facility. This continuous search for help from different sources has been found to be motivated by culture.

Cauce et al. (2002) argued that culture and context influence community members' help-seeking behaviours. In their opinion, adolescents in need of mental health services are more or less likely to seek help based on the prevailing cultural or

contextual influences. Some help-seeking pathways start with a consultation with family members, then a diviner, and end with a traditional healer or doctor. These pathways can be followed simultaneously depending on the perceived cause of the problem. Shai and Sodi (2013) found that affected members used various healthcare providers and agencies after becoming aware of symptoms suggestive of ill-health. The paths followed included, among others, traditional healers, spiritual healers, medical doctors (general practitioners) and mental health facilities.

The prevalent cultural norms on problem recognition, decision to seek help and service selection are subtle, elusive, and difficult to capture with the traditional techniques used for studying psychological phenomena. In their view, the effects of culture and context pervade the whole help-seeking process and therefore do not have specific efforts in the pathway (Arnault, 2009; Cauce et al., 2002). Most of the participants in the study by Shai and Sodi (2013) reported to have gone to a mental healthcare facility as their initial option for treatment. On the other hand, the remaining few went to other agencies prior to their visit to the mental healthcare system. Sodi and Phethi (2017) add that the treatment facility entered (chosen) was linked to its accommodation of the cultural or belief system of the participant or family members. The choice of the "treatment modalities by the patient is neither associated with the proximity nor the cost of treatment"; rather, it seems to be related to the patient's or the family's concept of the aetiology of the illness based on the spiritual belief (Asare & Danquah, 2017, p. 3).

2.9.2 Help seeking, perceived barriers and benefits

According to Champion and Skinner (2008), the perceived benefits entail the person's beliefs regarding envisaged benefits of the various available actions for reducing the disease threat. Furthermore, other "non-health-related perceptions, such as the financial savings related to quitting smoking or pleasing a family member by having a mammogram, may also influence behavioural decisions" (Champion & Skinner, 2008, p. 47). Thus, individuals exhibiting optimal beliefs in susceptibility and severity are not expected to accept any recommended health action unless they also perceive the

action as potentially beneficial by reducing the threat (Champion & Skinner, 2008; Janz & Becker, 1984; Glanz et al., 2008;).

The other important concept is 'perceived barriers' which is understood to describe the "potential negative aspects of a particular health action that is perceived as an impediment to undertaking recommended behaviours" (Champion & Skinner, 2008, p. 48). The unconscious, cost-benefit analysis occurs wherein individuals weigh the actions expected with perceived barriers (Skinner & Champion, 2015). Thus, combined levels of susceptibility and severity provide the energy or force to act and the perception of benefits (minus barriers) provides a preferred path of action (Janz & Becker, 1984; Glanz et al., 2008; Jung et al., 2017).

Perceived barrier and benefits helps in understanding health-behaviour in terms of individual decision-making (Lipari et al., 2017; Nagai, 2015). It suggests that the likelihood of a person to follow a certain health-related behaviour is highly dependent on an individual's perception of a threat to their personal health, and their belief that the behaviour recommended will be helpful in the reduction of this threat. According to this theory, individuals in distress and in need of assistance for their family members will adopt certain health-related behaviours (Jung et al., 2017; Lynch et al., 2018). If individuals perceive a threat in their lives, they will adopt a particular health behaviour to eliminate or reduce the threat. This is applicable for parents raising adolescents who abuse *nyaope*.

2.10 Concluding remarks

This chapter presented a review of South African literature on adolescents' abuse of *nyaope* and their parents' lived experiences in lieu of the abuse. The chapter commenced with an overview of substance abuse and addiction, the description and effects of *nyaope* on the users and their families. It elucidated the contributory factors to adolescent *nyaope* abuse. Parents' experiences of raising adolescents who abuse *nyaope* were also reviewed. Coping strategies used by parents with adolescents who abuse *nyaope* and their help-seeking pathways were discussed. Given the paucity of literature on help-seeking pathways and substance abuse, this chapter reiterated the

present study's novelty in its exploration of adolescent *nyaope* abuse and the lived experiences of the parents who raise these adolescents.

CHAPTER 3: THEORETICAL FRAMEWORK

3.1 Introduction

The theoretical framework is a systemic structure of theories or concepts of one or more theories that are central in understanding a phenomenon under investigation. These concepts aid the researcher in gaining an informed perspective about problems under investigation. This first section of the chapter discusses the relevant psychological models pertaining to drug problem and interventions, namely, the Help-Seeking pathways model, Biopsychosocial model (BPS), and Stress Strain Coping and Support (SSCS) model. The second part of the chapter dissects the conceptual framework adopted, that is, Bowen's Family System Theory and Afrocentricity. The blending of the perspectives was necessary considering that complex nature of the type of drug under investigation. No single approach would sufficiently nuance the understanding of parents and affected children's lived experiences with the nyaope drug.

3.2 Psychological Models

3.2.1 Help-seeking pathways model

Help-seeking pathways model has evolved over the years from biomedical model to help-seeking in mental health (e.g., Andersen, 1995; Goldsmith et al., 1988). Goldsmith and colleagues placed more emphasis on the cognitive decision-making process of individuals considering services (Goldsmith et al., 1988; Srebnik et al., 1996). These authors proposed a three phased help-seeking pathway (i.e., problem recognition, decision to seek help, and decision to select specific services) and identified factors that may influence each phase (Srebnik et al., 1996). Following this widely accepted model, Srebnik et al. (1996) proposed a further expansion of the mental health help-seeking model by recognising the impact social networks, attitudes, cultural practices on the help-seeking process and by further adapting the model for children and adolescents. In the Srebnik et al. model, the influence of social networks on help-seeking behaviour can be seen as a barrier or a facilitator of service utilisation (Srebnik et al., 1996). Social networks are hypothesized to facilitate treatment when

members of the network influence the parent to seek professional help and constitute a barrier when they influence the parent not to seek treatment (Srebnik et al., 1996).

Cauce et al., (2002) proposed a further revision of the model to facilitate its application to adolescents' mental health help-seeking behaviours. This was further adapted into a four phased model by Eiraldi et al. (2006) which was specifically designed for adolescents with Attention Deficit/Hyperactive Disorder (ADHD). The revised model was offered as a framework for understanding cultural and contextual factors affecting ethnic minority adolescents' pathways into services for mental health disorders (Hansen et al., 2021; Srebnik et al., 1996). This model further founded on the theoretical work of Bronfenbrenner (1979) who asserts that a child should be understood from his/her quality and context of the environment which influences the child's cognitive and social development. The four phases for help-seeking according to Cauce et al (2002) and Eiraldi et al. (2006) are as follows:

3.2.1.1 Problem recognition

According to Cauce et al. (2002) help-seeking begin when there is a problem or mental health need that is identified by the individual experiencing it and/or the caregiver of an individual. These authors argued that the need can be defined as "either epidemiologically defined need or as a subjective or perceived need" (Villatoro et al., 2018, p. 9). This implies that the need can be determined by a formal assessment conducted by the professionals or by the perception of parents based on their day-to-day observation. Notably, the identification and definition of a child or adolescent's mental health problems, as well as decisions about help-seeking are largely determined by the parent, in consultation with others, including the child (Combs et al., 1991). Parents should take note of behaviour difficulties, peer difficulties, academic performance decline, presence of comorbid disorders (Cause et al., 2002).

Srebnik et al. (1996) conceptualised problem recognition as an interaction of social networks (formal and informal) which subsequently leads to problem identification. Although individuals who are affected by mental health problems are instrumental in problem recognition, parents and other caregivers are mostly key in identifying problems young people rarely do. Cause et al. (2002) highlighted the characteristics

of parents such as single marital status, level of education, marital conflict, family disorganisation, parental psychopathology, parent-child relationship and mental health literacy plays a crucial role in problem recognition. Similarly, when parents experience stress which emanates from their children's condition, they may become harsher and less warm toward their children (Cornally & McCarthy, 2010; Villatoro et al., 2018). They may also be less sensitive to their children's distress or circumstances. The relative burden of care placed on a family has also been found to influence subjective need, with parents shouldering greater burdens less apt to notice psychological problems in their adolescents (Villatoro et al., 2018). Social norms for which behaviours are undesirable, deviant, or worthy of concern are another important contextual factor that has bearing on problem perception (Villatoro et al., 2018). Problem recognition and identification make up the first step in the help-seeking pathway, and it is clear that cultural and contextual factors play a key role with respect to both epidemiologically assessed need and perceived need (Cauce et al., 2002; Rickwood & Thomas, 2012; Villatoro et al., 2018).

3.2.1.2 Decision to seek help

The decision to seek is most likely to occur when a suspected mental health problem is recognized as undesirable with realization that it will not resolve on its own (Eiraldi et al., 2006; Rickwood & Thomas, 2012; Villatoro et al., 2018). It has been found that it is easy to recognise the existence of the problem, however it may not always agree on the nature and severity of the problem (Cauce, 2002; Srebnik et al., 1996; Villatoro et al., 2018). The decision to seek help and whether a problem is likely to remit without seeking help, is more difficult to evaluate, especially during the adolescent years, when some degree of antisocial behaviour and emotional instability may be considered normative (Rickwood et al., 2005; Villatoro et al., 2018). Srebnik et al. (1996) added that parents may have an attitude of believing that adolescents might outgrow certain unwanted behaviours. Ordinarily, adolescents have at some point disobeyed their parents, lied to authority figures, or used alcohol or drugs. Compounding the problem is the developmental stage of adolescence which is characterised by disequilibrium (Holmbeck et al., 2000). Therefore, it is not too surprising that many parents decide to ignore some behaviour problems, expecting they will disappear, or children will outgrow them over the course of development.

Key aspect on decision to seek help is what Srebnik et al. (1996) coined “help-seeking desirability” and mental health literacy. After recognising the problem, parents or individuals affected must develop the desire to seek help and the help required will be informed by the level of knowledge they have regarding mental health (Srebnik et al., 1996; Rickwood & Thomas, 2012). Among adults, Pescosolido et al. (1998) found that almost a quarter of all client contacts with mental health professionals were a function of mandated referrals from either schools or courts (Villatoro et al., 2018). Although there are no similar estimates of the number of adolescents in mandated treatment, subjective evidence suggests that this is also the case for adolescents to decide to seek help (Villatoro et al., 2018). Help-seeking for adolescent with substance related problems could be mandatory due to the fact that they are in most cases in conflict with the law and rules that govern certain institutions.

The decision to seek help is the second phase that is interconnected and interrelated to problem recognition. Problem recognition and decision to seek help may be influenced by contextual realities such as parental availability and support towards their teenagers (Barker, 2007). Cultural factors would mainly influence aetiological explanations of the teenager’s problem. Such definitions are likely to reflect cultural beliefs and values (Cauce et al., 2002; Lynch et al., 2018). This implies that those who holds strong grounds on prayer as a coping mechanism when faced with challenges, they are likely to opt for spiritual assistance and delay consultation with mental health professionals.

3.2.1.3 Service selection

Service selection is defined as a place or to whom the parents and their adolescents can consult with after identifying a problem and finally deciding to seek help (Villatoro et al., 2018). Selecting a source of help should logically flow from the first two phases, but it is seldom easy or straightforward, especially for adolescents and parents of adolescents (Barker, 2006; Cauce et al., 2002; Villatoro et al., 2018). Adolescents are neither children nor adults, and it is often unclear which treatment centres are available to them in rural areas. There is also variability in the rules and regulations about whether adolescents can be treated without parental consent (Cauce et al., 2002;

Eiraldi et al., 2006). However, in South Africa adolescents who are 14 years and above are able to consent by themselves for medical and mental health treatment procedures.

Given the reluctance of minority parents to seek help from formal mental health treatment providers, such as psychiatrists, social workers, or psychologists, access to treatment for minority youth is often facilitated by individuals outside of the mental health system (Villatoro et al., 2018). These individuals, acting as gatekeepers, provide a less threatening connection to mental health services for minority groups (Villatoro et al., 2018). Gatekeepers may include personnel or officials from schools, churches, community agencies, or known and respected members of the community familiar with the mental health system (Cauce et al., 2002; Villatoro et al., 2018).

3.2.1.4 Service utilisation

It is believed that a significant percentage of individuals who had problems would begin by self-help strategies (Richwood & Thomas, 2012; Zondo, 2008), such as purchasing non-prescribed medications and home-made cures (Zondo, 2008). According to Srebnik et al. (1996), service utilisation is informed by availability, accessibility, perceived quality of care, attitude of service providers and service integrity. Parents and their adolescents are likely to seek help from sources that guarantees comprehensive treatment such as pharmacology, rehabilitation, individual psychotherapy and further informed referrals (Cauce et al., 2002). Most importantly, eligibility and cost of the services rendered has been found to be of paramount determinant factor for utilisation. In South Africa, studies have revealed that rehabilitation services for substance abuse are expensive and makes it difficult for individuals from rural areas to access (Chabalala, 2016; Mahlangu, 2016).

3.2.2 Biopsychosocial model

The Bio psychosocial (BPS) model is a scientific model that was founded by George Engels, a Professor of Medicine and Psychiatry in 1977 (Engel, 1980; Masiak, 2013). This model was first presented as a paper in 1979 at a conference. The BPS model is based on the General Systems Theory (GST) that is applied in medicine and

psychiatry (Skewes & Gonzalez, 2013). General Systems Theory is a model that encompasses general aspects of reality about a phenomenon. It holds the view that biological (i.e. medical component of the problem), psychological (i.e. mental processes causing or exacerbating the problem) and social processes (i.e. social circumstances including religious element to the problem) should be central to the conceptualisation and treatment of any health-related challenges (Alvarez et al., 2012).

For the adolescent population, substance abuse has been explained in terms of "the interaction between genetic predisposition and psychosocial variables, including personality and temperament" (Skewes & Gonzalez, 2013, p. 64). Accordingly, some of personality variables that are believed to impact later substance use include sensation seeking, low harm avoidance, negative affectivity, and reward dependence (Skewes & Gonzalez, 2013; Orford et al., 2010). In addition to personality variables are the temperament variables that predict later substance problems, namely, low attention capacity, high emotionality, low sociability, and impulsivity (Skewes & Gonzalez, 2013). Generally, the model purports that substance abuse is a complex outcome of the interaction between biological, psychological, social, and spiritual determinants (Dogar, 2007; Skewes & Gonzalez, 2013). In spite, the BPS model has received some criticism, with Skewes and Gonzalez (2013) arguing that the model and science in general has not provided enough evidence on the factors that can explain the mechanisms or pathways underlying substance use, abuse, and dependence or how it explains progression from use, abuse to addiction. Benning (2015) noted three limitations in the BPS model: 1) it lacks philosophical coherence; 2) it does not have a sustained praxis and 3) it has failed to consider subjectivity. In view of these limitations, Du Plesis (2019) described this model as the framework that provides "conceptual scaffolding" for a therapist without indicating which methodology to utilise (p. 2). Generally, the traditional BPS has been demonstrated to be limited in conceptualising mental health conditions such as substance abuse especially how it affects family members (Engel, 1980; Skewes & Gonzalez, 2013). It is in this regard that, the researcher found Bowen Systems Theory which is a derivative of the BPS model more suitable for the present study.

According to Skewes and Gonzalez (2013), the BPS model conceptualised peer influence as a contributory factor to substance abuse. According to these authors, peers influence their fellow adolescents' values, attitudes, and behaviour in multiple domains, including substance abuse. This model holds the view that having friend that uses substance is a strong predictor of adolescent substance use, as it reinforces the perception that one's peer group endorses substance use (Skewes and Gonzalez, 2013). It is believed that when adolescents associate with peers who hold socially deviant attitudes and beliefs, their chances of substance use increase.

The BPS model subscribes to the submissions of Social Learning Theory (SLT) on adolescents' substance abuse. According to Skewes and Gonzalez (2013), SLT posits that modelling influences behaviour and those "adolescents who observe substance use in their parents are more likely to use substances themselves" (p. 66). Findings in these studies have found an association between parental approval of substance use and adolescent use of alcohol, tobacco, and marijuana (Alvarez et al., 2012; Orford et al., 2010; Skewes & Gonzalez, 2013).

In expounding the contributory factors to adolescents' substance abuse, the BPS model highlights some of the treatment models, including the use of medication as a treatment method (Skewes & Gonzalez, 2013; Wadgave & Nagesh, 2016). There are several medications that are helpful during substance abuse treatment, but no medication has been shown to cure or prevent addiction. According to Wadgave and Nagesh (2016) those who are addicted to smoking, nicotine replacement therapies such as the nicotine patch, gum, and nasal spray have been shown to double one's chances of successfully quitting. Furthermore, these tools work by gradually reducing the smoker's dependence on nicotine while extinguishing the smoking behaviour, with the goal of slowly tapering off the nicotine until one is free of the substance. For opiate dependence, methadone and buprenorphine have been shown to be effective at reducing cravings and avoiding withdrawal symptoms, but these medications have side effects and other consequences (Skewes & Gonzalez, 2013).

The BPS model posits that substance abuse treatment should adopt a holistic approach (Skewes & Gonzalez, 2013). Therefore, successful treatment is dependent upon comprehensive and accurate assessment and the matching of affected

individuals to the most appropriate treatment (Alvarez et al., 2012). However, recovery may or may not require abstinence, depending upon the degree of severity and/or the type of syndrome. The above implies that a substance-use disorder could be treated like any other chronic illness, as it will require ongoing treatment. It could be suggested that all service providers in the field of addiction should work together towards finding solutions to a variety of serious problems (Skewes & Gonzalez, 2013).

The recognition of the role of spirituality plays an essential role in this BPS model with respect to a person's self-identity and self-direction (Buckner, et al., 2021), especially in the case of the young person recovering from *nyaope* addiction. Galanter (2007) conducted a study on the relevance of spirituality in social services and found that a spiritual orientation plays a unique role in promoting an attitude that facilitates some service users' openness to change.

Gabbard and Kay (2001) assert that the conceptualisation through the lens of BPS model leads to the implementation of eclectic treatment model. Therefore, the researcher believes that *nyaope* users may do better with a combination of psychosocial-spiritual support and medical care (e.g. medication). Most importantly, assessment that is based on the BPS model requires that the service provider should be caring and have the communication skills necessary to develop rapport, establish therapeutic alliance, offer continuity of care, provide ongoing accessibility, and learn about the living conditions of the patients and significant others.

This study used BPS model as a lens to better understand the holistic needs of a *nyaope* user in the psychological, social, biological and spiritual domains. This understanding intends to guide in developing effective treatment and help seeking pathways for parents raising adolescents with *nyaope* abuse. It is equally important to note that each systemic level is interdependent with the others, and, theoretically, none has functional priority over the others (Alvarez et al., 2012). Theoretically, it further assist with aftercare and integration of services because treatment should focus on biological, psychological and social domains.

3.3.3 The Stress-Strain-Coping-Support (SSCS) Model

The Stress Strain Coping Model Support (SSCS) was developed and further refined by Jim Orford, Richard Vellerman, Guillermina Natera, Lorna Templeton and Alex Copello in the early 1990s (Orford et al., 1992; 1998; 2001; 2010; 2013). The SSCS model has been popular in health psychology due to its stance as a non-pathological model. According to Orford et al., (2013), the pathological models view the parents of the adolescents with drug problems as having been abusive to their children or as otherwise inadequate in their parenting. The pathological model does not pay attention to other family members such as sisters, brothers, grandparents, aunts, uncles and cousins who are similarly concerned about their relatives' drinking or drug taking (Kalam & Mthembu, 2018).

The SSCS model focuses on family members who are affected by the addiction of a close family member and/or a relative. According to Orford et al., (2010; 2013), this model treats the affected family member as an ordinary person who is exposed to a set of seriously stressful circumstances or conditions of adversity that are not of their own making. The model views the condition of family members who abuse substances in the family as similar to a relative's illness or disability, chronic family unemployment or poverty, and exposure to catastrophic events and their aftermath, e.g., flood, famine or earthquake (Orford et al., 2013).

In order to understand the stress and strain that Affected Family Members (AFM) experience, some South African studies attempted to use the case study of Ellen Pakkies, a mother who had murdered her drug-addicted son in response to the verbal and physical abuse she had experienced from him (Thesnaar, 2011). It was reported that she strangled her son and later handed herself to the police. This act followed several attempts to obtain protection from the police and support from her community with no success. This story depicts the emotions such as anger, hopelessness, isolation and devastation that parents with children who abuse drugs experience. Hence, the current study considered the lived experiences of the parents who raise adolescent *nyaope* abusers as vital (Masombuka, 2013; Rebello, 2015; Orford et al., 2010).

The SSCS model describes the emotional experience that AFMs go through when having a relative with addiction related problems (Orford et al., 2010). According to Orford et al., (2005), relatives often presents with worry which includes worry about the relative's physical and mental health, self-care, educational, work or other performance, finances, the friends kept by the relative, and their future. In addition, worry extends to the concern about the functioning of the whole family, the maintenance of good quality relationships both within the family and with others and concern about the ability of the family to function well now and in the future for the sake of all its members (Horvath & Urban, 2017; Orford et al., 2013).

The model also presents the coping strategies used by AFMs. To cope parents used multiple coping strategies such as observing the adolescent's behaviours, talking to the adolescent about his/her drug abuse and setting rules and punishments to limit the adolescent's drug abuse (Groenawald & Bhana, 2016; Orford et al., 2010). As a last and desperate attempt to cope, some parents stated that they had become withdrawn from the adolescent (Choete, 2011; Jackson et al., 2005; Orford et al., 2013).

The SSCS model recognises three broad ways of coping: putting up, withdrawing, and standing up (which refers to being actively involved with help-seeking activities of the child). Nearly all accounts of what AFMs do include examples of the ways in which they appear to put up with their relatives' problematic consumption. This is a large category of coping actions, including acceptance of the abuse, self-sacrifices made by restricting oneself or putting oneself out or withdraw in some way to accommodate the relative's substance use, uncritical support for the relative's behaviour, or simply inaction and resignation (Orford et al., 2010; 2013).

The last facet of the SSCS model is the support that AFMs ought to receive. Groenewald & Bhana (2016) found that parents of substance abusers were unable to obtain information about their child's addiction, which culminated in their feeling of "uninformed and helpless". In some instances, formal support services are available, but not easily accessible to parents or vice versa (Groenewald & Bhana, 2016). A Availability of support services may not always translate into the applicability or quality of those services (Chavalala, 2016; Usher et al., 2007). In their study, the mothers expressed dissatisfaction with the support structures they had available to them, as

some of the specialists responded to them unempathetically and at times the parents were blamed for their children's addiction (Groenewald & Bhana, 2016; Mabokela, 2013; Ngantweni, 2018). Similarly, Choate (2015) reported that the parents often felt like the therapists minimised their child's substance abuse problems, which further restricted their ability to identify and explore appropriate interventions.

In some developed countries such as the United Kingdom, psychosocial interventions have been developed with AFMs in mind (Velleman et al., 2008). However, developing countries such as South Africa still struggle to develop and implement interventions that are inclusive of AFMs due to the scarcity of specialists and most importantly, the low socioeconomic status of AFMs (Orford et al., 2010). There is still a dire need for support and treatment services such as behavioural therapy, marital therapy and family therapy and social behaviour and network therapy in South Africa (Copello et al., 2009). The other level of support includes community reinforcement and family training, pressures to change and a relational intervention sequence for engagement (Barber & Crisp, 1995; Meyer et al., 2008).

Copello et al., (2009) argue that the SSCS model has limitations just like any other model or theory. Part of the limitations is its reliance on specialist services and its dependence on research conducted in a small number of centres in developed countries. South Africa is a developing country with a significant portion of the country being rural and where most citizens do not afford specialist services. However, this model is relevant and most appropriate in the conceptualisation of the lived experiences of parents with adolescents who abuse *nyaope* as it can foster change in policy direction and establish the most appropriate intervention.

3.3 The Conceptual Framework

The present study blended Bowen Family Systems Theory and the Afrocentric approach to investigate the complex issue of *nyaope* abuse and its consequences for caregiver parents. The former will help elucidate the familial issues faced by affected caregivers, while the latter will nuance the spatial, cultural, and spiritual issues associated with the *nyaope* drug problem.

3.3.1 Bowen Family System Theory

The current study adopted the Bowen Family Systems Theory (BFST) as a lens to view the lived experiences of parents with adolescents who abuse *nyaope*. This theory has assisted in clarifying thinking, extending understanding, deepening discussion and enriching analysis on the lived experiences of parents with adolescents who abuse *nyaope*. There is a positive relationship between this theory with the aims and objectives of the current study. The current study intended to understand how the systems theory addresses addiction problems caused by *nyaope* abuse by an adolescent in a family. The theory emphasises on the experiences of the parents and their children who abuse substances such as *nyaope*.

3.3.1.1 The origin

BFST, also known as Bowen's theory, was developed by Murray Bowen who trained as a psychiatrist and practiced as psychoanalyts (Bowen, 1976; Brown, 1999). Bowen, who was born in 1913 in Tennessee (USA) and later passed on in 1990, began his interest in systems theory by involving mothers in the investigation and treatment of schizophrenia (Brown, 1999). This is where Bowen's trademark statement "there is a little schizophrenia in all of us" made him popular (Bowen, 1976).

Bowen moved from the traditional approach of the psychoanalytic model, which focuses on the individual patient and does not welcome the inclusion of other members who are related to the patient in the process of therapy. It was believed that therapists might contaminate the transference by seeing other members of the family. He also diverted from the severe psychiatric condition to less severe emotional problems. This conversion occurred in the late 1940s and gained momentum in the 1950s where he began to include family members in his therapy sessions. Subsequently, between 1959 and 1962, he began a thorough research on family emotional functioning leading to the publishing of the first material of developing ideas in 1966 (Hall, 2013). In 1972 and 1978 respectively, he published his first ever material called 'Theory and practice', which he regarded as a 'spectacular moment' in his career (Bowen, 1976; Hall, 2013).

In his research, Bowen (1976) related his own family experience to his theory. He continued to encourage his own students to identify and work triangles and intergenerational patterns in their own families rather than undertaking individual psychotherapy (Brown, 1999). This theory was described by Brown (1999) as one of the "first comprehensive theories" of family system theory functioning, which received little attention in the academic and clinical sphere in certain parts of the world (p. 94). In his observation during clinical practice, Bowen found that individual psychotherapy brings changes to one member of the family, which brings new unfamiliar interactional patterns; hence, the migration from the individual focus to a family-oriented approach.

3.3.1.2 Basic propositions of Bowen's theory

Bowen's theory emphasises the involvement of the whole family when treating a defiant family member or one with mental health problems (Sutphin et al., 2013). In addition, this theory contends that when a family member becomes dysfunctional due to substances, in particular *nyaope*, he or she would consequently cause the dysfunction of the entire family system. To unpack this theory, the researcher begins by discussing the origin of the theory, followed by the basic proposition of the theory and lastly its implication on the current study.

The theory postulates that an individual cannot be completely understood in isolation from those around him or her, but rather that the family forms a system which comprises independent individuals who can only be understood collectively within their broader system (Hall, 2013; Winek, 2009). The main focus of Bowen's theory is on patterns that develop in families that can lead to anxiety or neurosis and others that develop to neutralise anxiety or suffering (Bowen, 1976; Brown, 1999). According to this theory, anxiety is caused by "perception of either too much closeness or too much distance" in the relationship between a parent and the affected child (Brown, 1999, p. 95). The results of this anxiety within the family system will be determined by the current levels of external stress (Hlungwani et al., 2020). Fundamentally, Bowen applied a series of eight working interlocking concepts to help illustrate how families collaboratively provide a description of processes in emotional systems (Bowen 1976; Hall, 2013). These include differentiation of self, triangles, nuclear family emotional

system, family projection process and emotional cut-off (Brown, 1999; Bowen 1976; Hall, 2013).

Differentiation of self: According to Bowen (1976, p. 65), differentiation is considered the "cornerstone of the theory" of Bowen's theoretical framework, which defines people's relationships according to the "degree of fusion or differentiation, between emotional and intellectual functioning". Klever (2005) defines differentiation by how well individuals can uphold a sense of self in the midst of pressure from relationships, and how well one is able to maintain cognitive functioning in the middle of emotional pressure. According to Brown (1999), the concept of differentiation has no direct connection with the presence or absence of symptoms. The author added that people with the most fusion have most of the human problems, and those with the most differentiation, the fewest; but there can be people with intense fusion who manage to keep their relationships in balance, who are never subjected to severe stress, who never develop symptoms, and who appear normal.

According to Bowen, fusion or lack of differentiation is where individual choices are set aside in the service of achieving harmony within the system (Brown, 1999). This is expressed as an intense responsibility for another person's difficulties that resulted in tensions within the family system (Brown, 1999; Kerr & Bowen, 1988). Individuals with low levels of differentiation are less flexible, less adaptable, and more emotionally dependent on those around them. They are easily stressed into dysfunction, and it is difficult for them to recover from dysfunction. Brown (1999) presented an analogy of 'knee jerk reaction' in order to describe the fused relationship and how it responds to crises or perceived demands of another person in the family system. The fused relationship is commonly evident between the parent and the affected child in the family.

Triangles: Triangles are the smallest stable relationships in the unit and it exists in all families (Brown, 1999; Kerr & Bowen, 1988). Titelman (2012) described triangles as the basic building blocks in the family's emotional or relational system and refer to dyadic relationships that are dysfunctional. Bowen proposed that the third person becomes involved in a dyad when there is a great sense of tension (Titelman, 2012). In this concept, Bowen attempted to demonstrate how emotional problems in the

society were similar to emotional problems in the family. Delinquent or perceived problematic behaviour in a teenager is directly linked to the parents as well as society. Notably, the way a society deals with problems and teenage behaviour is similar to how the family deals with the same problem (Bowen, 1976).

Triangles can be simply understood as the inclusion of the third person into a conflict that includes two people (Gale & Muruthi, 2017). When the conflict or anxiety within the dyad (parents) is not adequately resolved, members in the dyad resort to a strategy of adding the third member, who in most cases becomes a child. Wang and Crane (2001) found that children who were triangled ended up scoring high in depression scale with some leading to substance abuse.

The nuclear family emotional process: The nuclear emotional family system consists of the extent to which emotional fusion can occur in a family system. This concept further describes the mechanisms which could be utilised when a family is faced with anxiety (Rasheed, 2010). Bowen identified four patterns within the nuclear family which attempt to absorb the level of un-differentiation. Firstly, emotional distance occurs in a fused family, where there are high levels of anxiety. “As a result of the close fusion and elevated levels of anxiety, a family member can create more distance than they actually would want as a means of handling emotional reactivity” (Bowen, 1976, p. 87). Secondly, marital conflict is recognised as a symptom of tension in a relationship or in the family. The degree of conflict in a marriage is generally a function of the degree of fusion in the relationship and the intensity of the underlying anxiety. Thirdly, transmission of the “problem to a child is influenced by the basic level of differentiation and level of chronic anxiety” (Rasheed, 2010, p. 178). As a result, children within the family develop physical, emotional and behavioural symptoms. Mothers are inclined to focus more of their energy onto a child, whereas a father would distance himself. Lastly, dysfunction in a spouse is a process which involves the manner in which spouses react to one another (Bowen, 1976).

Family projection process: This process describes how children develop symptoms when they get caught up in the previous generation’s anxiety about relationships (Brown, 1999). Children tend to internalise problems which may be evident in their parent’s marriage or in their family functioning (Brown, 1999). Bowen proposed that

this concept represented the way in which the level of differentiation is passed on from a parent to one or more children (Bowen, 1976). As a result of this projection process, the child may end up being either more, less or equally as differentiated as his or her parents (Rasheed, 2010).

Bowen (1976) contends that when the problem shifts from one area to another, it creates less chance of the problem to remain in a single area. This implies that when problems shifts from one party within the system, it has a potential of being projected to other members and areas of functioning within the family system. Bowen also explains the definite patterns on how the undifferentiation is distributed to children. It focuses first on one child. If the amount is too great for that child, the process will select others for lesser degrees of involvement. There are families in which the amount of "undifferentiation is so great it can seriously impair most of the children and leave one or two relatively out of the emotional process" (Bowen, 1976, p. 81). It is difficult to identify the orderly steps in the process due to chaos and disorder in families (Bowen, 1976).

In a simplistic form, the family projection process begins when there is a problem between parents that causes anxiety in the system and the child with least emotional separation from parents becomes vulnerable and develops behavioural and emotional symptoms (Bowen, 1976; Brown, 1999). This child who responds anxiously to the mother is likely to be misunderstood as a problem child (Bowen, 1976). The anxious parental effort goes into "sympathetic, solicitous, overprotective energy, which is directed more by the mother's anxiety than the reality needs of the child" (p. 83). In the average situation, there may be symptomatic episodes at stressful periods during childhood, which gradually increase to major symptoms during or after adolescence (Bowen, 1976; Brown, 1999).

Emotional cut-off: According to Brown (1999), emotional cut-off relates to the way individuals manage the intensity or anxiety in the system. Some resort to abrupt breakaways or emotional withdrawal from a situation. Kerr and Bowen (1988) add that this emotional cut-off from family may be to prevent confrontation and interrogation. Furthermore, it also relates to the degree of engagement between a parent and the child who is affected by a problem or has defected (Brown, 1999). This

concept describes “the manner in which people deal with the emotional intensity that exists between generations and the way some people handle their unresolved emotional attachment to their parental family” (Rasheed, 2010, p. 185). Individuals use denial to handle their unresolved attachments.

Additionally, all people have some degree of unresolved emotional attachment to their parents. Much thought went into the selection of a term to best describe this process of separation, isolation, withdrawal, running away, or denying the importance of the parental family (Bowen, 1976). The unresolved attachment is handled by the “intrapsychic process of denial and isolation of self while living close to the parents; or by physically running away; or by a combination of emotional isolation and physical distance” (Allen, 2014; Bowen, 1976), which is common amongst adolescents who abuse *nyaope*. It is important to also consider that cut-offs are not always dramatic, for some individuals, it might be maintaining silence when there is a situation that evokes anger (Brown, 1999; Bowen, 1976).

3.3.1.3 The implication on the current study

Relying on the theoretical concepts of this model, the researcher explored the role of families in predisposing an adolescent child to *nyaope* abuse problems. The study probed the ways in which family members, specifically parents, understand, and cope with the addiction of their adolescent, and the drug problem’s impact on their personal functioning and overall functioning of the family. From a family systems’ perspective, risk behaviours, such as *nyaope* use, are best understood when examining family interaction. For example, stressful parent-child interactions, family discord and raising an adolescent with a substance use disorder have been associated with increased substance use among parents.

Bowen theory conceptualises that adolescents who experience anxiety from a family system are likely to get predisposed to substance abuse as a coping mechanism. This occurs when anxiety increases and remains chronic for a certain period, the organism develops tension, either within itself or in the relationship system, and the tension results in symptoms or dysfunction or sickness. The tension may result in physiological symptoms or physical illness, in emotional dysfunction, in social illness characterised

by impulsiveness or withdrawal, or by social misbehaviour. There is also the phenomenon of the infectiousness of anxiety, through which anxiety can spread rapidly through the family, or through society. There is a kind of average level of differentiation for the family that has certain minor levels of difference in individuals within the family.

This theory informs treatment and help seeking pathways for parents raising adolescents who abuse *nyaope.* The understanding the interpersonal stress that emanates from the family system plays a crucial role in managing relapse and treatment recommendation and to help maintain abstinence. Therefore, addressing potential stressful parent-child interactions through family therapy has a high potential to lead to better long-term substance use outcomes for women with children in their care. A particular concern for Bowen is the way in which children and/or adolescents may separate themselves, emotionally and physically, from their family of origin. One significant aspect of Bowen's theory is the transmission of psychological dysfunctions, over many generations, that affect the interaction of disturbed families.

This theory further highlights the importance of functional roles and emotional relationships among members of the family. This theory allowed the researcher to explore the ways in which a family member, specifically parents, understand and cope with the addiction of their adolescent, and its impact on the family. The theory further facilitated the researcher's understanding of how the problem of *nyaope* abuse by one member of the family affects important relationships within the family system. These include: the relationship between a parent and their child; as well as the relationship between parents and other children.

3.3.2 Afrocentricity

The study also applies concepts from Afrocentricity to explore the lived experiences of African parents who have adolescents with *nyaope* abuse problems. Bowen's theory alone was limited, particularly where it concerned capturing the contextual issues informing the experiences, as Bowen's theory was influenced by European cultural beliefs and familial practices of his time. Therefore, context and time are different, necessitating a borrowing of some concepts from a lens which takes into

cognisance African reality, culture and beliefs. Afrocentricity then became a suitable theory that yielded an in-depth understanding and analysis of the particularity and peculiarity of African reality as essential in the lives of this study's participants.

There have been debates about Afrocentricity being an antithesis of the Eurocentric framework. Contrary to this debate, Afrocentricity is the proactive conceptualisation of African phenomenon rooted in African cosmology and the worldview of African people or people of African descent (Nobles, 2013). In the process of asserting the African worldview and epistemology, it is necessary to challenge and discard the western views that are skewed and claim universal application on African people (Chawane, 2016; Choate, 2020). Afrocentricity has not and does not concern itself with the understanding of European people and their perspectives.

3.3.2.1 The origin

The term Afrocentricity was developed in the 1970s and was popularised by Molefe Kete Asante during the 1980s, when he developed epistemological and methodological foundations for an Afrocentric curriculum based on an African perspective, but aiming at a global understanding (Asante, 2007; Chawane, 2016). He is a professor at the Department of African American Studies at Temple University (Philadelphia). Molefi Kete Asante defined Afrocentricity as a "mode of thought and action in which the centrality of African interests, values, and perspectives predominate" (Pellebon, 2007, p. 171). Afrocentricity could be also understood as a consciousness, quality of thought, mode of thought, mode of analysis, and an actionable perspective where Africans seek, from agency, to assert subject place within the context of African history (Asante, 2007).

The philosophy behind Afrocentricity is believed to have existed long before the era of Asante and other known philosophers. This tendency of focusing on Africa from an African perspective can be found in the USA in the early 1800s when it made one of its first appearances in an 1827 editorial in *Freedom's Journal*, the first black newspaper in the USA, which alleged a relationship between Africans and the ancient Egyptians (Chawane, 2016, p. 81). By tracing the existence of a magnificent ancient

Egyptian civilisation in Africa, it demonstrated that European claims of African inferiority were false (Chawane, 2016, p. 81).

3.3.2.2 Basic proposition

Afrocentricity is a theory of social change that seeks to address and undo the negatively skewed Eurocentric perspective of African and African American history (Adeleke, 2000; Asante, 1980). The negation of Eurocentric perspective follows the claim of its universal position that puts everything European at the centre and foregrounds it as universally significant to the exclusion of other realities. This happens in the undermining and exclusion of African values, cultural, social and political variances (Anderson, 1993), Worldviews and ways of being outside the European 'world' are often viewed from a negative standpoint and are seen as pathological. Basic to Afrocentricity is the belief that everyone has a specific culture and history that are the focal points from which they derive a sense of past and future (Asante, 1980). This study focused on the two main concepts relevant to the study in respect of Afrocentricity, namely, holism and shattered consciousness.

Holism: The Afrocentric paradigm holds the notion of holism, where a phenomenon has to be studied and understood in its entirety and not in fractions, more especially when it comes to studying African realities (Mazama, 2003; Msengana, 2006). Therefore, in studying African culture and behaviour, it requires researchers to place African ideals, values, and philosophies at the centre of an analysis (Alkebulan, 2007; Xulu, 2015). In view of this framework, parents' lived experiences were understood as an African experience consisting of all of their bio-psycho-social and spiritual experiences. Their experiences were essentially placed at the centre of analysis and their varying beliefs, cultural experiences and practices were deemed as integral.

The interrelatedness and interconnectedness highlighted above is based on the relationship African individuals have with three dimensions of communities (Nobles, 2013). The first dimension of community is the 'living-dead' known as *badimo/vhadzimu* (Baloyi & Ramose, 2016). These become important Intermediaries between the life force of goodness and their family. It is believed that there should be harmony and interdependence between the elements of the cosmos (universe).

Disconnection between parts of the cosmos (universe) may lead to undesirable or immoral conduct or put differently, it can lead to disharmony, diseases and suffering. When the human spirit is well, whole, and healthy, that is, in harmony, the human being is characterised by good health, confidence, competence, and a sense of full possibility and unlimited potentiality (Nobles, 2010, p. 13). Because a family in Western conception does not include ancestors' spirits, Bowen's concepts become constrained at this juncture; Afrocentricity, on the other hand, compensates for this shortcoming.

Shattered consciousness and fractured identity: The most profound psychological effect of slavery and colonialism for African people has been a sense of human alienation resulting from being infected with or assaulted by long-standing, ongoing sensorial information. Human alienation for African people is the sense of being disconnected from one's spirit (even though one is highly spiritual) and having a sense of not being truly or completely human (and not knowing it). Nobles classified this as "spirit damage" or the "suffering of the spirit" (Nobles et al., 2016).

According to Nobles et al., (2016), spirit beings which are referred to as ancestors in African context connect us to the metaphysical world. Consistent with these ideas, it is essential to have harmony between the physical being and the spirit being, as failure to do so could lead to diseases and socially undesirable behaviours. According to Nobles (2013), guided by the informative character of African deep thought, the development of an "African-centered classification of disease, that is, nosology, should at a minimum (a) use African language and logic and (b) explore the application and relevance of these ideas and notions in illuminating (clarification and study of) the "suffering of the spirit" (7). The "suffering of the spirit" (essentiality of being), can be evidenced in the experience of being human, the expression of being human and the essence of being human itself. These three domains or paths represent the arenas of spirit suffering and imbalance or disharmony reflected in our shattered consciousness and fractured identity (Nobles, 2013, p. 7). Given how *nyaope* abuse destroys the users physically with little chances of recovering destroys caregivers and family functioning as well as destabilising the community, Nobles' classification becomes essential.

Europe's psychological domination of Africa's mind can be understood as a clash of culture and consciousness (Nobles, 2013). This clash is centered on the meaning of being human and the question of human relations, both of which can be illuminated by the utilisation of a "memetic analysis". Dawkins (1989) defines "memes" as a unit of cultural inheritance that is naturally selected by virtue of its phenotypic consequence on the particular culture's own survival and replication. The meme itself is a unit of information residing in the brain.

3.3.2.3 The implications of the current study

According to the Afrocentric perspective, health and ill health are critical concepts in public health. According to African beliefs, health and ill health are conceptualised as the harmony or disharmony between the physical and spiritual realm. Health in the African perspective is achieved when harmony is achieved between individuals, their living families, communities and the living-dead, that is, their ancestors. This surfaced and further magnified the relevance of the concepts of interrelatedness and holism to the present study. It is therefore important to note that practicing holistic healing practices with patients and clients will help bring about whole health. Holistic healing practices will also go a long way to help in the prevention and cure of illnesses, diseases, and ailments.

The after-effects of colonialism, which were perpetuated by apartheid in South Africa, led to the confusion of identity. Many believe in the western-oriented religion, which has conflicting ideas with African religion. Individuals attempt to combine Christian belief and ancestral belief. This is what Nobles refers to as fractured identity and shattered consciousness. The need for the use of this framework is also supported by the fact that the existing substance abuse intervention models and programmes are largely founded on Eurocentric culture, and thus may be limited in other contexts. It therefore becomes imperative that research efforts into this area adopt a new lens that takes the local people's culture and traditions into cognisance. Hence, the current study located itself within the Afrocentric theoretical framework.

3.4 Concluding remarks

In this chapter, the different models and theories were discussed as the lens to view the phenomenon under investigation. One level, this study has considered western-oriented models and theories such as Biopsychosocial Model, Stress Strain Coping and Support Model, Health Belief Model as well as Bowen Family Systems Theory. At another level, the study noted the need to view the phenomenon under study from an African-oriented theory, namely, Afrocentricity. The next chapter focuses on the research methods followed in this study.

CHAPTER 4: RESEARCH METHODOLOGY

4.1 Introduction

This chapter discusses the research process and procedures that were followed while conducting this study. It begins by introducing the research design, which includes the epistemological stance and ontological position. The second part focuses on the chosen methodology and exact procedures followed. Lastly, the chapter discusses the quality criteria used and the ethical principles that were considered when conducting the study.

4.2 Research method

The present study was informed by the qualitative research approach. Ponterotto (2005) defines this approach as a "broad class of empirical procedures designed to describe and interpret the experiences of research participants in a context-specific setting". Qualitative studies seek to explore, understand, shed light on and investigate the complexities of the social world and meaning people assign to their lived experiences (Creswell, 2013; Patton, 2023; Turffour, 2017). Contrary to asking the 'how much' and 'how many' type of questions preferred by quantitative researchers, this approach is inductive and has been found to be the most appropriate in "exploring the 'what', 'why', and 'how' type of research questions (Tuffour, 2017, p.1). To operationalise a qualitative research project, it is important for researchers to understand the philosophical, paradigmatic, epistemological, and ontological aspects underpinning the study (Creswell, 2013; Flick, 2014).

In contrast to the quantitative research, which is strict in its approach to data and is based on positivism and, more recently, post-positivism, qualitative research is guided by interpretivists' philosophy. Philosophies underpinning research determine the type of data to be collected, how such data should be analysed and how to ensure the validity and reliability of the study (Cresswell, 2013; Salvador, 2016). This section draws some differences between the two philosophies with a greater emphasis placed

on interpretivism, the paradigm that informed the choice of the present study design, methods of data collection and analysis.

4.2.1 Positivism

Positivism is associated mostly with natural sciences and holds a strong view that suggests a singular logic of science and all aspiring science must conform to that singular logic (Neuman, 2014). This logic of science is referred to as positivism, which is founded on empirical knowledge. The general understanding is that a positivist approach is the actual science (Bhattacherjee, 2012). In this paradigm, empirical methods such as surveys, structured questionnaires and statistical analytical strategies that possess relatively good reliability and representativeness are preferred. Positivism is based on objective research, which relies on measurements of a phenomenon under investigation with the use of exact measures such as questionnaires or tests (Babbie & Mouton, 2011; Flick, 2019; Neuman, 2014).

In social science, the positivism paradigm posits that society shapes individuals through external strong forces such as socialisation, social class, gender and ethnic background (Alharahsheh & Pius, 2020; Ryan, 2018). It views human behaviour as objective, truth as absolute and reality as something that can be measured and is observable (Neuman, 2014). According to this paradigm, truth and reality are universal and can be achieved through objective measurement.

Scholars have found that the positivist paradigm has relative shortcomings when it comes to measuring constructs such as attitudes, intentions, and human thoughts due to the fact that these constructs cannot be observed and measured (Creswell, 2008; Ryan, 2018; Neuman, 2014). Additionally, it is believed that this paradigm is also limited when it comes to measuring lived experiences because its main focus is on labelling phenomena rather than understanding them from the worldview of the subjects under investigation (Alharahsheh & Pius, 2020). The current study aimed to understand the ‘world’ of the parents with children who abuse *nyaope*. It sought to understand the parents’ views regarding their children’s condition, how their children’s problems affected them, how they were coping and lastly, the help-seeking pathways they followed to help their children. Thus, it was unlikely viable for this paradigm to

assist in exploring the lived experiences of parents with adolescents who abuse *nyaope*.

4.2.2 Interpretivism

The present study was aligned to the interpretivist paradigm. Interpretivism is associated with qualitative studies and is premised on the notion that human beings interpret their world and act according to their interpretations of the world (Flick, 2014). To this end, a relativist ontological stance is always adopted, which suggests that 'truth' is understood as contextually relative (Thanh & Thanh, 2015), where space and time are critical considerations. It is believed that a single phenomenon can have multiple interpretations, bearing in mind cultural influences over time (Bhattacherjee, 2012; Cresswell, 2013; Neuman, 2014).

Interpretivism is based on the assumption that "social reality is not singular or objective but is rather shaped by human experiences and social contexts (ontology), and is therefore best studied within its socio-historic context by reconciling the subjective interpretations of its various participants (epistemology)" (Bhattacherjee, 2012, p.103). According to this paradigm, social reality is subjective and should be understood from the perspective of subjects under investigation. In addition, human beings derive meaning from their day-to-day experience and interpret their situations differently.

Interpretivism further posits that human beings are social beings who create meaning and constantly make sense of their worlds (Babbie & Moutton, 2011; Neuman, 2014). Added to that, these social beings have values that become an integral part of their lives (Flick, 2014). These values are not perceived as right or wrong; rather, as different, which implies that there are no superior beliefs and values. There has always been a debate on whether social science is a 'real science' or not (Babbie & Mouton, 2011; Creswell, 2008; Neuman, 2014). Much of the debate is largely based on ambiguities, lack of standardisation and most importantly, the accurate capturing of lived experiences rather than opinions. Although the positivists still hold the view that positivism is the only science, the interpretivist paradigm has been dominating social science, particularly in the field of psychology (Bhattacherjee, 2012).

Interpretivism was useful in understanding the lived experiences of parents with adolescents who abuse *nyaope*. These experiences included, amongst others, their understanding of the contributory factors to their children's problem, how their children's problems affected them, how they were coping and the help-seeking pathways they followed to address the problem. It was helpful to consider the relationship between the parents' lived experiences and their socio-economic backgrounds. This helped the researcher to determine the effect of this relationship on the parents' coping mechanisms against their children's problems.

4.2.3 Rationale for choosing qualitative approach

Qualitative research methods refer to comprehensive scientific methods preferred generally in social sciences and psychology in particular (Flick, 2019). In the current study, this method aided the researcher to describe, explore and interpret the lived experiences of parents with adolescents who abuse *nyaope* in the rural setting of the Limpopo Province (Creswell, 2013; Denzin & Lincoln, 2008). In addition, this method often attempts to depict a world in which reality is socially constructed, complex and ever changing (Creswell, 2008; Sloan & Bowe, 2014).

Qualitative methods allowed the researcher's to be an active participant during data collection and most importantly, to understand the phenomenon from the participants' perspectives in order to acquire knowledge (Flick 2014). The subjectivity of the researcher and of those being studied became part of the research process (Creswell, 2009). This allowed the researcher to reflect on his actions, feelings and observations in the field, and thus become part of the interpretation of the data acquired. The researcher paid special attention to the participants' subjective meanings and the manner in which they experienced events, e.g., parenting adolescents who abuse *nyaope*. The approach further assisted the researcher to achieve the following objectives:-

- To ascertain the parents' understanding of the contributory factors to *nyaope* abuse problems.
- To determine the psychological impact of the adolescents' *nyaope* abuse problem on parents and the functioning of the overall family.

- To identify and describe the strategies used by parents to cope with *nyaope* abuse problems of their adolescent children.
- To explore the parents' views regarding the treatment that their adolescent children were receiving or should receive.
- To document the help-seeking pathways that the parents followed to manage their adolescent children's *nyaope* abuse problems.
- Based on the phenomenological account, develop a contextually relevant help-seeking pathway model for parents with adolescents who abuse nyaope.

The study explored the thoughts, feelings, perceptions and reflections of the participants to gain insights into how the participants make sense of their lived experiences. The qualitative approach proved to be the most appropriate method, undergirded by the hermeneutic phenomenological design and the Interpretative phenomenological analysis.

4.3 Study design: Phenomenological philosophy and praxis

Epistemologically, the present study was underpinned by the phenomenological tradition. Epistemology is grounded in philosophy and is primarily concerned with the theory of knowledge (Crowther & Thomson, 2020). Epistemologically, researchers attempt to answer questions like "what is the nature of knowledge?" and "how is knowledge produced?" (Willig, 2013, p. 8). A researcher's epistemological stance has a direct link to the ontological position and it is important to demystify this position in the beginning of the research process (Ormston et al., 2014). Ontology is specifically concerned with the nature of the world (Ormston et al., 2014). When thinking ontologically, researchers should attempt to answer questions such as, "what is there to know?" or "what is the nature of reality?" (Bello, 2010; Goodall, 2014). The researcher adopted this stance to gain an in-depth understanding of how individual participants described and interpreted the phenomenon investigated from their vantage point or subjective standpoint (Smith, 2004; Goodall, 2014).

Phenomenology is a philosophical perspective and one of the several qualitative traditions that helps researchers to "explore and understand everyday experiences

without pre-supposing knowledge of those experiences" (Reiners, 2012, p.1). This philosophy was introduced by Edmund Husserl, a European philosopher in the 20th century (Dowling, 2007; Owen, 2008). Although there are several scholars, such as Merleau-Ponty, Heidegger, Gadamer, Merleau–Ponty and Ricoeur, who significantly advanced Husserl's thoughts, Husserl and Heideggar remain as the key figures in phenomenology (Converse, 2012; Dowling, 2007). Their contribution differs to some extent, but they converge in their emphasis on lived experiences. This section presents the historical and disciplinary origin of phenomenology, phenomenological philosophy, and phenomenology philosophy of praxis, types of phenomenology and lastly, the design of choice, which is the hermeneutic phenomenological design.

4.3.1 Historical and disciplinary origin

The philosophical origins of phenomenology can be traced to the ancient Platonic times (Converse, 2012; Dowling, 2007; Reiners, 2012; Petropoulos, 2021). Edmund Husserl, a German philosopher grounded his thoughts on Brentano's principle of intentionality (Converse, 2012; Dowling, 2007). This principle was developed by Brentano who was a psychologist with the goal of "understanding human thoughts and experiences through rigorous and unbiased study of things as they appear" (Dowling, 2007, p. 132).

What made Husserl's phenomenology distinct from natural science was the idea of philosophical reduction (Roy, 2023). This entails the stripping away of the researcher's preconceptions of a phenomenon to experience its pure essence. This is a hallmark of Husserlian phenomenology (Converse, 2012; Roy, 2023). Husserl's phenomenology emphasised a way of coming to know through the actual experience of a phenomenon (experiential epistemology) with a goal of describing the experience of the phenomenon (Englander, 2016; Dowling 2007).

Husserl has provided the prominent and central argument about intentionality as an essential feature of consciousness. Giorgi (2010) indicates that the implication of consciousness is always directed at an object in our world and therefore people are inherently related to the objects they perceive in their world. The concept of intentionality helps us to direct our attention towards how people perceive objects as

they present themselves to consciousness (Leal & Melo, 2018). Husserl famously argued that in order to describe and fully understand any given phenomena, “we must go back to the things themselves” (Husserl, 1970, p. 252). This is an important statement as Husserl argued that we often experience the world using the natural attitude, which means that we take our experiences for granted, do not fully focus on them and perceive them with regard to our pre-existing expectations (Smith & Osborn, 2009). However, this way of living prevents objects from showing themselves fully (Leal & Melo, 2018). Therefore, to achieve a deeper understanding, people must “bracket” their presuppositions and preconceptions (also known as “epoche” and “phenomenological reduction”).

The second contributor to phenomenological philosophy is Martin Heidegger who was a student of Husserl (Davidsen, 2013; Giorgi, 2010). Heidegger advanced this philosophy by taking a different posture and argues that phenomenology should be used to investigate the ontological question that is the ‘meaning of being’, rather than focus on experiential epistemology (Converse, 2012). Contrary to the thoughts of Husserl, Heidegger stated that what is to be uncovered is not the essence of the phenomenon, but the ‘being’ of the phenomenon (Converse, 2012). The Heideggerian concept of ‘being’ is abstract, but generally, Heidegger was mostly concerned with the meaning of our understanding of what makes entities what they are. Heidegger believed that the world was an essential part of our understanding of the meaning of being and was not separate (Converse, 2012; Davidsen, 2013; Giorgi, 2010).

Heidegger moved away from the concept of intentionality and advanced Husserl thought by bringing in two concepts, hermeneutic circle and reflexivity (Dowling 2007, Counsel, 2011). He believes that the nature of being is an ongoing, circular process so that the meaning of being in the world is also circular (Converse, 2012). Before entering the circle, the researcher must have worked out or come to know his or her ‘fore-having, fore-sight, and fore-conception’ which he referred to as reflexivity. Thus, interpretation takes place with the understanding that the researcher is part of their historical, social, and political world (Converse, 2012). The current study was grounded on Heidegger’s theory (Englander, 2017).

Hans-Georg Gadamer is another philosopher who contributed to phenomenology through further development of the hermeneutic circle (Converse, 2012; Dowling 2007). Even though Gadamer did not intend for his philosophy of hermeneutics to be used in creating a research method, it has inspired an interpretive method that enables the uncovering of meaning and understanding between texts and the interpreting researcher (Dowling 2007, Converse, 2012; Counsel, 2011). Gadamer took the position that a writer is embedded in the social, cultural and historical world, and thus this 'situatedness' needs to be considered when interpreting the writer's text (Converse, 2012; Gadamer 2004). Gadamer envisioned the hermeneutic circle as a process of movement between the details of the text and the interpreter of the text. In this movement, the preconceptions of the interpreter are incorporated into the process and shifted from preconceptions to new understandings as the interpretive process moved forward (Converse, 2012; Rodgers 2005).

Another philosopher who built on the writings of Husserl and Heidegger was Merleau–Ponty (Godden & Kutsyuruba, 2023). He began by bringing in the concept of 'phenomenology of perception' which aims to rediscover first experience, which he terms as the ''primacy of perception'' (Godden & Kutsyuruba, 2023). Merleau–Ponty concurs with Husserl and disagrees with Heidegger as he advocates phenomenological reduction in order to reach an original awareness. The goal of Merleau–Ponty's 'phenomenology of origins' is to help us view our experience in a new light, not relying on the categories of our reflective experience; a pre-reflective experience (Horrigan et al., 2016). Merleau–Ponty's writings has been found to be useful in nursing research and this is evident in the utilisation of the four existentials considered to belong to the fundamental structure of the lifeworld; lived space (spatiality), lived body (corporeality), lived time (temporality), and lived human relation (relationality or communality), are productive for the process of phenomenological questioning, reflecting and writing (Dowling, 2007).

4.3.2 Phenomenological philosophy

The philosophy of phenomenology began with Husserl, who used it to describe the experience of a phenomenon in consciousness (Converse, 2012; Dowling 2007). Heidegger built on that philosophy to investigate the meaning of 'being'. Gadamer

further developed Heidegger's hermeneutic circle, emphasising text and conversation as media of interpretation (Converse, 2012). Even though there are many philosophers who discussed phenomenology, Husserl's and Heidegger's philosophical writings have been the most influential in inspiring research methodology, and Gadamer has been the most influential in developing a way of interpreting text (Converse, 2012; Dowling 2007).

Smith et al. (2009) argue that through the use of phenomenology, a researcher can gain an insight into how to study and understand human experience in its own right. Husserl has highlighted the importance of engaging in reflective and reflexive thinking whilst studying experience and consequently, the present researcher adopted a number of strategies to support this throughout the research process (Leal & Melo, 2018). However, like Heidegger, the researcher does not believe that people are able to fully bracket off their prior-knowledge, experience and preconceptions; on the contrary, one can only attempt to do this (Leal & Melo, 2018). The researcher did not intend to capture the universal essence of the experience under study either, like Husserl aspired to; instead, he sought to understand personal perceptions and individual experiences (Begley & Quayle, 2007). Studying experience is a complex challenge; hence, the aim was to produce an account of close experiences rather than distant experiences (Smith, 2011).

4.3.3 Phenomenology philosophy of praxis

Phenomenology was extended from being a philosophy to a method of scientific study, which occurred over decades and was viewed as an elusive change (Dowling, 2007; Sloan & Bowe, 2014). This extension may be seen as one example of advancing phenomenology from philosophy to methodology, as there have been many variations in the application of the philosophy of phenomenology and many variations in the application of the methodologies of phenomenology and those methodologies (Dowling, 2007; Sloan & Bowe, 2014). Thus, there are different types of phenomenology within the field of qualitative investigative methods. Some have their backgrounds in descriptive phenomenology developed by Husserl and some in hermeneutic phenomenology developed by Heidegger. Interpretive phenomenological analysis also became a prominent member of the list of qualitative methodologies and

is applied to many qualitative studies in human science (Dowling, 2007), including the current study.

Heidegger hermeneutic phenomenological design was adopted whereas IPA guided the analysis of data. Heidegger argues that people should be located within particular contexts, which is why the current study focused on the lived experiences of parents living with adolescents who abuse *nyaope* in the rural areas of Limpopo. During the process of investigation and analysis, the researcher became an active participant when collecting and interpreting the findings.

4.3.4 Types of phenomenology

Dowling (2007) posits that there are two types of phenomenology, namely; Descriptive phenomenology (developed by Husserl) and Hermeneutic phenomenology (developed by Heidegger). According to Sloan and Bowe (2014), these two types of phenomenology have some similarities. For instance, both these traditions emerged from German philosophy; their creators having worked with and influenced one another (Converse, 2012; Sloan & Bowe, 2014). Each of these philosophers sought to uncover the life world or human lived experience (Sloan & Bowe, 2014). Husserl and Heidegger were convinced that the world is simply one life world among many worlds; therefore, they both called for a review of the truth of the human world and people as conscious beings. However, there are also numerous differences between the descriptive phenomenology and the hermeneutic phenomenology. Hermeneutic phenomenology is relatively more complex than descriptive phenomenology (Dowling, 2007; Sloan & Bowe, 2014). For the hermeneutic (or interpretive) phenomenology, time is an important factor whereas the same cannot be said about descriptive phenomenology. This added complexity was an attempt, by Heidegger, to provide more clarity about phenomena for the researcher, and to allow more practical applications of the approach to a wider range of scenarios to which phenomenology might be applied (Sloan & Bowe, 2014).

In descriptive phenomenology, one has the technique of ‘bracketing off’ influences around a phenomenon to get to the essences. In hermeneutic phenomenology, there are approaches that aid the researcher to interpret the meanings found in relation to

phenomena. These approaches often suggest the analysis of texts to find these meanings and allow interpretation (Connely, 2010; Sloan & Bowe, 2014). It primary focus is on “understanding the meaning of experience by searching for themes, engaging with the data interpretively, with less emphasis on the essences that are important to descriptive phenomenology” (Sloan & Bowe, 2014, p. 9). Also, “hermeneutic phenomenology prefers not to formalise an analytical method so that the context of the phenomenon itself can dictate how the data are analysed” (Sloan & Bowe, 2014, p. 9).

4.3.5 Hermeneutic Phenomenological design

Heidegger contends that hermeneutic phenomenology is a research method founded on the ontological view that lived experiences are an interpretive process (Smith, 2007). This design aims to achieve understanding through interpretation and adopts a process that clarifies the phenomenon of interest in its context (Dowling & Cooney, 2012; Hein & Austin 2001). According to Dowling (2007), Heidegger used the phrase “Being-in-the-world” to refer to how human beings exist, act or are involved in the world. He believed that understanding is the reciprocal activity and proposed the concept of “hermeneutic circle” (p. 135). The current study was grounded in the work of Martin Heidegger who advanced interpritivist hermeneutic phenomenology. The fundamental basis of hermeneutic phenomenology is that human beings survive in the world that is essentially hidden, forgotten, disguised and withdrawn (Dowling, 2007). This design serves to destruct and look past the everyday superficial understanding in order to obtain the meaning of lived experiences (Crowther & Thomson, 2020), e.g., the lived experiences of parents with children who abuse *nyaope*.

4.4 Setting

The present study was undertaken in the Mokopane area, Waterberg District, in the Limpopo Province. Mokopane, previously known as Potgietersrus, is dominated by Northern Sotho (also referred to as Sepedi), IsiNdebele, and Xitsonga speaking people with Northern Sotho being the most spoken language. Despite being surrounded by mining areas and reportedly rich in minerals such as platinum, the local population is characterised by high levels of unemployment, particularly amongst

economically active youths. It is reported that most people depend on social grants, which shows the sub-average socio-economic status.

In the Limpopo Province, Waterberg District (particularly Bela Bela and Mokopane) is amongst the areas that are known to be hotspots for substance abuse (specifically *nyaope*). Hence, the current study targeted Mokopane local township (Mahwelereng) and surrounding villages (Sekgakgapeng, Mazombana and Tshamahansi), as shown in Figure1 below.

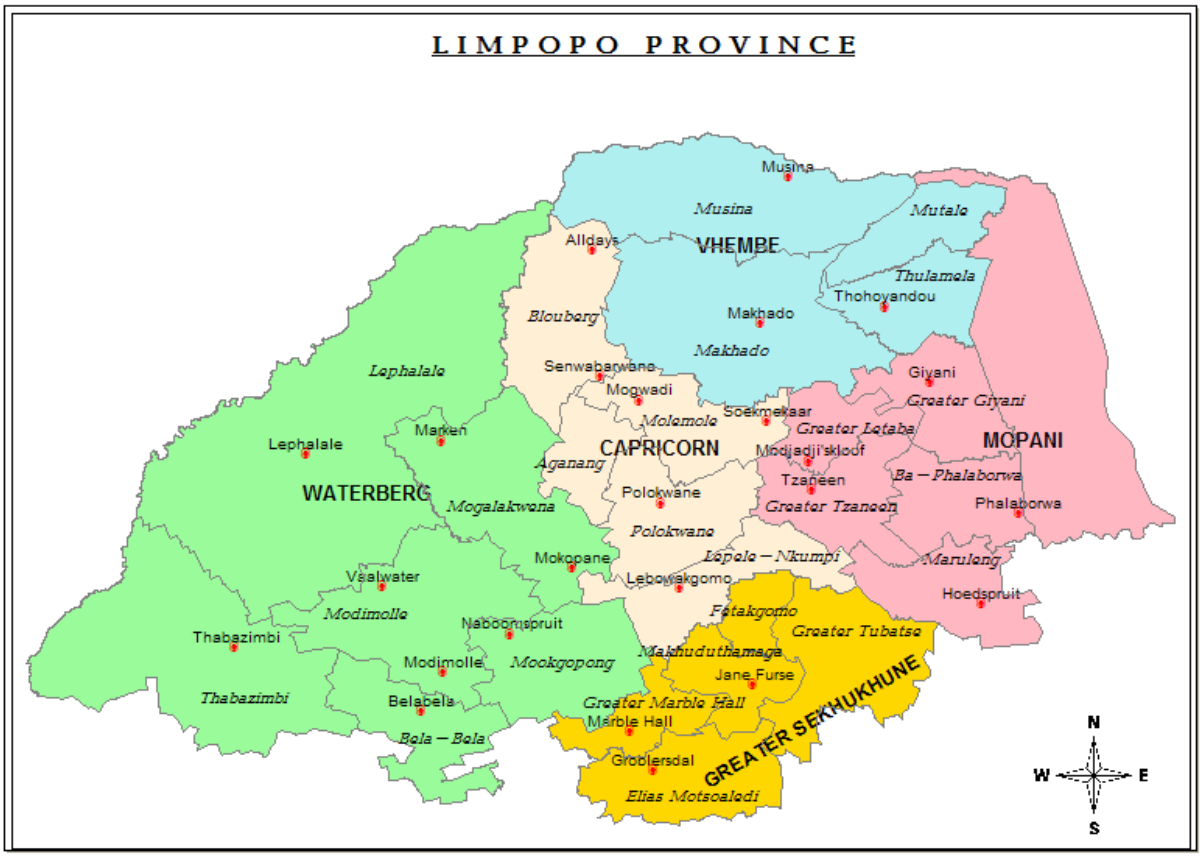


Figure 1: This map shows Limpopo Province. The study was conducted in Waterberg District (Green part), Mokopane area (triangled).

4.5 Population and sampling

Population refers to the entire group that the researcher intends to draw conclusions about. In research terminology, the population can be explained as a comprehensive group of individuals, institutions, objects and so forth with common characteristics that are of interest to a researcher (Flick, 2019). In the current study, the population was

all the parents with adolescents who were identified as abusing *nyaope* and residing in the town of Mokopane and surrounding villages.

It is from these areas (Mahwelereng, Sekgakgapeng, Mazombana and Tshamahansi) that the study sample was drawn. A sample refers to a group of people who are selected from the population for inclusion in the study. In IPA, the sample size is generally small (between 6 to 12 participants) due to its nature of analysis that involves detailed case-by-case analysis of individual transcript, which takes time (Smith & Osborn, 2012, p. 55). The sample of this study was parents of children who were using *nyaope*. These children were identified through rehabilitation centres around Mokopane, Mokopane Victim Empowerment Program (MVEP) and area Social Work offices. These are children who confirmed that they were using *nyaope* and sought help from different sectors in the community. The participants were drawn from the Mokopane Township (Mahwelereng), and three surrounding villages, namely, Tsamahanzi, Mazombana and Sekgakgapeng.

The participants were selected through purposive and snowball sampling strategies. Purposive sampling is a deliberate choice of participants based on the qualities they possess in line with the objectives of a study. Snowball sampling is the strategy used by a researcher to identify a few respondents who match the criteria for inclusion and then asks them to recommend other known respondents who also meet the criteria. This chain referral is mainly used where there is an interconnected network of people (Creswell, 2008; Neuman, 2011).

Purposive sampling was used to identify the first four participants. The participants were identified through the assistance of Social Workers in a local rehabilitation centre whereas the others were identified by employees working for MVEP. Snowballing was then employed after each interview, where the initial participants were requested to refer the researcher to other parents in the community who shared a similar problem of children abusing *nyaope*. The researcher continued snowballing through referrals made or recommended by parents of adolescents abusing *nyaope* until saturation. Upon reaching the 8th participant, the researcher was convinced that saturation had been achieved and continued until the 11th participant (Babbie & Mouton, 2011; Neuman, 2011).

This was consistent with the literature that posits that sampling must be theoretically consistent with the qualitative paradigm in general, and with IPA's orientation in particular. The participants were selected purposely because they could provide insight into particular experiences that were consistent with the research objectives. In terms of sample size, the study envisaged selecting 10 participants; however, 11 participants were included for the current study (Gentles et al., 2015; Neuman, 2011). This inclusion was done until the researcher was satisfied with saturation. Following the selection of these participants, preparation for data collection through interviews commenced.

4.6 Data collection strategy: Semi-structured interviews

A questionnaire was developed to capture the demographic profile of the participants. This profile included, amongst others, gender, parents' age, age of the child, marital status, employment status, religion as well as residential address (see Annexure 2a & 2b). A semi-structured interview guide (see Annexure 4a and 4b) was also developed in lieu of the objectives of the study. Semi-structured interviews were used as data collection instruments with each parent (see Annexure 4a for interview schedule - English version and Annexure 4b for interview schedule - Sepedi version). Semi-structured interviews are in-depth interviews, where the respondents have to answer pre-set open-ended questions (Patton, 2023). This type of interview allowed the researcher to clarify ambiguous statements, permit exploration of topics and to elicit an experiential account of the lived experience by the parents with adolescents who abuse *nyaope* (Turner, 2010). Smith and Osborn (2012) describe this method as the most appropriate for IPA, as it makes the interview process a collaborative exercise between the researcher and the participants as the primary experts. Data were stored on digital audio recorders with the permission of the participants. The researcher also took field notes for the later review and analysis, as well as to ensure that none of the data were lost.

4.6.1 Procedure

After securing Ethical Clearance from the University of Limpopo, the researcher went to the field to begin with the process of collecting data. Two rehabilitation centres and a Victim Empowerment Program (VEP) that works with substance abusers, particularly *nyaope* abusers, were identified. The researcher explained the purpose of the research and requested the contact details of the parents who have children who abuse *nyaope* and subsequently scheduled appointments with them. Only the parents of children between the ages of 13 – 19 years were included in the study. These were parents of children who were abusing *nyaope* with most of them having attempted to seek help and a few of them still awaiting professional help. The parents of children above the age of 19 were excluded from the study.

Before participating in the study, a thorough explanation of the aim and objectives of the study was provided. The ethical aspects and nature of the interview were also explained to the participants. Those who understood the purpose of the study and agreed to participate were given a consent form to sign as a confirmation of their voluntary participation. After each interview, the researcher requested a referral of other parents who had adolescents who abused *nyaope*. In interpretive phenomenology, Heidegger (1971) views language as a central tool for human expression of experience and exploration of lived experience. Therefore, during data collection, all the interviews were conducted in Northern Sotho, with a single interview lasting between 15 and 45 minutes. Field notes were recorded immediately after each interview. The researcher also used an audio recorder to capture the interviews with the permission of the participants. The field notes were used to capture the essential aspects of the data, such as significant observations and points. The audio recordings were coded and saved as Pt A to Pt K in electronic devices. The researcher used a Registered Counsellor (a trained professional in the field of psychology) as a research assistant.

4.7 Data analysis

IPA was used as an analytical method to derive meaning from the collected data in the current study. IPA is grounded in the principles of hermeneutic phenomenology design and aims to explore in detail how participants make sense of their personal and social world (Smith & Osborn, 2007). It assists the researcher to explore the

individuals' meaning-making related to certain events and significant personal experiences (Miller & Barrio-Minton, 2016). IPA was developed by Jonathan Smith and has been found to be the preferred strategy in clinical and counselling psychology because of its focus on the lived experiences of subjects under investigation (Alase, 2017; McCormack & Joseph, 2018). This strategy enabled the fulfilment of the aim and objectives of this study. It also allowed the parents to detail the experiences and/or predicaments of raising children who abuse *nyaope*. The method also allowed the researcher to become an active participant in the data collection and analytical processes, respectively (Alase, 2017; Creswell, 2013).

Before data analysis, each case was assigned a code. A trail of field notes were prepared and aligned to each relevant code. During this preparation, where there was missing information that was necessary for the study, the participants were called to provide required information. There were other interviews that were considered to be obsolete due to poor quality and exclusion criteria. The following IPA steps were used in analysing the data collected (Smith and Osborn, 2003):-

Step 1: Reading and re-reading.
According to Smith and Osborn (2003), this step involves reading the transcript for a number of times, the left-hand margin being used to annotate what is interesting or significant about what the respondent said. It is important in the first stage of the analysis to read and reread the transcript closely to become as familiar as possible with the account. Each reading has the potential to throw up new insights. This is close to being a free textual analysis. One returns to the beginning of the transcript again, and uses the other margin to document emerging themes.

Smith and Osborn (2003) further indicate that the initial notes are transformed into concise phrases, which are used to capture the essential quality of what was found in the text. The themes move the response to a slightly higher level of abstraction and may invoke more psychological terminology. This transformation of initial notes into themes is continued through the whole transcript. It may well be that similar themes emerge as one goes through the transcript and where that happens, the same theme title is therefore repeated.

To ensure that this first step is followed, the researcher first paid close attention to one transcript for a full examination. One script was read several times to fully understand the text. This process included reading the transcript and listening to the audio to capture the lived experience as accurately as possible. Subsequent to that, initial notes were captured with central issues within the participant's narrative and reflected the analysts' observations and reactions to the data. Salient points from the interview were captured and initial comments were noted in an attempt to bracket these and focus on what was being said.

Step 2: Developing and identifying emergent themes

According to Smith and Osborn (2003), this step involves listing emergent themes on a sheet of paper, and then one looks for connections between them. The initial list includes the chronological order of emergent themes. It is based on the sequence in which the themes emerge in the transcript. The next stage involves a more analytical or theoretical ordering, as the researcher tries to make sense of the connections between emergent themes. In this instance, some of the themes may cluster together, whereas the others may emerge as superordinate concepts.

To ensure compliance with this stage, the researcher started by examining the content at an exploratory level. This involved documenting topics of apparent importance and subsequently trying to capture the meaning of these topics. The researcher focused on the content and described the objects of concern; reflected on the specific use of language; asked questions of the data and moved towards a more conceptual understanding of what it meant to have these concerns in the context of the study.

Step 3: Abstracting and integrating themes/clustering themes

According to Smith and Osborn (2003), this step involves clustering themes as they emerge, where they are checked in the transcript to make sure the connections work for the primary source material and the actual words of the participant. This form of analysis is iterative and involves a close interaction between the reader and the text. The researcher is the one who draws on interpretative resources to make sense of what the participant is saying while constantly checking his or her own sense-making against what the participant actually said.

The themes move the response to a slightly higher level of abstraction and may involve more psychological terminology. At the same time, the thread back to what the participant actually said and one's initial response should be apparent. Thus, the skill at this stage is finding expressions that are high level enough to allow theoretical connections within and across cases, but which are still grounded in the particularity of the specific thing mentioned.

I ensured that this step is adhered to by collating themes into groups based on their connection, generating a list of superordinate (higher level) and subordinate (lower level) themes. The aim of this stage was to focus on discrete chunks of the text in order to recall what was learned through exploratory commenting. Concise statements (emergent themes) were developed to capture and reflect understanding (See Table 2 in chapter 5).

Step 4: Moving to the next case

In this step, a single participants' transcript can be written up as a case study in its own right or, more often, the analysis can move on to incorporate interviews with a number of different individuals. One can either use the themes from the first case to help orientate the subsequent analysis or put the table of themes for participant 1 aside and work on transcript 2 from scratch. Whichever approach is adopted, one needs to be disciplined to discern repeating patterns as well as acknowledge new issues emerging as one works through the transcripts. In this way, the researcher should aim to respect convergences and divergences in the data, recognising the ways in which accounts from the participants are similar and also different (Smith & Osborn, 2003).

In order to comply with this step, the researcher tried to cluster previous themes and keep an open mind to do justice to the individuality of each new case. The researcher then developed a summary table and clustered the themes. In this step, the researcher carefully identified higher order themes and eliminated non-relevant or sub themes not found prevalent throughout the text or lacking significant insight in the phenomenon of parents living with the adolescents who abuse *nyaope.* The remaining transcripts were then analysed using stages 1-4. Each case was approached in its own right to allow new themes to be developed.

Step 5: Looking for patterns across cases

A single participant's transcript can be written up as a case study in its own right or, more often, the analysis can move on to incorporate interviews with a number of different individuals. One can either use the themes from the first case to help orient the subsequent analysis or put the table of themes for participant 1 aside and work on transcript 2 from scratch. Whichever approach is adopted, one needs to be disciplined to discern repeating patterns while also acknowledging new issues emerging as one works through the transcripts. The researcher noted the convergences and divergences in the data, recognising ways in which accounts from participants were both similar and different in numerous respects (Smith & Osborn, 2003).

Consistent with this step, patterns of shared higher order qualities across cases were identified with special focus on idiosyncratic (peculiar themes appearing for the first time) instances. The foregoing stages were then repeated for each remaining transcript while acknowledging convergences and divergences in the data. This stage involved searching for connections across cases. Through this process, superordinate and subordinate themes were relabelled and reconfigured. Subordinate themes that were not recurrent in at least half of the transcripts were discarded. The subordinate themes were drawn together and this resulted in a number of superordinate themes for the groups, each with a number of related subordinate themes (see Table 2) in Chapter 5).

4.8 Quality criteria

Qualitative research project, IPA in particular, relies more on the quality of the data collection procedures and analysis to ensure trustworthiness in qualitative research (Anney, 2014). In the current study, the quality criteria were guided by dependability, credibility, confirmability and transferability. This section expounds the processes that were followed to ensure and maintain the rigour and trustworthiness of this study.

4.8.1 Dependability

According to Anney, (2014, p. 271), "dependability refers to the stability of findings over time". Shenton (2003) adds that the process of ensuring dependability includes

reporting all the details followed while conducting the study in order to allow future researchers to repeat the work and possibly yield similar results. In this way, other researchers may be able to realise the extent to which research practices have been applied. Anney (2014) posits that dependability is established through an audit trail, peer examination and stepwise replication.

An audit trail involves an examination of the process and product to validate the data, where a researcher accounts for all the research decisions and activities to show how the data were collected, recorded and analysed. Peer examination involves the researcher's discussion of the research process and findings with neutral colleagues, such as supervisors, who have experience of qualitative research. Lastly, stepwise replication involves a data evaluation procedure where two or more researchers analyse the same data separately and compare the results (Anney, 2014; Shenton, 2003).

In the current study, dependability was ensured through the involvement of the Registered Counselor who assisted the researcher (a Clinical Psychologist) in conducting some of the interviews. Most importantly, data were collected over three different periods with a gap of more than three months. The third time was as a result of some discrepancies in the data collected. The discrepancies that were identified were corrected by discarding the data under question and going back to collect data to replace the discarded ones. The process of data collection relied on the guidance of the supervisor and co supervisor who are knowledgeable about qualitative research, which helped the researcher who had limited expertise on this type of research.

4.8.2 Transferability

Transferability refers to the degree to which the results of qualitative research can be transferred to other contexts with other respondents; it is the interpretive equivalent of generalisability in quantitative research (Anney, 2014; Tobin & Begley, 2004). Research findings of a qualitative study are always from a small population and sample; it is highly unlikely that findings and conclusions can be applicable to other situations or environments (Shenton, 2003).

Since the study was conducted in a small segment of Waterberg District in Limpopo Province, South Africa, the results may not be generalised outside this group. This segment included the parents of the adolescents who abuse *nyaope* from the rural areas and some from a township, which usually accommodates middle-class citizens. Caution should be applied when intending to transfer the findings of this study to other settings. This is because the phenomenon (*nyaope*) under investigation is relatively unique to the South African population; therefore, it would be highly unlikely to be applicable or difficult to generalise the results of this study to other countries.

3.8.3 Confirmability

Confirmability refers to the degree to which the results of an inquiry could be confirmed or corroborated by other researchers (Anney, 2014). Confirmability is "concerned with establishing that data and interpretations of the findings are not figments of the inquirer's imagination, but are clearly derived from the data" (Tobin & Begley, 2004, p. 392). Shenton (2003) highlights that rigorous steps must be taken to ensure that the findings of the study are the result of the experiences and ideas of the participants, rather than the characteristics and preferences of the researcher.

In the current study, confirmability was established through field journaling and triangulation, which included the use of different methods and personnel with in-depth knowledge of data collection and analysis. The researcher also ensured confirmability of the results by producing an audit trail, interview guide, as well as recording and fully transcribing interviews and detailing the coding procedure.

4.8.4 Credibility

Credibility is defined as the confidence that can be placed in the truth of the research findings (Anney, 2014). Tracy (2010) refers to credibility as the "trustworthiness, verisimilitude, and plausibility" of the research findings (p. 842). Credibility establishes whether or not the research findings represent credible information drawn from the participants' original data and is a correct interpretation of the participants' original views (Tobin & Begley, 2004). In ensuring credibility in qualitative research, there are strategies that need to be taken into consideration. The following strategies highlighted

by Anney (2014) and Shenton (2003) ensured the credibility of the current study: background and qualification of the researcher; iterative questioning; frequent briefing sessions; reflexivity, tactics to ensure honesty from participants; peer examination, and structural coherence.

The current study was conducted by an expert (registered Clinical Psychologist) in the field of study and was supervised by Clinical Psychologists (supervisor and co supervisor) who are also experts in the field of study and in qualitative research. During the study, briefing sessions (supervision) to guide the process of data collection and analysis were held. These sessions also assisted with the improvement of iterative questioning. The researcher ensured that the data were collected over a period of 18 months with a gap of 6 months and more on varied times with the use of a field journal. As a Clinical Psychologist with experience in clinical practice, clinical interviews skills aided in the generation of tactics to ensure honesty from the participants through iterative questioning during data collection. This process was essential for the credibility of this study.

4.9 Ethical considerations

A code of ethics is formulated to guide and regulate the relations of researchers to the participants and the field they intend to study (Flick, 2019). Social science research has become an issue of ethics due to the violation of human rights and manipulation of results. In research, ethical considerations assist in adherence to research principles and most importantly, in respecting and protecting human rights. Ethical considerations in research ensure that researchers act in a way that is not harmful to society or an individual (Davies, 2020).

The Turfloop Research Ethics Committee (TREC) at the University of Limpopo is responsible for ensuring that all research projects conducted by its students adheres to ethical guidelines and international best practice. The current study has adhered to all the relevant ethical guidelines that are discussed below, namely, permission to conduct the study; voluntary participation and informed consent; confidentiality, privacy and anonymity; benefits and risks/harms; respect and dignity; and lastly, consideration of the vulnerable population.

4.9.1 Permission to conduct the study

To ensure sound ethical standards, the research proposal passed through all the stages of review and ethical clearance before the study was conducted. Before undertaking the study, the researcher sought ethical clearance from the University's ethics committee (See Annexure 2) with project number TREC/01/2019:PG. Gatekeepers' permission was sought from parents through consent forms for conducting interviews.

4.9.2 Voluntary participation and Informed consent

Informed consent is a critical component of the ethics of all types of research and in traditional research approaches. It is usually built into research design; for example, in the form of consent forms or boxes to be ticked and signed on the questionnaires (Flick, 2014). Roberts (2015) believes that informed consent should involve three basic criteria, which are, consent should be given by a competent person, the particular person should be adequately informed and such a person should consent voluntarily. To ensure voluntary participation and consent, the researcher explained the aim and objectives of the research. Furthermore, the risks/ham and benefits of the research were also explained to the participants before commencing with the study. The participants were requested to affirm their informed consent in a written form (See Annexure 3a). The researcher used audio recorders to record the interviews with the permission of the participants.

4.9.3 Confidentiality, privacy and anonymity

The issue of confidentiality and anonymity is a key consideration in research ethics, particularly in qualitative research practices (Flick, 2014). Generally, this involves anonymising data so that the research participants cannot be identified. It further involves the encryption of specific details (names, addresses, etc.) with the aim of protecting the identities of the participants (Roberts, 2015). Research participants who agreed to participate in this study were assured of the confidentiality of the information that they provided. The consent form provided for informed consent (See Annexure

3a) did not have space for identifying particulars. However, there were those who mentioned their identifying information and that of their children during the interviews. The researcher ensured that during transcription, those names were replaced with pseudonyms. This assisted with the principle of privacy and anonymity, which was maintained throughout the study. Where limits of confidentiality and privacy were envisaged, they were discussed with the participants during the request of their consent to participate. The data collected were safely stored and remain accessible only to the researcher and the supervisors.

4.9.4 Benefits and risks/harm

According to Strang (2015), when conducting social science research, it is important to consider the principle of benefits and avoidance of risks/harm. Benefits may simply refer to a valued or desired outcome and an advantage that is received after participating in a study (Flick, 2014). These benefits can be direct, indirect or beneficial to others. Direct benefits include a situation where the participant receives direct psychological, social, economical or medical benefits or direct assistance in any other form. Indirect benefits include benefits directed to an organisation and a family that one is associated with. These benefits may also include policy changes that might benefit the community at large.

Social research can, to some extent, become exploitative and intrusive, which is why the researcher must ensure that the participants are safe, and that anticipated harm is reduced or mitigated (Flick, 2014). Most investigations are likely to cause psychological harm or injury to participants. Psychological harm includes undesirable changes in thought processes and emotions. Roberts (2015) postulates that collecting data may confront the researcher with challenges, more especially when investigating lived experiences and coping strategies. It is believed that such a research might revive the pain and/or negative emotional reaction that was experienced. The researcher should ask themselves whether it is worthy to conduct research or ensure that aftercare programmes are in place beforehand (Flick, 2014; Roberts, 2015). Social science research should have an element of benefits to those who are participating.

The current study investigated the lived experiences of parents with adolescents who abuse *nyaope*. Given the pain associated with the experiences of witnessing one's own child destroying their own future through drugs, the researcher must tread carefully when engaging the parents about the subject (Flick, 2014). Most parents reported that they are still experiencing psychological and physical difficulties. They were referred to medical practitioners and psychologists at the nearest hospital and processes of appointments were simplified. Regarding benefits, participants were informed about the aim and objectives of the study, which included, amongst others, documenting their coping strategies, treatment and help-seeking pathways. The results of this study might influence policy-making on managing *nyaope* abuse in disadvantaged communities.

4.9.5 Respect and dignity

According to Bell and Bryman (2007), research process should meet the requirement of respect and dignity which involves the need to "ensure physical and psychological wellbeing of either research participants, the researcher or others" (p. 61). Flick (2019) postulates that the dignity and respect of the participants are linked to the consent given by the participant, to sufficient and adequate information provided as a basis for giving that consent, and that the consent is given voluntarily. There is a need to guarantee the participants' confidentiality, which means that the information about them is only used in a way that makes it impossible for other persons to identify the participants or for any institution to use it against the interest of the participant (Bell & Bryman, 2007). Dignity and respect are some of the central aspects to be considered when conducting human research. In this study, all relevant information (consent form: see Annexure 3a and 3b) was provided to the participants and the questions were prepared and raised in a humane manner as well as in the language of the participants' choice (See Interview guide: see Annexure 4a and 4b). The participants were informed that they were allowed to voluntarily participate and withdraw at any time. This study also placed the issue of culture and beliefs of the participants at the centre of the study, as stated in the theoretical framework and methodology sections.

4.9.6 Vulnerable persons

A vulnerable person is any individual that is at the risk of harm or abuse due to physical or mental health problems and socioeconomic problems. Persons who are included in the vulnerable population include children, elderly, mentally ill persons and persons with disability (Bracken-Roche et al., 2017; Hurst, 2013). The current study included parents raising adolescents who abuse *nyaope* only and no member of a vulnerable population (i.e. children, mentally ill, etc.) participated in this study.

4.10 Reflexivity

IPA is grounded within hermeneutics and phenomenology (Dowling, 2007). It aims to understand individuals' experiences and how individuals make sense of their experiences (Dowling & Conney, 2012)). The participants "make sense of their world" and the researcher seeks to make sense of the participants' view of the world (Smith & Osborn, 2008, p. 53). IPA entails reflexivity, which involves examining one's own judgments, practices, and belief systems during the data collection and analysis process. The goal of being reflexive is to identify any personal beliefs that may have incidentally affected the research. During reflexivity, one must be prepared to question their own assumptions (Dowling, 2007; Haynes, 2012).

The current study began with the development of a research proposal, which made the researcher realise that he is inexperienced in qualitative research. The researcher also realised that he was so eager to complete the study to become a PhD holder to an extent that he was susceptible to "cutting corners" rather than investing time on accumulating deep knowledge regarding qualitative research and its theoretical underpinnings. However, the researcher ultimately focused on mastering research much more than merely being certificated. Through supervision and doctoral workshops, the researcher realised that it is difficult to manipulate processes in qualitative research. Thus, one must patiently and meticulously go through each phase of the research process.

The researcher approached this project with enthusiasm and had a great interest in the lived experiences of the parents raising adolescents who abuse *nyaope.* During

data collection, it was difficult to locate parents with children between the ages of 12 and 19 years. Due to the pressure of time, the researcher decided to include even the children above 20 years who were not part of the research objectives. Through supervision, this impatience was noticed and the data had to be discarded. To some extent, the researcher utterly was discouraged because the data that was discarded held some of the strong opinions he had prior to the inception of the research process.

The interview schedule was developed, refined and updated through consultation with the supervisors. The schedule therefore underwent considerable re-drafting and editing by language experts throughout these processes. These processes were significant because the researcher then realised that the initial drafts were influenced by his preconceived views regarding the subject matter. In fact, he was imposing his experiences with the clients who consulted for generic substance abuse and not *nyaope* in particular. However, the final draft was neutral and focused on the objectives of the study.

The researcher found that repeated listening of the audio-recordings, repeated reading of the transcripts and leaving time between analysing different transcripts contributed to the delay, although they facilitated an in-depth understanding. The researcher tried to approach each new transcript as if it was the first. In the process, the researcher was able to note the links in the data and the salient themes. The researcher found the process both enjoyable and interesting, but extremely time-consuming. It was difficult to develop statements that were concise and that represented a lucid understanding of the phenomenon under investigation.

4.11 Concluding remarks

This chapter highlighted the relevance of selecting a qualitative approach, especially when it is guided by interpretivism and the hermeneutic phenomenological design. This approach and design aided the researcher to explore the lived experiences of the parents raising adolescents who abuse *nyaope* in Mokopane. This design was relevant for the current study because it allowed a purposive and snowball selection of the participants. Furthermore, the design permitted the use of in-depth interviews, which further allowed the participants to express their lived experiences. The process

followed the IPA analysis of data and the attainment of the trustworthiness of the findings. The ethical considerations and reflexivity in relation to the study were discussed in detail. The next chapter presents the results.

CHAPTER 5: RESULTS

5.1 Introduction

This chapter presents the phenomenological and interpretative narrative of the research results. It begins with the full demographic details of the participants. It further presents an in-depth analysis of five superordinate themes with the related subordinate themes. The analysis section is preceded by a reflection on the analysis process. The chapter concludes by highlighting salient aspects of the results.

5.2 Demographics of the participants

The demographic information of the participants is presented on Table 2 below. The study had 11 participants (coded Pt A to Pt K) who are parents of adolescents (only boys between the age of 16 and 19) who abuse *nyaope*. The sample of this study is summarised in Table 2 and entails the gender distribution of the participating parents (females = 73%; males = 27%). The participants' age categories were 35 years – 45 years (18%), 46 – 55 years (54%) as well as 56 years and older (27%). Regarding marital status, 46% of the participants reported to be single, 27% reported to be divorced and/or separated, 18% of the participants were widowed whereas 09 % were married.

The majority of the participants were Born-Again Christians (BAC) at 63.63% (07), followed by those subscribing to churches that are called Traditional Christians (TC), who contributed 27.27% (03). Lastly, 9.09% (01) did not belong to any religious grouping. For the purpose of this study, BAC refers to participants who are affiliated to Pentecostal Christian churches, popularly referred to as charismatic churches. TC refers to those participants who are affiliated at Apostolic Zion Churches and Zion Christian Church (ZCC). Furthermore, the distribution by place of residence shows that most participants were from the rural areas (70%), followed by those from semi-rural (townships) (30%). The majority of the participants (73%) indicated that they were unemployed whilst 27% were employed. Of the employed participants, 67% were formally employed whereas 33% were informally employed.

Table 1: Demographic information

A	F	48	19	+05 years	Single	Unemployed	TC	Rural
B	M	48	18	+05 years	Separated	Unemployed	BAC	Rural
C	F	52	19	+03 years	Widow	Unemployed	BAC	Rural
D	F	38	17	+05 years	Separated	Social Worker	BAC	Township
E	M	44	18	+03 years	Divorced	General Worker	BAC	Township
F	M	47	19	+04 years	Married	Unemployed	TC	Rural
G	F	48	18	+05 years	Single	Odd jobs	BAC	Rural
H	F	58	19	+05 years	Single	Unemployed	BAC	Rural
I	F	56	17	+04 Years	Widow	Unemployed	N/A	Township
J	F	56	18	+05 years	Single	Unemployed	TC	Rural
K	F	52	16	+04 years	Single	Unemployed	BAC	Township

5.3 Presentation of findings

This section presents the summary of all the themes that emerged from the interviews with the participants. Five superordinate themes and their related subordinate themes are presented on Table 3 below. Tables have been included to provide a visual descriptive representation of the prevalence of subordinate themes across the data. During the discussion of the subordinate themes, extracts and/or quotations from the

results transcripts were used to substantiate each theme. Noteworthy, pseudonyms were used against the transcribed data to ensure the participants' anonymity.

Table 2: Superordinate Themes and related Subordinate Themes

Themes No	Superordinate theme	Subordinate theme
1	Parents' view on contributory factors to *nyaope* abuse	Peer pressure Social problems Spiritual causal factors Availability and easy access
2	Impact of *nyaope* abuse on parents	Psychological health impact Physical health impact Financial burden Stigmatisation
3	Coping strategies	Spirituality Emotional ventilation Social support Engaged and withdrawn coping strategy
4	Treatment sought	Reliance on social services Reliance on rehabilitation services Reliance on medical services Reliance on spiritual services
5	Help-seeking pathways	Social services Rehabilitation services Medical services Spiritual services

5.3.1 Parents' view on contributory factors to nyaope abuse

The first superordinate theme was the parents' view on what contributed to their children's *nyaope* abuse problem. The participants stated that the factors that contribute to their children's *nyaope* abuse range from peer pressure; exposure to drugs and need to experiment; social problems; as well as spiritual causal factors. Table 4 below represents the parents' responses regarding each subordinate theme.

Table 3: Subordinate Themes emerging from Superordinate Theme 1

Subordinate themes	A	B	C	D	E	F	G	H	I	J	K
Peer pressure		✓	✓	✓	✓	✓	✓	✓	✓		✓
Social problems	✓	✓	✓	✓	✓	✓	✓		✓	✓	
Spiritual causal factor		✓	✓		✓	✓			✓		✓
Availability and easy access	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓

5.3.1.1 Peer pressure

Nine participants said that peer pressure contributed to their children's *nyaope* abuse. These participants believed that their children were influenced by their friends to engage in *nyaope* abuse. Participants stated that their children were once well-behaved and did not engage in deviant behaviours until they associated with friends who are perceived as mischievous. Participants seem to have a close observation of their childrens' overt behaviour, case in point being Pt C who said her child *"didn't smoke nyaope before but after making friends, he started smoking nyaope".* This was supported by Pt K who added that her child used to enjoy going to church but suddenly changed and joined the children who abuse *nyaope*. The extracts below affirm that peer pressure contributes to *nyaope* abuse:

> *He likes friends. He was a church boy; he used to be part of the church choir. He just changed all of a sudden, and everything became a mess* ***(Pt K).***

> *I know him as a good child but then after I saw him with his friends, judging from how they looked, I knew that they may be engaging in such things (****Pt B).***

According to these participants, their children had a good moral compass until they started associating with friends who are known in the community as *nyaope* abusers. Pt I indicated that she was aware that her child's friend introduced most of the young people in the community to *nyaope*, and this friend managed to get help and leave

others in the deep end. In her own words, Participant I said: "*It is friends. The friend who introduced all of them to this thing went to rehab and came back".*

Furthermore, the participants believed that participating in youth groups' extra mural activities can contribute to *nyaope* abuse. Pt H said that he *"started by dancing for a kwaito group, only to find out that they were actually smoking that 'thing' there".* Apparently, these groups had some level of pressure or influence on their children because they wanted to be identified with the group and gain a sense of belonging. This influence can be associated with the external locus of control where these adolescents are easily influenced by external pressures such as friends' perspective on drugs.

5.3.1.2 Social problems

Nine participants reported that social problems contributed to their children's *nyaope* abuse. These participants believed that family separation, divorce, parental substance abuse, family dysfunction and poverty contributed to their children's *nyaope* abuse. Pt K believes that her child started abusing *nyaope* after she (Pt K) separated with his father and subsequently the father stopped supporting them. Her response was:

> *I don't really know because their father had since left home for the city. He used to come home and would bring us money. The other boy went to the city and it happened to be where Sipho's father was. When he came back, he told Sipho that his father is giving them 'meat' and Sipho got angry but kept this to himself. Eventually, he opened up and told us that he heard someone saying that his father is giving people 'meat'. At that time, his father had stopped visiting and giving us money. My child then started using nyaope* ***(Pt K)****.*

The participants also believed that problems arising from home, which amongst others included parental substance abuse, contributed to their children's *nyaope* abuse. Seemingly, some children become emotionally affected by their parents' substance abuse and seek solace from *nyaope*. Pt F substantiated this notion by explaining that her husband would abuse alcohol in front of the children and would prioritise buying alcohol over supporting the academic activities of their child. This is said to have driven

Pt F's child to *nyaope* abuse, as the child felt neglected by his father. According to Pt F,

> *He was bothered by his father's behaviour. His father is a drunkard. My son loves working and is eager to learn short courses but there was no money because the father spent all the money buying alcohol. This troubled him because I remember he once told me that if he was working, he would also look for a post for his father far away from them because he is not helping in anything. Even his friends said that it was caused by his dad, he doesn't do anything for him and he feels neglected* ***(Pt F).***

Other social problems include a dysfunctional family structure, where there is parental separation, single parenting and/or step parenting. According to Pt B, he realised that his child had problems after separation and would meet up with the mother to find solutions to the child's problem. On the other hand, Pt A believed that step parenting contributed to her child's *nyaope* abuse because her child felt unloved and uncared for, which led to *nyaope* abuse. Pt A further said, "*I understand that he doesn't look after other children because they are not his"****.***

Unemployment and poverty were also mentioned as the contributory factors to *nyaope* abuse. Clearly, the low socioeconomic status of the parents and their children contributes to loneliness and boredom, which leads to *nyaope* abuse. Pt K affirmed it thus, "*our children are smoking nyaope; they are all smoking because they are unemployed"****.*** Pt E concurred that a sedentary lifestyle contributes *to nyaope* abuse: *"I would say maybe it is loneliness, not having anything to do"*. Some of the extracts below support this:

> *I think it's poverty; it's not witchcraft* ***(Pt J).***

> *When I asked him, he said he was stressed because he was working at Sunbake and they told them to stop coming to work. He is not working and his sister who used to take care of everyone in the house passed away and left kids* ***(Pt J).***

So, he went to rehab and came back fine. He spent two months clean but I started noticing signs that he is no longer fine, he started acting dodgy and I realised that things are no longer the same. When he came back, he avoided a lot of friends, but the only stressing thing is that he is not finding a job, and he is giving up ***(Pt D).***

Participants associated their poor socio-economic status most specifically lack of employment opportunities for their children as a contributing factor to *nyaope* abuse. This situation is believed to cause significant levels of stress on the part of adolescents which leads to *nyaope* abuse as self-medication. Socio economic status further contributes as a contributory factor for relapse amongst young people.

5.3.1.3 Spiritual causal explanations

Six participants indicated that spiritual issues might have contributed to their children's *nyaope* abuse. Participants mentioned that their children seem to have been bewitched. This came as a suspicion following how *nyaope* abuse destroys its users psychologically, socially, physically and future prospects. Pt E could not understand why her child continues to abuse *nyaope* even when there is clear evidence of its effects by saying "*sometimes you may even think he was bewitched. You can ask yourself why can't he can't see how bad this thing is, and why can't he stop taking it*"**.** That *nyaope* abuse is a spiritual attack and therefore requires spiritual intervention is affirmed by Pt F who said:

I ended up going to prophets and they told us that he is under spiritual attacks. It's like they saw that his future is going to be bright so they blocked him with their spells. Those are the things we are told by prophets. We went to 2 different prophets and they both told us the same thing. The pastor from Warmbath talked about him disappearing and going to the river and the river will take him and never come back. We then went to another pastor to get a second opinion. He told us that they want to cut his future short and to block him from prospering. They say he is being used and that is how they disguise their plan by using friends to offer him nyaope. In this way, we will not be suspicious so that they will blame it on the things he smokes ***(Pt F).***

This thing seems like it has a demon ***(Pt F).***

Participants attributed *nyaope* abuse to spiritual causal factors. It is believed that there is evil spirits that disguised themselves as peer pressure and other means. Participants hold this strong view because of how adolescents continue to abuse *nyaope* despite catastrophic effects of *nyaope* and its ability to destroy the future prospects of young persons.

5.3.1.4 Availability, easy access and need to experiment

Eight participants reported that availability and easy access to *nyaope* contributed to their children's *nyaope* abuse. Participants believe that their children started abusing *nyaope* due to its easy access and availability. Pt I said her child started using *nyaope* when "*he asked if he can test and then he was hooked".* This experiment succeeded mainly because *nyaope* was available for the child to test. Pt C also said that her child was experimenting with *nyaope* because it was available: "*the first time I asked him as to what made him end up smoking this thing, his response was that he was just trying it out"***.** The participants' children felt the need to experiment with *nyaope* due to their constant exposure to it. However, the participants revealed that their children started by smoking cigarettes, glue, dagga (cannabis) and later felt the need to experiment with *nyaope* after observing their friends, as the extracts below affirm:

> *When he started, he was only smoking cigarettes. He then met friends, who introduced him to weed and ended up smoking nyaope. He was curious to know how nyaope is like. Then, it was how he started smoking, according to how he explained to me* ***(Pt F).***

> *He started by asking for R10, the glue for shoes was R10 at that time; so, he would always say mama please give me R10 and then all of a sudden, he started using nyaope* ***(Pt H).***

Regarding the exposure to drugs, the participants believed that the availability and easy access to drugs resulted in their children addicted to *nyaope*. These participants

believed that certain locations exposed and/or predisposed their children to *nyaope* abuse due to its predominant availability and easy access in those locations. PT said that the child "*did not even know this nyaope thing. Things went wrong when we got here. I even regret the decision to relocate. It is unfortunate that I couldn't pay rent, and when you don't pay they evict you* ***(Pt G)***.

5.3.2 Impact of nyaope abuse on parents

The second superordinate theme was the impact of *nyaope* abuse on the parents. The theme is divided into four subordinate themes, namely, psychological impacts, physical health impacts, financial burden and stigmatisation. Table 5 below represents the participants' responses on subordinate themes.

Table 4: Subordinate themes emerging from Superordinate Theme 2

Subordinate themes	A	B	C	D	E	F	G	H	I	J	K
Psychological health impact	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Physical health impact	✓	✓	✓			✓	✓		✓	✓	✓
Financial burden	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Stigmatisation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	

5.3.2.1 Psychological health impact

All the participants reported that they were under severe psychological difficulty due to their children's *nyaope* abuse. They further reported that they experienced an excruciating emotional pain, with most responses being "it hurt me a lot", "it worries me a lot" and "it is very painful", referring to how they felt about their children who abuse *nyaope*. Participants presented with cognitive symptoms that included denial, embarrassment, hopelessness, helplessness, disappointment, self-blame, guilt, poor self-image, and poor self-esteem. They experienced so many psychological difficulties that their view of the world around them changed significantly.

Pt F indicated that she was in denial after realising that her child was abusing *nyaope*. However, this denial was followed by disappointment and embarrassment as her son was known to be a well-behaved child. Beginning her narration with a sigh, Pt F said:

"*Eish! I was so disappointed because my son was known to be a good boy who looked after himself and was also dedicated to his studies. I was actually in denial at first, hurting and crying, always embarrassed".* Pt B also felt embarrassed as his respected status in the community was at the risk of being diminished due to his child's *nyaope* abuse. He said: "*I feel embarrassed when I walk around the community; I'm always deep in thoughts".* Thus, *nyaope* abuse negatively affected the parents' emotional health and their reputations in the community.

The participants revealed that they blamed themselves and that their view of themselves completely changed. Pt C and Pt E indicated that they were always feeling ashamed because the whole community was aware of their situation and thus concluded that they did not have control over their children. Pt C said: "*to be honest my brother, it is a disgrace in the community to have a child who smokes nyaope. It is difficult because people will think we don't have discipline and we can't manage our child".* In addition to this, Pt E highlighted that she was in pain and sometimes blamed herself for her child's behaviour. The excerpts below affirm the foregoing submission:

> *It really disturbed me a lot. Wherever I go, people tell me that my son is smoking this 'thing', he is not bathing and he has changed. I blame myself sometimes* ***(Pt E).***
>
> *I am not comfortable around people as well because I know that they talk behind my back, specifically about such issues. It feels as if it is written on my back that my child smokes nyaope* ***(Pt D).***
>
> *What this child started worries me a lot. I'm extremely affected to a point that when people laugh or they stare at my house while passing, I always think that they are probably thinking that's the home for that nyaope smoking boy. It is so bad that I can't even face people* ***(Pt I).***

The participants presented with feelings of hopelessness and helplessness mainly because *nyaope* abuse has a low recovery rate, high relapse rate, treatment is not available in rural areas and exorbitant costs associated with the management of their

children's condition. Pt C said "*I don't know what to do anymore"*, exhibiting a sense of helplessness and hopelessness. Similarly, Pt J, Pt C and Pt D said:

> *What is going to happen in my home when the only son I had is on nyaope. I never thought Kgahliso can smoke nyaope* ***(Pt J)****.*
>
> *It has become hard even at home and we even think that we can swallow him and give birth to him again* ***(Pt C)****.*
>
> *It is very painful. It hurts me when I think about his future because I know the kind of a person he is. It is difficult for me because he has defaulted. I am not comfortable around people as well because I know that they talk behind my back, specifically about such issues. It feels as if it is written on my back that my child smokes nyaope* ***(Pt D)****.*

The participants also reported that they experienced emotional pain, worry, irritability, fear, anger and frustration upon learning that their children were abusing *nyaope*. All the participants reported that they were deeply hurt by the condition of their children and how *nyaope* abuse threatened their children's future prospects.

Participants experience severe emotional pain as a result of having a child who abuses *nyaope.* Pt C conceptualised her situation as emotionally abusive because she had just lost her husband and felt like she had also lost her child. Pt C further said: *"This is pure emotional abuse and there is nothing we can do to be better. His father just passed on not so long and this is the time we should not be experiencing such emotions. We should be comfortable knowing that we have a man in the house but it's as if both of them have passed on"*. This feeling was followed by anger and irritability: *"I would just get angry and not talk to anyone about such things"* ***(Pt C)****.*

The participants reported that having a child who abuse *nyaope* leads to the development of frustration and fear. To this effect, Pt B and Pt C respectively indicated that, "*You end up accepting solutions from anyone"* and *"When I began to notice that he is abusing nyaope, I became frustrated. He started acting strange"*. These responses reflect the level of frustration experienced by the participants. The

participants were even afraid that their children might be killed through mob justice since *nyaope* boys are associated with crime and wrongdoings. In fact, some of the boys who abuse *nyaope* die because of the excessive use of *nyaope*. Hence, the participants reported:

> *I even asked him to open his eyes for him to see how this nyaope is destroying the nation, people die because of it. The time I was still working in town to clean the toilets, we would find many people lying dead there* ***(Pt A)****.*

> *The danger is that I'm afraid that it kills. Death may come unexpectedly as it pushes you to always smoke it. If you don't have it then it becomes a problem because as they say you end up having cramps* ***(Pt C)****.*

> *When he is not home, my heart!!!… If I hear noises, I scream his name. I scream because I want to know if he is around or not. Eish! This child! I have stress because of Kgahliso* ***(Pt J)****.*

The participants reported difficulty in sleeping due to preoccupation with thoughts regarding the safety of their children. Pt I said, "*I can't sleep when he is not at home"* whereas Pt G stated that, *"I experience sleepless nights. I hardly ever sleep at night".* These participants find it difficult to sleep because they think of worst scenarios such as their children being attacked by community members or killed, as expressed by Pt I who said: "*I would wonder where he is, and every time I hear noise outside I would think the worst"*. In addition to experiencing difficulty with sleeping, Pt G indicated that she found it *"even difficult to eat".*

The participants also mentioned that they were socially withdrawn and felt no need to visit friends and some family members. This withdrawal is directly linked with avoiding situations that reminds them of their ordeal. The participants believed that avoiding people and situations that constantly remind them of their painful situation was their coping strategy. Pt F said: "*It hurt me a lot. I was actually in denial at first, hurting and crying, always embarrassed. He even caused me to stop visiting my friends".*

5.3.2.2 Physical health impact

Eight participants revealed that the situation triggered some medical conditions and also complicated some of their pre-existing medical conditions. Pt J mentioned that she was on medical treatment of High Blood Pressure, which she believed was triggered by her constant preoccupation with thoughts about the condition of her child. The medical personnel also asked Pt J if she had any psychological stress and, in her elaboration, she said, "*I am now on treatment for High Blood Pressure. They sat me down at the clinic asking me what is bothering me, I explained my child's situation to them. I told them that my son smokes nyaope and my life is not well".* Pt C also said, "*I have High Blood Pressure and maybe it's because I think a lot".* Some participants reported experiencing significant weight loss due to their children's *nyaope* abuse:

> *They called him and told him that his habit is making me lose weight and he said he will stop. That is what he always says* ***(Pt J).***

> *I lost a lot of weight. I have High Blood Pressure, so these days the level goes up very high, but I am better now. My clothes didn't fit me anymore. It is only now that I am starting to regain weight; my clothes were not fitting me at all* ***(Pt A).***

Participants further reported that they experience different kinds of pain, including headaches due to overthinking about their children's condition. Pt H reported that a headache and general body pain compelled her to consult a medical officer for stress medication. Pt I said: "*I feel as if I'm still carrying him, as if I'm about to give birth. I feel a lot of pain. Now it's the end of the month, there are pills I drink that I must get. I had a terrible pain around my neck. It was so painful when I tried to lift my head. There was something moving on top of my head every day. It was as if there's water in my head and it was heavy. I drink pills that I bought at the pharmacy, the packaging shows a person holding their head. The pills made me a bit better the past two months that I have been taking them*".

5.3.2.3 Financial burden

Eleven participants reported that they had incurred financial loss and burden due to the condition of their children. They mentioned that their children stole money at home and around the community. In such cases, the parents were expected to recover or financially replace the losses caused by their children. Most participants reported that their children stole everything at home and in the community:

> *He sells anything he finds; it is difficult to notice at that moment but one realises after a while that something is missing. One day you will look for a certain t-shirt and not find it, and on another day when you look for a baby trouser, you realise that it is not there* ***(Pt A).***

> *When soap disappears, we know it's him without even asking him. We just know that it's him because there is no other person who can come from somewhere and take a soap bar or meat from the fridge. He steals chicken feet and intestines, so that he gets money to buy nyaope because we don't give him money like we used to before. He steals tablechum canisters, tupperware as well and he no longer has good clothes anymore* ***(Pt C).***

> *He was asking for money, stealing and lots of things were disappearing* ***(Pt E).***

> *What I see is that he is messing up. When he finds something in the house he steals it; when I send him to the shops he goes and never comes back with the money given to him, the same money that will assist in the up-keep of the house. I don't send him anymore, if I do send him, I send him accompanied by someone* ***(Pt A)****.*

Participants also mentioned that they were responsible for funding their children's medical costs, including transport to treatment centres, medication that is often sold at private pharmacies and costs for rehabilitation centres. Most rehabilitation centres are situated far from their locations. Furthermore, parents had to maintain the lives of other children and at the same time care for the affected child:

So, I am waiting for money, we'll go to the doctor and get the prescription, and then go and buy the medication because it is reportedly expensive. We won't eat this month; we'll starve and see if he'll really stop. All I want is to preserve his life. I want him to live because he is taking his own life with this thing ***(Pt G).***

We did not go anywhere, we just spoke about it because we are struggling, and we do not have money. We did speak about going to the doctor and about a medicine called Methadone. He said if we can get R300, we can go to the doctor and then the doctor will refer us to a place where they sell the medication for R300. I asked him where I was going to get that money. Because he can see that I can't even afford my household…. I told him that I am not working; my husband and I depend on pension money ***(Pt I).***

I made a plan to get some money in order to take him to a place where they can drain it out of his system, then I realized after a while that he got help ***(Pt B).***

Most participants were from rural and semi-rural areas, with most of them being unemployed, which further adds to their psychological burdens. They revealed that they incurred significant financial loss because of their children's *nyaope* abuse. The children steal from their parents and community at large to feed their addiction and the parents ultimately have to replace the stolen items. Moreover, the cost of rehabilitation of nyaope abuse is exorbitantly expensive, which is a challenge for the parents from a low socioeconomic background.

5.3.2.4 Stigmatisation

Nine participants highlighted that there is a stigma in the community when one has a child who abuses *nyaope*. There is a strong negative perception towards parents with adolescents who abuse *nyaope*. These parents are viewed as failures and generally blamed for their childrens' behaviour. They mentioned that they were given derogatory names and were not respected in the community. Parents with children who abuse *nyaope* are given names, belittled and not dignified because they are perceived as

responsible for their children's *nyaope* abuse, which has a negative impact in the community as it increases the rate of crime. The participants elaborated thus:

> *Hey! When I visit them (neighbours), they start talking about nyaope. Their talks are indirectly meant to hurt me. Mm-hmm, for example, if something is stolen, they will blame it on nyaope addicts. They give me a bad look and give me labels. When something goes missing, the first suspect is my son. So as for me, I will not confide in them as I am not comfortable around them* ***(Pt F).***

> *To be honest my brother, it is a disgrace in the community to have a child who smokes nyaope. It is difficult because people will think we don't have discipline and we can't manage our child. It has become hard even at home and we even think that we can swallow him and give birth to him again* ***(Pt C).***

> *Katlego made us feel very small a long time ago. No one respects us around here. We have no dignity at all. Even when we are walking on the streets, we are nothing* ***(Pt G).***

> *They don't treat us like human beings anymore. If anything gets lost around here even if it is not my child, you will find them searching around my yard. People disrespect me; I don't have dignity anymore* ***(Pt J).***

> *I feel embarrassed when I walk on the streets; I'm always deep in thoughts; I am a respected person in the community even on the streets. I am that person who helps others but I don't see myself the same anymore, I have lost my dignity because of my child. I am no longer respected in the community because of this boy* ***(Pt B).***

Results reveal the stigma attached to having a child who abuses *nyaope* in a community. The community blames the parents for their children's behaviour. The psychological health impact of having a child who abuses *nyaope* is dire and cumulative. Participants experience psychological difficulties ranging from cognitive, behavioural to emotional symptoms. These symptoms are in keeping with those

experienced by individuals with severe psychopathology such as Major Depressive Disorder.

5.3.4 Parental coping strategies

The third superordinate theme was the coping strategies used by the parents with adolescents who abuse *nyaope*. These results were divided into three subordinate themes, namely, prayer as a strategy, emotional ventilation, and social support. Table 6 represents the participants' responses on subordinate themes.

Table 5: Subordinate themes emerging from Superordinate Theme 3

Subordinate themes	A	B	C	D	E	F	G	H	I	J	K
Prayer as a strategy			✓	✓		✓	✓	✓		✓	✓
Social support	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Engaged and withdrawn	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Emotional ventilation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

5.2.4.1 Prayer as a strategy

Seven participants revealed that they relied on prayer to cope with the emotional difficulties that arise from parenting an adolescent who abuses *nyaope*. Pt J who is affiliated to Traditional Churches, that is, churches that subscribe to the African belief system and the Western belief system, said: "*I pray to God and my ancestors for my child to stop smoking".* Prayer in this regard is presented as a coping mechanism as it generates hope that the supernatural powers will intervene to help the affected child recover. Pt G indicated that she prayed to God to have "mercy on her", which implies that she feels as if her child's condition is a punishment from God. In essence, the participants mentioned that they prayed "day and night for help". This amplifies their level of desperation and also their level of trust in prayer as an effective coping mechanism.

5.3.4.2 Emotional ventilation as a strategy

Eleven participants reported that sharing their emotions with others was an effective strategy to cope with their situation. The participants highlighted that they expressed their frustration and emotional pain to other family members, friends and neighbours. The ventilation of emotions primarily helped them to cope with their situation as they received advice on how to help for their children. Pt F reported that she vents her emotions through journaling:

> *Most of the time, I just write things down. If I write, I feel relieved from pressure* ***(Pt F).***

> *I am very open, I don't hide my feelings. I don't hide that my son smokes nyaope* ***(Pt J).***

> *I am able to approach some older people next to where I stay who have a home and kids. I talk to them about my problems. They say you must never hide your problems* ***(Pt H).***

Participants believed that sharing their experiences with other people whether qualified to assist or not are a form of healing. It is believed that hiding these feelings and thoughts precipitates the feelings of sadness and delays the prospects of seeking help.

5.3.4.3 Social support

Six participants reported that they used available social support to cope with their situation. The participants utilised accessible social ties such as family members, neighbours and professionals:

> *I am able to approach some older people next to where I stay who have a home and kids. I talk to them about my problems. They say you must never hide your problems* ***(Pt H).***

I am very open, I don't hide my feelings. I don't hide that my son smokes nyaope. Even his brothers from Tshamahansi were asking if he is still smoking nyaope and I told them yes ***(Pt J).***

Social support from dependable members of the family, society as well as professionals has been found to assist with coping with the emotional demands of raising adolescents who abuse *nyaope*.

5.3.3.4 Engaged and withdrawn

Participants reported that they initially engaged their kids with hope that they would change. Their engagements included reprimanding, whipping, and seeking help on their behalf. The hope that emanated from the engagement was comforting enabled them to cope with their situation. However, when engagements failed, the parents withdrew as they had lost hope and became helpless. Giving up on their attempts to assist their children seemed an appropriate coping mechanism to them. Pt F used alcohol as a withdrawal strategy and coping mechanism: "*I would find comfort in wine, although I don't like alcohol. I always had a glass of wine because it reduced my stress and the humiliation".*

5.3.4 Treatment sought by families with nyaope abusers

The fourth superodinate theme was the treatment sought and should have been received by the parents of adolescents who abused *nyaope.* Four subordinate themes emerged, namely; reliance on social services; reliance on rehabilitation services; reliance on medical and mental health services; and reliance on spirituality. Table 7 represents the participants' responses on the subordinate themes.

Table 6: Subordinate themes emerging from superordinate Theme 4

Subordinate themes	A	B	C	D	E	F	G	H	I	J	K
Reliance on social services		✓	✓	✓	✓	✓		✓		✓	✓
Reliance on rehabilitation services		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Reliance on medical services	✓		✓	✓	✓	✓	✓		✓	✓	✓
Reliance on spiritual services			✓	✓	✓	✓	✓	✓		✓	

5.3.4.1 Reliance on social welfare services

Seven participants indicated that they were advised by community members and relatives who once sought help with rehabilitation services from Social Workers with their children who abused *nyaope.* According to the participants, these consultations were mainly for acquiring help with access to rehabilitation programmes to assist their children. These consultations aimed at screening for the adolescents' willingness to undergo rehabilitation programmes and hopefully place them on a waiting list. Social Work services were in a high demand for their intervention against substance-related problems, particularly, *nyaope* abuse. The participants said:

> *I saw these other kids from the opposite street. They have been to rehab. I asked them and they told me that they started at the Social Workers, I then decided to go. My son also agreed, we thought maybe we might get help and they sent him to rehab* ***(Pt I).***

> *At that time, we started going to Social Workers but he had not accepted going to a rehab. He eventually took himself to the Social Worker where he completed the forms then he called me and told me that I was needed at the Social Workers. I went to the Social Worker where we completed the forms together, wherein he was asked to confirm that he indeed intends to quit taking drugs. He also had to explain what prompted him to consider quitting* ***(Pt D).***

> *We consulted the Social Worker, and in fact he is the one who said that this thing is troubling him* ***(Pt E).***

Nyaope abuse seems to be overburdening the provision of Social Work services. Some of these participants consulted with Social Workers and were placed on the waiting list whereas some were promised to be called back and were still waiting with little hope. Pt H said: *"I have been to Social Workers. They took my details and said they would come to check me but they never did".* The participants complained about the long waiting list for rehabilitation services and poor communication from Social Workers regarding the progress with application to rehabilitation centres.

5.3.4.2 Reliance on rehabilitation programmes

All the participants mentioned that they knew that the solution to their children's *nyaope* abuse relied on rehabilitation programmes. This programme was believed to help retain the optimal functioning of their children. These programmes lasted between five and six weeks. Some of the participants said:

> *I don't know because they call it in English, these things that help the children drain nyaope out of their system; if he does not quit, what must I do to get help?* ***(Pt B).***
>
> *I sent him to rehab for six weeks in Gauteng, Randfontein* ***(Pt E).***
>
> *I spoke to someone who said I can take him to another place where they will be able to take this drug out of his body but it requires money. I made a plan to get some money in order to take him to a place where they can drain it out of his system, and then I realised after a while that he got help. He became a normal person again but it looks like his friends are back in the picture* ***(Pt B).***

It was reported that these services were offered at an exorbitant cost that was unaffordable to most participants as most of the centres are mainly located in Gauteng Province. Following barriers of costs, participants whose children received rehabilitation programmes complained about the high relapse rate. They reported that their children were only fine for a few weeks to a month and thereafter relapsed. Pt D and Pt F mentioned that their children went for rehabilitation and were fine for a few months; however, they relapsed due to the lack of employment opportunities. "*Yes, I*

*did. Gauteng, Randfontein. He came back fresh after six weeks, but as the time went by, he went back to using it again" (*Pt E). Pt K said: "*I went to SANCA in Polokwane and another centre in Mokopane until we reached Pretoria. When he came back from rehabi he relapsed and then I took him to a doctor*". Some of the responses were:

> *It took six months before he agreed on seeking treatment from the rehabilitation centres*. *He went to a rehabilitation centre in Gauteng for six weeks* ***(Pt F).***
>
> *Yes, I did. Gauteng, Randfontein. He came back fresh after six weeks, but as the time went by, he went back to using it again* ***(Pt E).***
>
> *I went to SANCA in Polokwane and another centre in Mokopane until we reached Pretoria. When he came back from rehab, he relapsed and then I took him to a doctor* ***(Pt K).***
>
> *So, he went to a rehab a long time ago and I don't remember who took him there; he came back clean and not smoking anymore and even got a job in Lephalale. Then after he lost the job he came back and went back to the very same friends again* ***(Pt C).***
>
> *So, he went to rehab and came back fine. He spent two months clean but I started seeing signs that he is no longer fine, he started acting dodgy then I saw that things are no longer the same* ***(Pt D).***
>
> *I found an organisation that said that they were willing to help with this nyaope addiction. I looked for help from this organisation and they promised to help him. However, it looks like they are using a list to help them so they are taking time. I believe he is far in the waiting list so my wish is that he gets urgent help, where they can take him in now and help him* ***(Pt C).***
>
> *And I am hopeful that when he comes back he won't relapse again because he once tried to quit and failed when his father was still alive* ***(Pt I).***

Participants lamented the fact that there are no rehabilitation facilities in Limpopo Province. In addition to that challenge, there is a long waiting list that these members from Limpopo Province are subjected to keep up with. Following this challenges, is the high relapse rate.

5.3.4.3 Reliance on medical practitioners

Nine participants revealed that they consulted with medical practitioners to cope with raising the children with *nyaope* abuse. The Medical Officers prescribed stress relief medication for the participants and symptom relief medication called methodone that temporarily relieves pain and other withdrawal symptoms for their children. This is what the participants had to say:

> *The doctor gave him treatment and he was fine. When he had to go for his follow up check-up he refused to go with me and insisted that to go alone* ***(Pt K).***

> *He once told us about medication that costs R340. It is pills and liquid medicine taken orally. From how he explained it to us, it's like when he drinks the medication he is able to stop smoking nyaope. If he doesn't get the medication, then he won't stop* ***(Pt C).***

> *A very long time because he was denying it and claiming that he had quit. He was hiding behind the usage of Methadone medication which relieves stomach pains* ***(Pt F).***

> *My friend spoke about a certain medication called 'methadone.' We went to the doctor, and he prescribed the medicine for us. But the medication didn't last long because when it finishes, he craves for more. This medication is very expensive. It didn't work that much for us* ***(Pt F).***

> *I tried a lot of things, even a doctor who said that he has medication. They examined him, they gave him medication and he tried to quit. Actually, it was*

like he left drugs completely but after some few days he went back to smoking. The medication is very expensive ***(Pt E).***

The medical doctor gave him pills and told me to make sure that there is always food around when he takes the pills. I made sure I made him food and I saw him getting much better. After 3 days or so, I saw him going over the bridge again, I asked him about it and he said that he gets bored sleeping the whole day he is just chilling with his friends ***(Pt J).***

Participants also raised concern over the affordability of the medication and were unable to purchase it. Participants revealed that this medication was expensive as they were mostly unemployed, as the following responses confirm:

He asked me to buy him the medication at the pharmacy and I told him I can't afford it since I'm not working ***(Pt A).***

He said that we must go to hospital and see the doctor when we have money. The doctor will give us a prescription for the medication needed for him to stop using nyaope. So, I'm waiting for the end of the month so that I can get money and then we can go to hospital like he says ***(Pt G).***

Pt I and Pt H reported that they did not purchase medical treatment for their children only, but also for themselves. They started experiencing severe psychological symptoms to a point where they sought medical attention and stress medication was prescribed. The excerpts below support this assertion:-

I feel as if I'm still carrying him, as if I'm about to give birth. I feel a lot of pain. Now it's the end of the month, there are pills I drink that I must get. I had a terrible pain around my neck. It was so painful when I tried to lift my head. There was something moving on top of my head every day. It was as if there's water in my head and it was heavy. I drink pills that I bought at the pharmacy. The packaging shows a person holding their head. The pills made me a bit better the past two months that I have been taking them ***(Pt I).***

I will go consult Eliah for stress medication so that it does not hit me hard one of these days ***(Pt H).***

Most participants revealed that they consulted Medical Officers who prescribed the medication called Methodone with the aim of helping with cessation and management of withdrawal symptoms of *nyaope*. This medication was reportedly expensive for the parents who are from poor socioeconomic backgrounds.

5.3.4.4 Reliance on the spirituality

Five participants indicated that they either sought or were planning to seek spiritual assistance. Pt D reported that she prayed for her child, sent him to pastors for prayers and also performed some Christian rituals, such as applying anointing oil on him. Pt F believed that his child was attacked spiritually: "*We saw this as a spiritual attack"* hence, his reliance on supernatural powers. Pt J said: "*I pray to God and my ancestors for my child to stop smoking"*. Pt E and Pt H were still planning to consult with prophets and pastors who would pray for their children. However, participants raised concerns that their children should be willing to change because the instructions given by the prophets should be applied by their children. Pt E added: "*The problem is that if you get help from church as a parent, it would be useless if he doesn't go to church. Reason being instructions at church must be applied by him, not a parent"*. All the participants referred to their spirituality as the anchor and source of hope in their hopeless situations. Prayer to God and ancestors has been used as a treatment modality with the hope that God will answer and heal their children from the perceived spiritual attack (*nyaope* abuse). Willingness and motivation to change are key variables in both spiritual and scientific treatment on substance abuse.

5.3.5 Help-seeking pathways

The fifth superordinate theme was the help-seeking pathways used by parents who have adolescents who abuse *nyaope.* The results were divided into four subordinate themes, namely; social services; rehabilitation services; medical services; and spiritual services. Table 8 represents the participants' responses on subordinate themes.

Table 7: Subordinate themes emerging Superordinate Theme 5

Subordinate themes	A	B	C	D	E	F	G	H	I	J	K
Social services				✓	✓	✓		✓	✓	✓	✓
Rehabilitation services	✓		✓	✓	✓	✓		✓		✓	✓
Medical services	✓	✓	✓	✓	✓					✓	✓
Spiritual service		✓		✓		✓				✓	

5.3.5.1 Social services

Participants reported that their first point of contact was Social Work offices. The participants believed that Social Workers could assist the individuals with substance-related problems. This belief emanated from the members who once utilised the services. However, other members had not sought Social Work-related services, although they held the view that social services should be the first point of contact. Other participants were waiting to be contacted by Social Workers. On the significance of the Social Work services in addressing *nyaope* abuse, the participants said:

> *The only Social Workers I saw were the ones from SANCA in Polokwane… From there they referred him to a rehab in Pretoria (first point of contact) (**PT K).***
>
> *We started going to Social Workers but he had not accepted going to a rehab…. (first point of contact) **(Pt D).***

> *I did go to the Social Workers…. It was after I saw other kids from the opposite street who went to rehab. I asked them and they told me that they started at the social workers, I then decided to go. My son also agreed (first point of contact) (**PT I).***

> *We consulted the Social Worker, and in fact, he is the one who said that this thing is troubling him…. (first point of contact) **(Pt E).***

These results indicate that the participants around the rural areas of Mokopane believed that social services were the primary option for seeking help for their children. They believed that Social Workers should be the first point of contact in matters related to assisting the children who abuse *nyaope*.

5.3.5.2 Rehabilitation services

Participants mentioned that rehabilitation centres were the second point of contact. The services received at rehabilitation centres were believed to remove *nyaope* in the adolescents' bodies. Even those who have never been to rehabilitation centres held the view that rehabilitation centres were the second point of contact. Some of the responses were:

> *There was a place in town where I registered him. I was then referred to Polokwane SANCA and I went with him. From there, they referred him to a rehab in Pretoria (second point of contact) (**PT K).***
>
> *He asked me to take him to rehab, I told him I don't have money. We only get social grant for 1 child and the money helps with stokvel and food in the house **(Pt A).***
>
> *So, he went to rehab and came back fine. He spent two months clean but I started seeing signs that he is no longer fine, he started acting dodgy then I saw that things are no longer the same (second point of contact) **(Pt D).***
>
> *I found an organisation that said that they were willing to help with this nyaope addiction. I looked for help from this organisation and they promised to help him. However, it looks like they are using a list to help them so they are taking time. I believe he is far in the waiting list so my wish is that he gets urgent help, where they can take him in now and help him **(Pt C).***

From Social Workers, participants revealed that their second point of contact were rehabilitation services. They utilised these services while others are awaiting such services due to the long list.

5.3.5.3 Medical services

The third point of contact was the medical services in the private sector. This referral pathway was considered to assist with the severe withdrawal symptoms of *nyaope* abuse. The participants believed that medical practitioners had a drug that could help to cure the unbearable symptoms of *nyaope*. Participants reported that these medical services were not cost-effective and its efficacy was very low. The participants went on to say:

> *It is easy to find guidance anywhere but what is more important is finding a place where they can take nyaope out of his system. I think if I go to the hospital maybe I'll get help that will restore my child back to his normal self* ***(Pt B).***

> *The first thing I did was to inform her cousin sister who recommended that we see the doctor. She was heartbroken because she knows that he was functional and productive. She took us to the doctor using her car. Upon arrival, that doctor asked him how many bags of nyaope he smokes in a day and he replied that he smokes 3. He also asked him where he buys them and how much they cost and he answered and said he buys them for R40. He asked him how much he buys weed and he said that a full match box costs R15 and a half is R10. He then took a calculator and gave him the total cost. He told him that he could've bought a car and all he did was cry (First point of contact) (****PT J)****.*

> *When he came back from rehab, he relapsed. I took him to a doctor who prescribed treatment and he was later fine. When he had to go for his follow-up, he refused to go with me and insisted on going alone (second point of contact) (****PT K).***

> *Yes, he sought help. He said the medication is a doctor's prescription note which his friend has. I told him that as a trolley potter, he can save R20 everyday then when it reaches R150 I will go and buy it for him, but he never did* ***(Pt A).***

> *He once told us about medication that cost R340. It is pills and liquid medicine taken orally* ***(Pt C).***

My friend spoke about a certain medication called 'methadone.' We went to the doctor, and he prescribed the medicine for us. But the medication didn't last long because when it finishes, he craves for more. This medication is very expensive. It didn't work that much for us ***(Pt I).***

Evidently, the participants around Mokopane depended on the medical treatment called Methodone to reduce the pain of withdrawal symptoms. Despite there being reports regarding the affordability of this medication, members continue to utilise it as an alternative method.

5.3.5.4 Spiritual services

The participants indicated that the fourth point of contact was spiritual services. Although they reported several challenges with this service, they perceived it as a dependable platform. The following excerpts support this perception:

I ended up going to prophets and they told us that he is under spiritual attacks (third point of contact) ***(Pt D).***

I ended up going to prophets and they told us that he is under spiritual attacks. It's like they saw that his future is going to be bright so they blocked him with their spells. Those are the things we are told by prophets, we went to 2 different prophets and they both told us the same thing. The pastor from Warmbath talked about him disappearing and going to the river and the river will take him and never come back. We then went to another pastor to get a second opinion. He told us that they want to cut his future short and to block him from prospering. They say he is being used and that is how they disguise their plan by using friends to offer him nyaope. In this way, we will not be suspicious so that they will blame it on the things he smokes ***(Pt F).***

We just prayed, the pastors also prayed for him. His uncle gave him anointing oil ***(Pt D).***

We just prayed, the pastors also prayed for him. His uncle gave him anointing oil. He is also a person who loves reading scriptures, it is quite shocking that this person is actually aware of these things ***(Pt D).***

I pray for him. I lay my hands and pray for him. I also talk with him ***(Pt H).***

The results revealed that spiritual assistance was sought by some of the participants who believed that their children were under spiritual attack.

5.4 Reflexivity

During data collection (interview), the researcher participants who were smoking and drinking inside the house with no consideration of other people who might have been non-smokers. The researcher's attitude or prejudice towards smoking was constantly creeping in during the process of analysis and to some extent, nearly affected the interpretation of the results. However, the researcher had to constantly guard against that prejudice in the collection and analysis of data.

When visiting one participant for interviews, she was gambling at a casino hotel. She stated that she visits the place every day for gambling. She appeared like an individual who was addicted to gambling. Due to the researcher's educational background, he could not resist associating her child's addiction to substance with her addiction to gambling. Furthermore, the researcher assumed that she did not have time to offer proper parenting due to her unavailability. The participant did not mention it as a problem, which is why the researcher ruled out the assumption because her gambling behaviour did not emerge as a contributor factor to substance abuse during the analysis of data.

Most of the participants are from poverty-stricken backgrounds; this was evident from the infrastructures and the overall appearance of the household. With all of the above observations made during interviews, the researcher was slightly apprehensive when he first noticed this theme emerging across cases. He was careful to not pathologize any observation and allow the process of analysis to continue uncontaminated.

Engaging in this research has been personally rewarding for the researcher as he felt that his knowledge and research skills have increased immensely. However, conducting this study was quite challenging at times, particularly during the data analysis process. The researcher would, at times, relate to the emotional impact that many of the participants went through due to a family member's substance abuse problem and its impact on the entire family. To some extent, the researcher shared the participants' emotional difficulties. Notwithstanding, through this study, the researcher gained more knowledge and developed a passion to work with the parents who have adolescents with *nyaope* abuse problems. This study further taught the researcher that parents play a pivotal role in assisting their children to cease (ab)using *nyaope*.

5.5 Concluding remarks

The chapter began by presenting the demographic profile of the participants. This was followed by the results of the study, which included a descriptive analysis. The analysis revealed how the participants' responded to their children's abuse of *nyaope*. Superordinate and subordinate themes were generated from the responses and analysed. The last part of the chapter provided the researcher's reflexivity on the results of the study and their analysis. The next chapter is a discussion of the results of the study.

CHAPTER 6: DISCUSSION

6.1 Introduction

The previous chapter presented study findings. The purpose of this chapter is to present and discuss the results while reflecting on the existing theories and empirical studies including the theoretical framework. The study explored the lived experiences of parents raising adolescents who abuse *nyaope*. The study intended to answer the central question guiding the study, that is, 'What are the lived experiences of parents with adolescents who abuse *nyaope*? In the previous chapter, the researcher was able to generate themes that assisted in revealing the experiences of parents with children abusing *nyaope*. This chapter provides more insights into the findings. Towards the end, a Help-Seeking Model informed by phenomenological account of parents is offered as the main contribution of the present study.

6.2 Parents' view on the contributory factors to *nyaope* abuse

Nyaope abuse is a national mental and public health concern, and arguably the drug s highly addictive with the highest rates of relapse. Contributory factors associated with *nyaope* abuse are many, however, in the present study, it was found that for adolescents, peer pressure and social problems were the major risk factors. It was also found that availability, easy access to *nyaope*, and the need to experiment with the drug were part of the contributors to its abuse. Spiritual explanations emerged in this investigation as a seldom reported risk factor.

6.2.1 Spiritual causal explanations

Parents believe that teenagers who abuse *nyaope* are spiritually attacked. They hold views that their children were bewitched; explanations which were confirmed by spiritualist such as prophets and pastors during formal consultations. To the researcher's knowledge this view has rarely been associated or reported to be a risk factor within the substance use disorder (SUD) spectrum. Indeed, culture and cultural beliefs always influence how people view and deal with ill-health. Mufamadi and Sodi (2010) highlight that in African communities, witchcraft, sorcery, spirit possession and disregard of cultural norms are often blamed for people suffering including in cases of

mental illness. Shange and Ross (2022) also offer some support that supernatural/spiritual (ancestral calling and witchcraft) and breach of customs are common causes of mental illness. Although this may be true in line as per individuals' cultural formulations of ill-health, the researcher seeks to argue this point further. Given the magnitude to which the substance is destructive and not amenable to treatment, one argument for the spiritual interpretation associated with *Nyaope* abuse may be that parents ascribe it to divine forces to find meaning. Meaning making is central to coping, especially in the wake of traumatic experiences that regularly challenge people's global beliefs. The teenage drug abuse problem shatters parents' consciousness leading to fractured identities. Finding themselves in a state of suffering or disharmony (Nobles et al., 2016), parents could be resorting or borrowing from their African worldview to recreate meaning and survive the ordeal. It is this thinking, which as was evident in this study, that goes on to inform parents holding onto such beliefs' health-seeking behaviours.

6.2.2 Peer pressure

Associating with mischievous friends who abuse *nyaope* is perceived a contributor to teenagers' abuse of *nyaope*. In this study, parents maintained that their children were well-behaved, but by associating with mischievous friends, they started abusing *nyaope.* Similarly, Masombuka (2013) found that parents were able to notice that their children were abusing *nyaope* when they started relating with suspicious strangers who were allegedly using *nyaope*. Peer pressure is not a standalone factor as children coming from broken families, who are abused and/or suffering some mental health-related problems are easily influenced by their peers and start using drugs as a stress reliever. This was also echoed by Nevhutalu (2017) who reported that new *nyaope* users were recruited by their friends who recommended *nyaope* for self-medicating purposes and to escape life difficulties. This is because the drug elicits the most 'euphoric' feeling; hence, peers, especially those with life problems, fall for it (Khumalo, 2016).

Studies found that young people whose peers were abusing drugs or addicts were more likely to use drugs themselves when compared to those with friends who did not smoke or have addictions (Dintwe, 2017; Nevhutalu, 2017). Part of the reasons

provided for using *nyaope* was to fit in within the group and gain respect amongst their peers (Dintwe, 2017). Fernandes and Mokwena (2016) supported this finding by presenting a concept of external locus of control (LOC). External LOC refers to the degree to which people get influenced to behave in a particular way by external circumstances. Authors found that external LOC contributes to the use of *nyaope* and further acts as a predictive indicator of the recovery process. Adolescents with external LOC will therefore be easily influenced by external factors such as friends who abuse *nyaope* and have welcoming attitudes towards substances. It is along the same lines that Simons-Morton (2007) found that adolescents were easily influenced mostly by their friends to smoke or drink alcohol.

The Bio-Psychosocial model (BPS) supports the findings of peer pressure as a contributory factor to *nyaope* abuse. Skewes and Gonzalez (2013) indicate that the BPS model conceptualised peer influence as a contributory factor to substance abuse because peers influence adolescents' values, attitudes, and behaviour in multiple domains, including substance abuse. In addition, having a peer group that uses substances is a strong predictor of adolescent substance use (Masiak, 2013). It is believed that when adolescents associate with peers who hold socially deviant attitudes and beliefs, the risk of substance use increases (Griffith, 2005). This finding suggests that South African teenagers remain at a risk of using *nyaope,* more so, teenagers coming from broken families, those suffering from mental health problems or with high levels of external locus of control. The latter is even more worrisome considering that teenagers are generally peer-group oriented in their identity search.

6.2.3 Social problems

In this study, parents highlighted that social problems such as family separation and divorce, family dysfunction, parental substance abuse, poverty and unemployment contributed to their children' *nyaope* abuse problem. In the same vein, poor parenting in the form of ineffective parenting or angry or absent parents contributed to children abusing *nyaope*. These results were also consistent with past studies which reported that disintegrated, single-parented or step-parented families all contributed to teenagers abusing nyaope (Khumalo, 2016; Nevhutalu, 2017). Several other studies add that family risk factors, such as domestic violence, marital conflict, child

maltreatment, parenting style, disruptive parent-child relationships, and poor family structures can impact negatively on the development of young people, which might predispose a young person to the use of substances (Choate, 2015; Groenewald & Bhana, 2016).

Nevhutalu's findings resonate with this study's findings in that they both affirm that *nyaope* addicts view life as unfair mainly because their parents are unemployed and consequently cannot provide for them. Khumalo (2016) adds that most addicts believe that if they were from affluent backgrounds or working, they would have not involved themselves in *nyaope* abuse. The combination of poverty, unemployment and the addictive nature of *nyaope* results in the users committing crime, mostly petty theft, to sustain their habits (Mokwena & Huma, 2014). Scholars argue convincingly that individuals with a low socioeconomic status are more susceptible to *nyaope* abuse (Dintwe, 2017; Mokwena & Morejele, 2016; Radebe, 2017).

The findings also revealed that parents who abuse of substances also contribute towards their children abusing substances. Choate (2015) supports these findings by stating that the parents' past substance abuse contributes to their child's substance abuse. Parents further believe that poverty and unemployment contributed to their children abusing *nyaope* as they found life difficult and unbearable without a source of income either from parents or themselves as users. These findings were supported by BPS model which indicated that social learning influences behaviour and those adolescents who observe substance use in their parents are more likely to use substances themselves (Griffith, 2005; Skewes & Gonzalez, 2013). However, there is evidence that modelling is not the only way in which parents influence their adolescents' behaviour. The findings of these studies note the association between parental approval of substance use and adolescents' use of alcohol, tobacco, and marijuana.

These results build on the existing evidence that Bowen presented as differentiation of self, triangles, and emotional cut-off. These concepts support the findings in this study by conceptualising how adolescents fail to manage the family problems leading to maladaptive behaviours such as *nyaope* abuse (Brown, 1999). This is expressed as an intense responsibility for another person's difficulties that resulted in tensions

within the family system (Brown, 1999; Kerr & Bowen, 1988). Individuals with low levels of differentiation are less flexible, less adaptable, and more emotionally dependent on those around them. They are easily stressed into dysfunction, and it is difficult for them to recover from dysfunction. Brown (1999) presented an analogy of 'knee jerk reaction' to describe the fused relationship and how it responds to crises or perceived demands of another person in the family system.

6.2.4 Availability, easy access and need to experiment

The results of this study have shown that parents believe that the availability and easy access of *nyaope* as well as the need to experiment contributed to their children's abuse of *nyaope*. According to the parents, availability and easy access refers to the areas where *nyaope* is sold without law enforcement neutralising the sellers and also associating with friends who always have *nyaope* at their disposal. These findings are consistent with Dintwe's (2017) results, which classified *nyaope* as a township drug used by those who belong to a low socioeconomic class. The authors found that users had easy access and could afford *nyaope* as compared to heroin and other drugs that are regarded as expensive and difficult to access. Mokwena (2015) adds that easy access to *nyaope* has been one of the current situations among the South African youth and when accessibility of drugs is easy, chances of people trying out and consequently being addicted to drugs is increased.

Nevhutalu (2017) affirms that *nyaope* is cheap and readily available some. Compounding the problem is that some *nyaope* users can make their own *nyaope* by crushing HIV medication and mix it with other readily available drugs and poisons. Ramlagan et al. (2010) reported that most of their participants mentioned the prices of the drug and the availability of drug dealers as contributory factors to drug abuse. Mokwena (2015) asserts that communities struggle with the mushrooming of dealers on their doorsteps and an increasing number of young people who are addicted to the drug and find it very difficult to stop the use. It was found that *nyaope* dealers could be easily located with little effort whenever one wanted to buy the drug from them (Dintwe, 2017; Monyakane, 2018; Nevhutalu, 2017). The findings were further supported by the BPS model, which ascribes modelling and availability of substances as significant influences of behaviour (Skewes & Gonzalez, 2013).

In lieu of the findings, a strict policy on drug monitoring at schools is important to reduce and/or ultimately stop the availability and use of *nyaope*. This monitoring should include the presence of law enforcement agencies such as the South African Police Services (SAPS) at schools. The curriculum at school should incorporate and enforce lessons, curriculum and/or programmes that discourage the use of *nyaope*. It has also been found that places where adolescents engage in extra-mural activities (dance groups and soccer) contribute to the use of *nyaope* abuse. Therefore, these places also require vigilance from the SAPS. Furthermore, the process of criminalisation of *nyaope* should be accelerated to reduce the increased usage of this drug in rural areas.

There should be enforcement of policies that ensure access control to drugs/substances and exclusively allow access to qualified professionals for medical and scientific purposes. This will assist to curb the scourge of *nyaope* since it solely relies on the mixture of different drugs/substances. This enforcement of policies should be extended to monitoring of substances in sporting facilities since peers usually influence each other during extra-mural activities. Research on integration of western medicine, traditional medicine and spiritual services should continue probing *nyaope* abuse. Future studies should focus on spiritual causal factors with the aim to influence the integration of western medicine, traditional medicine and spiritual services in rural communities. Future studies should also take into account preventive and support programmes aimed at assisting adolescents and their families in rural areas.

Practicing mental health practitioners should place emphasis on elements of external LOC on the part of adolescents when rehabilitating them and during the provision of aftercare programmes. This should be extended to professionals like Social Workers, Counselling Psychologists, Registered Counsellors and other relevant mental health professionals when conducting preventive programmes to communities and most importantly schools. There should be political will to implement the White Paper on Families and a Drug Master Plan with priority given to rural communities that are the capital of *nyaope* abuse. These findings further suggest the strong need to stimulate rural economy, which should focus on alleviating poverty and unemployment. This will contribute to the stability of families, encourage young people to focus on education

and generally improve the livelihoods in rural areas. This will address one of the contributory factors, i.e. social problems.

6.3 Impact of nyaope abuse on parents

Parenting an adolescent who abuses *nyaope* is a daunting task that is followed by a plethora of challenges to the family and the community. Parental experiences are multifaceted, and the current study found that parents experience severe psychological symptoms due to their children's *nyaope* abuse. It was also found that parents experience physical symptoms; financial burden and stigmatisation due to having a child who abuses *nyaope*.

6.3.1 Psychological health impact

Parenting a child who abuses *nyaope* can be devastating and cause severe psychological distress. In this study, it was found that parents with adolescents who abuse *nyaope* experienced diagnosable Major Depressive Disorder. In addition, they experienced feelings that are similar to those of individuals who are grieving a loved one although their children are still alive. These findings are consistent with those from (Dykes & Casker, 2021; Nkosi, 2017), which found that parents experience severe emotional pain as a result of parenting children who abuse *nyaope*. Nkosi (2017) suggested that for some parents they felt like grieving the child who is still alive because of how addiction captures the child and destroys the future prospect of the child.

These findings are further supported by studies that found that parents experience feelings of shame, embarrassment, emotional pain, anger, guild, self-blame and blaming others (Choate, 2011; Dykes & Casker, 2021; Groenewald & Bhana, 2017; Khumalo, 2016; Masombuka, 2013). Additionally, parents became helpless and hopeless because of how *nyaope* captured and destroyed the lives of young people with minimal prospects of receiving proper treatment in rural areas (Mathibela, 2017; Masombuka, 2013).

These findings are consistent with the SSCS model which explains the emotional experience of Affected Family Members (AFM) who have a relative with addiction-related problems. According to Orford et al., (2005), AFMs are mainly worried about the mental, physical, financial, educational and future prospects of the addict. This worry further extends concerns about the functioning of the whole family, the maintenance of good quality relationships both within the family and with others and concern about the ability of the family to function well now and in the future for the sake of all its members. Some of the emotions include anger, hopelessness, isolation and devastation that parents with children who abuse drugs experience, which are also relatable to the findings of the current study (Masombuka, 2013; Rebello, 2015; Orford et al., 2010).

The results yielded a clearer understanding of Bowen Family Systems Theory, which contends that when a member of the family becomes dysfunctional due to addiction or any other illness; they consequently cause the dysfunction of the entire family system. Parents were found to be the most affected when their children had addiction problems (Brown, 1999; Bowen, 1976). According to this theory, individuals with low levels of differentiation are less flexible, less adaptable, and more emotionally dependent on those around them. They are easily stressed into dysfunction, and it is difficult for them to recover from dysfunction. Brown (1999) presented an analogy of 'knee jerk reaction' to describe a fused relationship and how it responds to crises or perceived demands of another person in the family system. The fused relationship is commonly evident between the parent and the affected child in the family. Kerr and Bowen (1988) add that emotional cut-off from the family may become common with the aim to prevent confrontation and interrogation. Furthermore, it also relates to the degree of engagement between a parent and the child who is affected by a problem or defected (Brown, 1999). This concept describes the manner in which people deal with the emotional intensity that exists between generations and the way some people handle their unresolved emotional attachment to their parental family.

6.3.2 Physical health impact

Parents who experience severe psychological symptoms often present with physical symptoms, some of which warrant medical attention. In the current study, parents

reported that they experienced physical symptoms as a result of excessive worry about their children's condition. These physical symptoms include general body pains and significant weight loss. Parents also indicated that their stress triggered medical conditions like High Blood Pressure (HBP). These findings are supported by Dykes and Casker (2021) who found that parents with adolescents who abuse substances also experience physical symptoms as a result of caring for an adolescent who abuses substances. Authors revealed that one parent would get too much stress to a point that it triggered asthmatic attacks. These parents indicated that every time they consulted with medical officers, they would be told that there was no other medical basis to their condition, but stress.

Findings are also consistent with the findings from Ngantweni (2018), who stated that there are health-related problems associated with living with adolescents who abuse substances. Nkosi (2017) adds that parents experience medically-related problems such as heart problems and High Blood Pressure. Mathibela (2017) further found that some of the parents who presented with physical symptoms were put on depression medication by medical officers while others verbalised that they were struggling with hypertension, stress and other stress-related diseases.

6.3.3 Financial burden

Parents reported the financial burden they incurred by having a child who abused *nyaope.* Parents assumed the responsibility for the costs associated with treatment of their children, which were reportedly expensive. They also became responsible to for the recovery and or reimbursement of stolen items from their home and the community. Noteworthy, this burden is carried by parents who are from a low socioeconomic status with most of them being unemployed, which further adds on the psychological burden. These findings are consistent with those from Choate (2015), who noted that some parents' financial burdens were as a result of the adolescents' stealing behaviours and damage to property, where parents were expected to replace or repair the damage or loss.

Dykes and Casker (2021) supported findings by stating that some parents reported that their children would use money for drugs with the full knowledge that their parents

were already struggling financially. Authors also found that some children incurred debts with relatives and neighbours in pretence of buying food and household items. They borrowed money is used for buying drugs and sadly becomes the responsibility of the parents to repay. Mathibela (2017) found that the parents were frustrated with their children because they would steal from home and community to maintain the addiction. It is regrettably parents who bear the financial burden of their children's addiction behavior.

6.3.4 Stigmatisation

There is a negative perception and judgment from communities against families with children who have social ills such as addiction to substances. Families with children who are addicted to substances are viewed as part of the contributory factor. In this study, it was found that parents with children who abuse *nyaope* are stigmatised by their community members. The parents reported that they felt stripped of their dignity, sense of respect and were assigned derogatory names by their community members. These findings are consistent with those of Radebe (2017) who found that parents with children who abuse *nyaope* had experienced rejection and were given derogatory names by family members and the community, which brought them shame, humiliation and indignity when walking in the streets. Mathibela (2017) found that parents became frustrated due to them community members who ostracise and treat them as if they were condoning the behaviour of their teenagers instead of realising that they were also challenged by it.

6.4 Parental Coping strategies

The psychological impact of having a child who abuses *nyaope* necessitates effective coping strategies. However, developing effective coping strategies is difficult; hence, parents utilise whichever method that seems to work for them. In this study, it was found that parents relied on spirituality and social support to cope with their difficulties. They also relied on emotional ventilation, 'engaged' and 'withdrawn' strategies to cope with the difficulty of raising a child who abuses *nyaope*.

6.4.1 Reliance on spiritual intervention

Given the belief that their children are spiritually attacked, parents resorted to praying to their ancestors and God as a strategy to cope with their difficulties. Prayer to supernatural powers has been found to be a dependable coping strategy as it is perceived as effective in managing the stress that emanates from having an adolescent who abuses *nyaope*. Support comes from Mathibela (2017) who found that parents utilised spiritual services which include praying and going to church to cope with difficulties in their lives. According to Mathibela (2017), parents believed that prayer and going to church will assist them in coping with children who were abusing substances. Masombuka (2013) adds that when parents realised that their children's addiction problem was persisting despite talking to them, they tried to get religious help from faith-based organisations, which also assisted them to cope. Reliance on their spirituality gives them (parents) hope and faith (Koenig, 2009; Swartbooi, 2013). Thus, religion plays a vital role in people's lives as it brings hope; hence, the parents turn to their religion as they seek to understand their children's problems (Mafa & Makhubele, 2020). The findings of these studies revealed that parents often relied on religion and spirituality to cope with their challenges (Masombuka 2013).

6.4.2 Social support

Parents revealed that they relied on accessible social ties such as family members, professionals, friends, neighbours, and fellow parents who have similar problems. These findings are confirmed by Choate (2015) who found that parents would reach out to family members and professionals to cope with emotional difficulties that arise due to having a child who abuse *nyaope.* Parents reported a growing desperation and an increased inability to effectively cope, but they found that reaching out for help could be useful at times as they sought ways to cope with their children's *nyaope* abuse. Orford et al., (2010) add that social support from both formal (professional) and informal networks like friends and family provided the parents with required emotional and material support. Affected families require reliable social support networks that can help them to cope with their difficulties.

Nkosi (2017) reports that parents received social support from the community policing forum, community Social Workers and centre for youth and community development, which helped them to cope with their difficulties. Mafa and Makhubele (2020) state that social support includes emotional support from family and friends that have the potential to promote long-term sobriety for the service user. Masombuka and Qalinge (2020) further aver that parents with children who abuse *nyaope* need professional programmes designed to support the users' parents. From the participants' point of view, formal support structures such as the fellow parent companion could assist them to cope with the user's drug addiction. Participants noted that although they often knew fellow parents of *nyaope* users from the community, they were scared to seek the necessary help and support due to the fear of ostracization and stigmatisation.

Masombuka and Qalinge (2020) proffer that parents with children who abuse *nyaope* need professional programmes designed to support them. These parents indicated that formal support structures, such as a fellow parent companion, enabled them to cope with their children's *nyaope* abuse. Although they often knew fellow parents of *nyaope* users from the community, they were scared to seek the necessary help and support based on preconceived notions, notwithstanding the fact that they all experienced similar emotions. Choate (2015) supported this finding by revealing that regardless of the need of support, parents reported increased desperation and inability to effectively cope, although they found more reasons not to seek help from fellow parents, which amplified the pressures to cope. These pressures are minimised by getting professionals to assist in creating networks beyond therapeutic setting.

In a study by Felker et al., (2019), individuals with family members who abuse substances indicated that support groups are important for attracting and maintaining the interest of the adolescents in participating in the treatment process. This study noted the challenge of shortage of resources that is experienced by many countries. As part of recovery, many adolescents used their experiences as an opportunity to be role models to others. This support group is good for providing the service users with role models, as it accords them the opportunity to form new and healthy interpersonal relationships and gain understanding of the addiction and the recovery process, allows them to interact socially, gives them a sense of belonging, and provides an opportunity for shared experiences of recovery.

Parents extended the expected support to community members. Findings revealed that community members usually blame parents with adolescents who abuse *nyaope* for being responsible for their children's behaviour. The support systems required by parents of adolescents who abuse *nyaope* can be categorised into support from family, friends, professionals, and the community at large. Emotional support from family and friends has the potential to promote long-term sobriety for the service user (Mafa & Makhubele, 2020). These support groups are also important for adolescents as they rely on the acceptance and influence of peers. Therefore, ensuring that a positive peer group supports the adolescent becomes imperative. Due to the lack of human resource, these services are not available, which compromises aftercare services. Parents felt that participation in such programmes and groups would have been beneficial to them. In assisting most adolescents' recovery, parents also needed support in their caregiving responsibility (Masombuka & Qalinge, 2020).

6.4.3 Engaged and withdrawn strategies

The findings in this study revealed that parents utilise the technique called 'engaged and withdrawn' as a coping strategy. This implies that parents cope with their challenges through engagement, which includes reprimanding, whipping and assisting with help-seeking. After that, they also cope through withdrawing from helping and assisting, which is like 'giving up'. These findings are consistent with previous literature which found that parents adopted multiple coping approaches, including 'engaged and withdrawn'. In this study, the majority of parents utilised engagements with the addict which involved vigilance, talking to the adolescent about his/her drug abuse, setting rules and punishments to limit the adolescent's drug abuse. Withdrawing, on the other hand, was evident in the way the parents disengaged from the adolescent. Similarly, research by Jackson et al. (2007) showed that parents would disengage from their adolescents as a last and desperate attempt to cope. This is where parents would give up and decide not to involve themselves at all.

This coping strategy was supported by the SSCS model, which presents the coping strategies used by AFMs. This model indicates that parents use multiple coping strategies, such as observing the adolescent's behaviours, talking to the adolescent

about his/her drug abuse and setting rules and punishments to limit the adolescent's drug abuse. As a last and desperate attempt to cope, the parents also indicated that they had become withdrawn from the adolescent, which was also reported by Jackson et al., (2007) in their study of parents' experiences of adolescent substance abuse. The SSCS model summarises this coping strategy as: putting up, withdrawing, and standing up.

6.5 Treatment sought by parents with adolescents who abuse *nyaope*

Receiving efficient treatment for *nyaope* addiction in rural areas has been a difficult task for addicts and their caregivers. The findings in this study highlight challenges experienced by parents in rural areas, which include unreliable social services, access to rehabilitation services, and expensive medical services. In this study, it was found that parents in rural areas of Limpopo Province experienced difficulties in finding proper care for their children. Those who sought treatment indicated that they relied on social services, rehabilitation services, medical services and lastly, spiritual services.

6.5.1 Reliance on social services

Services of social workers have always been central regarding substance-related problems. These services are mainly aimed at screening and facilitating processes of being admitted at rehabilitation centres. In this study, it was found that parents relied on Social Workers in order for their adolescents to be screened and referred to rehabilitation centres. This study also revealed that parents perceive Social Work services as being inefficient due to their long waiting lists, which delay their inclusion for rehabilitation services that are in another province.

These findings were supported by studies that found that parents with children who abuse *nyaope* in rural areas relied on Social Workers for referral to rehabilitation centres (Mahlangu, 2016; Nkosi, 2017; Radebe, 2017). This finding was also supported by Dada et al., (2016) who found that a significant percentage of referral sources to rehabilitation centres were Social Workers. This is consistent with the White Paper on Families (2021), Drug Master Plan (2016), and Treatment and Prevention of

Substance Abuse Act, all of which place social services at the forefront on the treatment of substance-related problems.

Nkosi (2017) similarly found that the names of the children who abused *nyaope* were taken and the parents were promised to be called so that their children could be included in rehabilitation programmes. The findings were silent on the aftercare programmes for substance abusers. According to Orford et al., (2010), parents felt they needed Social Workers and the government to come up with programmes that protect them from their children who abuse substances, as they are frequently in danger of being assaulted by them. These situations occur when parents refuse to give out money when their substance-dependent children are in need of money.

Findings identified the omission of parents in the treatment process. These parents should receive emotional support during the process of assisting their children and continue with psychological support to equip them with skills to manage their children following the rehabilitation programme.

6.5.2 Reliance on rehabilitation services

Rehabilitation programmes are the most and only evidence-based method for treatment of substance addiction, including *nyaope*. In the current study, some parents revealed that their children attended rehabilitation programmes; however, these programmes are offered in Gauteng only and all those who attended relapsed within a few weeks. The only substance abuse treatment centre available in Limpopo Province is an aftercare centre (outpatient). Dada et al., (2016) supported this finding by a report that shows that there is no official inpatient rehabilitation centre in Limpopo Province. In this province, there are outpatient treatment centres that have been proven to be effective as an aftercare facility. Mokwena (2015) conducted a study in three different townships situated in three different provinces, and the findings indicated that there is a lack of drug (specifically *nyaope*) rehabilitation services in South Africa. Khumalo (2016) adds that most drug treatment centres are situated in upmarket areas in Gauteng and Western Cape Provinces. The study also revealed that Kwazulu-Natal Province, just like Limpopo Province, has a limited number of treatment centres with three common centres that cater for outpatients only.

The findings of a study conducted in the Limpopo Province (Vhembe District) by Nevhutalu (2017) revealed that with the dramatic rise of *nyaope* abuse, it is surprising that there is no single rehabilitation centre in the whole of Thulamela Municipality. The unavailability of rehabilitation centres as well as the huge numbers of *nyaope* users has somehow desensitised some communities to the magnitude of the problem. The few participants who went for rehabilitation stated that rehabilitation did not help them at all and that almost all of them resumed *nyaope* smoking a few days after being discharged from rehabilitation centres, some even on the same day. This has therefore resulted in both the users and their families accepting that there is very little that can be done to change the plight of *nyaope* users (Mokwena & Huma, 2014).

Mokwena and Huma (2014) conducted a study in the townships that have rehabilitation centres and found that those centres were ineffective. In this study, a few participants who went for rehabilitation stated that rehabilitation did not help them at all and that almost all of them resumed *nyaope* smoking a few days after discharge from rehabilitation centres. This difficulty in recovering is associated with the unavailability of a tailor-made treatment of *nyaope.* The problem of *nyaope* addiction is further compounded by the high levels of unmet substance abuse treatment needs, particularly within the poorer South African communities, as well as the high cost of medication required for the withdrawal symptoms associated with heroin addiction (Mothibi, 2016).

6.5.3 Reliance on medical services

Addiction to substances or drugs is characterised by severe withdrawal symptoms among the users. These symptoms include, amongst others, severe physical pain. The findings of this study revealed that parents consulted with medical practitioners for the prescription of methodone to assist their children with withdrawal symptoms of *nyaope* abuse. These findings are consistent with those of Thomas and Velaphi (2014) who found that adolescents who abuse *nyaope* reported that they preferred methadone to treat their withdrawal symptoms as it has been proven to be effective for others (Khumalo, 2016; Thomas & Velaphi, 2014). However, methadone has been found to be part of the *nyaope* constituents and could be ineffective in reducing the

withdrawal symptoms caused by itself (Khine & Mokwena, 2016; Mokwena & Bekker, 2019).

6.5.4 Reliance on spiritual services

When human beings are faced with difficult situations without convincing solutions, they mostly rely on the supernatural for solutions. This includes their reliance on spiritual intervention for substance-related problems based on the conviction that addicted members are spiritually attacked. Research findings revealed that parents sought and some are planning to seek spiritual assistance. The assistance is based on the premise that their children's situation is as a result of spiritual attacks.

Similarly, Mafa and Makhubele (2020) found that parents relied on their spirituality and used religion as a crucial element to bring hope; hence, the parents turn to their religion as they seek to understand their children's problems. The authors also add that some parents preferred spiritual intervention (prayer) over professional intervention. Mathibela (2017) supports the findings of this study by stating that parents appreciated the fact that the church is supportive and gives them and their adolescents hope. Mahlangu (2016) highlights the significance of actively involving spiritual elements in the treatment and aftercare of *nyaope* addicts. Findings in this study reveal that restoration with a higher power gives the parents and the adolescents a sense of peace, hope, motivation and courage to deal with the harsh withdrawal symptoms and fight relapse.

Regarding policy implications, the Drug Master Plan and White Paper on families cover all the aspects necessary for the management of *nyaope* abuse. There is a need to enforce the available policy framework. This will include establishing a treatment centre in the Limpopo Province that caters for all affected districts. The findings suggest that parents should be the integral part of the treatment process. These parents should receive emotional support during the process of assisting their children and continue with psychological support to assert them with skills to manage their children following the rehabilitation programme. Future research should focus on developing the multifaceted treatment modality that is tailor-made for adolescents of African descent in rural areas.

6.6 Help-seeking pathways

Help-seeking in mental health is an integral part of recovery and aftercare treatment. It is informed by the knowledge individuals have about their condition or those of their loved ones. Additionally, culture and belief systems have also been found to be the important elements to help-seeking behaviour. Individuals suffering from mental disorders, such as addiction, delay to seek help or seek help in wrong places. In the current study, the parents' first point of contact in search of help for their children's condition is Social Work services, followed by rehabilitation centres. They also revealed that they subsequently seek medical and spiritual assistance depending on the need. The findings are consistent with the findings from Shai and Sodi (2012), who found that individuals who entered the mental healthcare system as their initial treatment point were informed by the knowledge they had about the illness and severity of symptoms, e.g., manifestation of aggressive behaviour. Sodi and Phethi (2017) add that the choice of the treatment modalities by the patient is neither associated with the proximity nor the cost of treatment; rather, it seems to be related to the patient's or the family's concept of the aetiology of the illness, which is based on the spiritual belief (Sodi & Phethi, 2017).

This finding is consistent with the existing model on help-seeking pathways called HBM, which is based on several primary concepts that predict why people will take action to prevent, to screen for, or to control illness conditions; these include perceived susceptibility, seriousness, benefits and barriers to behaviour, cues to action, and most recently, self-efficacy. According to this model, parents will seek help based on the belief in the likelihood of their adolescents' behaviour of *nyaope* abuse getting worse (perceived susceptibility). Parents are believed to seek help based on the seriousness of the problem affecting their adolescents, which affects the overall family system, social relations and even culminates in death at times (Janz & Becker, 1984; Glanz et al., 2008). This model also supports the findings by stating that parents will seek help based on their belief regarding perceived benefits. These parents would first approach social services to receive rehabilitation, which is believed to be the well-known method of treating substance-related problems (Janz & Becker, 1984; Glanz et al., 2008).

Perceived barriers could be understood to describe the potential negative aspects of a particular health action, which is perceived as an impediment to undertaking recommended behaviours. A kind of nonconscious, cost-benefit analysis occurs wherein individuals weigh the actions expected benefits with perceived barriers. Thus, combined levels of susceptibility and severity provide the energy or force to act and the perception of benefits (minus barriers) provide a preferred path of action (Janz & Becker, 1984; Glanz et al., 2008).

According to the HBM, health-behaviour is explained in terms of individual decision-making. It suggests that the likelihood of a person to follow certain health-related behaviour is highly dependent on an individual's perception of a threat to their personal health, and their belief that the behaviour recommended will be helpful in the reduction of this threat. According to this theory, individuals in distress and in need of assistance for their family members will adopt certain health-related behaviours if individuals perceive threat in their lives and if they believe that adopting that health behaviour will reduce the threat (Becker, 1974; Glanz et al., 2008).

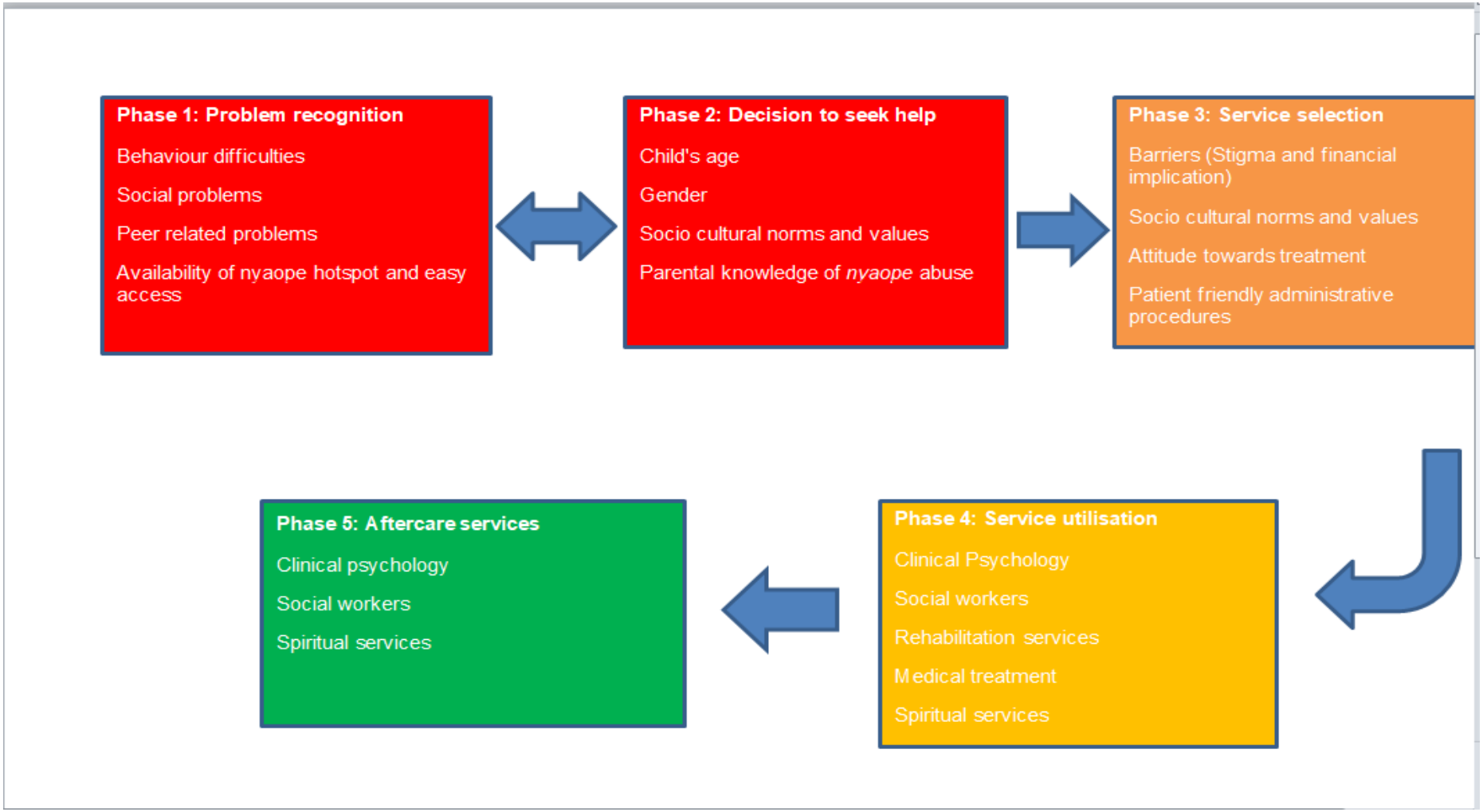
6.7 Towards a help-seeking pathway model for parents with adolescents who abuse *nyaope*

This section presents a *nyaope* abuse adapted help-seeking pathway model. The model is adapted from the works of previous scholars who suggested similar stages for help-seeking with general mental health problems (Anderson & Newman, 1973; Cauce et al., 2002; Goldsmith et al., 1988; Srebnik et al., 1996). The stages were further developed and applied to specific mental health conditions such as teenage suicide and ADHD (Eiraldi et al., 2006; Rickwood et al., 2005). The present model (See Diagram 2) is targeted at families and adolescents abusing *nyaope*. The current study adopted four phases reported previously (Anderson and Newman, 1973; Cauce et al., 2002; Eiraldi et al., 2006; Goldsmith et al., 1988; Rickwood et al., 2005; Srebnik et al., 1996) and added the fifth phase informed by the present study findings.

The model seeks to offer insights into pathways which could be followed by parents with adolescents with *nyaope-abuse problems* particularly, from disadvantaged black-

African communities of South Africa. Considering the study findings, the model closely examines spatial and cultural influences (Cauce et al., 2002). The five stages that could be followed are as follows; Phase 1: guides in terms of early problem recognition; phase 2: Assist in decision making; phase 3: Guides in terms of Service selection; phase 4: Highlights available services to utilise, and, lastly, phase 5: Aid in the aftercare for relapse prevention. Here below, the model is interrogated stage by stage while borrowing from previous models yet reflecting on the current study findings.

Diagram2: Help-seeking model



6.7.1 Phase 1: Problem recognition

According to Cauce et al. (2002) help-seeking begin when there is a problem or mental health need that is identified by the individual experiencing it and/or the caregiver of an individual. These authors argued that the need can be defined as either epidemiologically defined need and/or as a subjective or perceived need. This implies that the need can be determined by a formal assessment conducted by the professionals or by the perception of parents based on their day-to-day observation. Notably, the identification and definition of a child or adolescent's mental health problems, as well as decisions about help-seeking are largely determined by the parent, in consultation with others, including the child (Burns et al., 1992; Combs et al., 1991). Parents should take note of behaviour difficulties, peer difficulties, academic performance decline, presence of comorbid disorders (Cause et al., 2002).

Srebnik et al. (1996) conceptualised problem recognition as an interaction of social networks (formal and informal) which subsequently leads to problem identification. Although individuals who are affected by mental health problems are instrumental in problem recognition, parents and other caregivers are mostly key in identifying problems young people rarely do. Cause et al. (2002) highlighted the characteristics of parents such as single marital status, level of education, marital conflict, family disorganisation, parental psychopathology, parent-child relationship and mental health literacy plays a crucial role in problem recognition. Likewise, when parents are themselves under stress and struggling to get by a scenario more likely for poor, minority families, parenting suffers and parents may become harsher and less warm toward their children (Cornally & McCarthy, 2010; McLoyd, 1995). They may also be less sensitive to their children's distress.

The relative burden of care placed on a family has also been found to influence subjective need, with parents shouldering greater burdens less apt to notice psychological problems in their adolescents. Social norms for which behaviours are undesirable, deviant, or worthy of concern are another important contextual factor that has bearing on problem perception. Problem recognition and identification make up the first step in the help-seeking pathway, and cultural and contextual factors are

always influential in problem recognition and identifications (Cauce et al., 2002; Rickwood & Thomas, 2012).

Problem identification is the key step towards help-seeking and problem management. For families with teenagers with *nyaope* abuse problems, their ability to identify signs and symptoms of the problem becomes important. This model admits the difficulty of a parent to recognise *nyaope* abuse during adolescence which is characterised by developmental and common behavioural challenges. Parents should be able to take note of any behavioural and relational changes including academic performance declines. Present study findings indicate that significant percentage of adolescents who abused *nyaope* presented with emotional and behavioural changes which impaired their day-to-day functioning.

To exemplify, *nyaope* abusers can be identifiable earlier by the following signs and symptoms such as; poor hygiene; compulsive stealing at home and around the community; significant weight loss; mood swings; aggression; sleep disturbances; impaired concentration; and lack of energy. Problem recognition requires parents to pay attention to these changes including deteriorations or decline from previous level of functioning especially teenagers' personal, social and/or academic functioning. This study found that parents from low socio-economic status finds it difficult to monitor their children's changes in behaviour due to working far from home and lack of assistance with household commitments. Therefore, for stage one, key is the ability to identify substance abuse symptoms.

While identification of early symptoms of *nyaope* abuse is key, in the same vein, identification of potential risk factors is also key. Findings of this study indicate that the behavioural changes that indicates signs of *nyaope* abuse were a consequent of multi-layered problems. These changes and problems can be a manifestation of psychological (external LOC, peer pressure), social (family separation, family dysfunction, step parenting, single parent family, divorce) and economic (unemployment, poverty) difficulties or challenges experienced by teenagers. A systemic analysis is key in mapping-out potential risk factors. At a community level, peer pressure is a major risk-factor that parent should pay attention to. Adolescents with an external LOC are particularly at risk of succumbing to peer influence especially

when coming from broken-families and with emotional problems. External LOC refers to the degree to which people get influenced to behave in a particular way by external circumstances such as friends and other factors such availability of drugs. In view of this, parents should pay closer attention to how their children could be easily influenced and the hotspot of *nyaope* in their areas. Problem recognition and identification make up the first step in the help-seeking pathway.

6.7.2 Phase 2: Decision to seek help

The decision to seek is most likely to occur when a mental health problem is recognized as undesirable and when it is realised that it will not disappear or vanish on its own (Eiraldi et al., 2006; Rickwood & Thomas, 2012). Recognising the problem is relatively easy for parents or adolescents, although they may not always agree on the nature and severity of the problem (Cauce, 2002; Srebnik et al., 1996). The decision to seek help and whether a problem is likely to remit without seeking help, is more difficult to evaluate, especially during the adolescent years, when some degree of antisocial behaviour and emotional instability may be considered normative (Rickwood et al., 2005). Srebnik et al. (1996) added that parents may have an attitude of believing that adolescents might outgrow certain unwanted behaviours. Ordinarily, adolescents have at some point disobeyed their parents, lied to authority figures, or used alcohol or drugs. Compounding the problem is the developmental stage of adolescence which is characterised by disequilibrium (Holmbeck et al., 2000). Therefore, it is not too surprising that many parents decide to ignore some behaviour problems, expecting they will disappear, or children will outgrow them over the course of development.

The key aspect on decision to seek help is what Srebnik et al. (1996) coined ‘help-seeking desirability’ and ‘mental health literacy’. After recognising the problem, parents or individuals affected must develop the desire to seek help and the help required will be informed by the level of knowledge they have regarding mental health (Srebnik et al., 1996; Rickwood & Thomas, 2012). Among adults, Pescosolido et al. (1998) found that almost a quarter of all client contacts with mental health professionals were a function of mandated referrals from either schools or courts. Although there are no similar estimates of the number of adolescents in mandated treatment, subjective

evidence suggests that this is also the case for adolescents to decide to seek help. Help-seeking for adolescent with substance related problems could be mandatory because they are in most cases in conflict with the law and rules that govern certain institutions.

The decision to seek help is the second phase that is interconnected and interrelated to problem recognition. Problem recognition and decision to seek help may be influenced by contextual realities such as parental availability and support towards their teenagers (Barker, 2007). Cultural factors would mainly influence aetiological explanations of the teenager's problem. Such definitions are likely to reflect cultural beliefs and values (Cauce et al., 2002; Lynch et al., 2018). This implies that those who holds strong grounds on prayer as a coping mechanism when faced with challenges, they are likely opt for spiritual assistance and delay consultation with mental health professionals.

In the diagram above, problem recognition and decision-making phases are depicted with a red colour in the model to highlight that the two phases are red flag or critical phases towards *nyaope* abuse help-seeking. These phases are critical because early identification of any condition and most specifically of *nyaope* abuse problem will lead to better decision making thus leading to relative swift recovery process. The current study findings revealed few factors to be considered in making a decision to seek help for the adolescent with *nyaope* abuse problem. Evidence illustrates that the onset of *nyaope* abuse is between the ages of 10 and 14. Although parental skills are essential and lifelong, parents should be encouraged to be extra vigilant during the onset of adolescents' because it is a critical period for development of bad and good behaviours. In addition, findings indicated that males are more likely to abuse *nyaope* as compared to females. In the current study, all participants where males however literature has shown rising trends of females who are abusing *nyaope*. Likewise, parents should be assisted with knowledge (mental health literacy) about *nyaope* in order to identify and seek appropriate help for their children. This knowledge should be on-going due to the fact that *nyaope* abuse is a novel and a dynamic challenge to South African community.

6.7.3 Phase 3: Service selection

Service selection is defined as a place or to whom the parents and their adolescents can consult with after identifying a problem and finally deciding to seek help. Selecting a source of help should logically flow from the first two phases, but it is seldom easy or straightforward, especially for adolescents and parents of adolescents (Cauce et al., 2002; Barker, 2006).

Findings in this study revealed that parents are reluctant to seek and select appropriate sources of intervention due to financial implications, negative attitude towards service providers, concerns about stigma and patient administrative procedures that are in most cases not user friendly. Rural communities lack resources such as professionals, centres that assist with substance abuse and generally rehabilitation centres. Seemingly, parents are discouraged, reluctant and lack confidence in services that are rendered in rural areas. These sociocultural and economic challenges all will have an influence on service selection.

This proposed phase of the model seeks to assist parents to dismantle barriers that delay and discourage them from seeking help. It has been noted that these barriers which include shortage of social workers, unavailability of rehabilitation centres in the province, and stigma are also responsible for lack of support towards teenagers who have commenced with treatment and further affects aftercare treatment which consequently leads to relapse. Parents should be motivated that there are strides from South African government (Drug Master Plan and White Paper on Families) to make services available to rural areas with ease and affordable. These services are mainly offered by Clinical Psychologists, Psychiatrists, Social Workers who are adequately trained to render mental health related services to families and affected individuals.

Findings of the current study revealed that most of the parents with adolescents who abuse *nyaope* they themselves presents with diagnosable psychological conditions (e.g., Major Depressive Disorder). This implies that affected parents might have difficulties to make informed decisions in helping their children because such conditions interfere with proper support and impair their judgement on help-seeking pathways. In this phase, it is essential for parents to seek help for themselves with

Clinical Psychologist for individual psychotherapy. Evidence illustrates those parents as primary caregivers to their children need to be empowered to deal with the emotional and cognitive demands from the scourge of *nyaope* abuse. This empowerment includes emotional catharsis, coping strategies, problem solving skills and making informed referrals that will help to manage and support their adolescents. The main reason of asserting parents is due to the long-term intervention that is needed in managing their *nyaope* abuse which is inherently stressful. *Nyaope* abuse intervention require lengthy period due to the fact that there is waiting period for rehabilitation program and the high relapse rate.

6.7.4 Phase 4: Service utilisation

It is believed that a significant percentage of individuals who had problems would begin by self-help strategies (Richwood & Thomas, 2012; Zondo, 2008), such as purchasing non-prescribed medications and home-made cures (Zondo, 2008). According to Srebnik et al. (1996), service utilisation is informed by availability, accessibility, perceived quality of care, attitude of service providers and service integrity. Parents and their adolescents are likely to seek help from sources that guarantees comprehensive treatment such as pharmacology, rehabilitation, individual psychotherapy and further informed referrals (Cause et al., 2002). Most importantly, eligibility and cost of the services rendered has been found to be of paramount determinant factor for utilisation. In South Africa, studies have revealed that rehabilitation services for substance abuse are expensive and makes it difficult for individuals from rural areas to access (Chabalala, 2016; Mahlangu, 2016).

Immediate services at disposal in most rural and township settings are social-welfare services. It goes that first contact professionals can always be social workers. Parents should be educated and encouraged to consult with Social Workers to help screen for substance abuse, basic counselling and administrative procedures, and possible referral of affected teenagers to rehabilitation centres. This process should occur simultaneously with their consultation with Clinical Psychologist. For adolescent with *nyaope* abuse to be accepted in public rehabilitation centres, there should be an assessment by Social Workers followed by their consultation report. Accordingly, rehabilitation programmes which are considered the most and only evidence-based

method for treatment of addiction, *nyaope* in particular will be commenced. This remains one of the dependable help-seeking pathways for assisting adolescents with *nyaope* abuse.

Due to scarcity of resources and delays in receiving help, medical intervention should be sought to manage withdrawal symptoms while waiting for rehab procedure to unfold. *Nyaope* abuse presents with severe withdrawal symptoms which includes unbearable stomach cramps. While managing adolescents who abuse *nyaope,* it is important to consult with medical officers for management of withdrawal symptoms which have been found to be a trigger of high rate of relapse amongst nyaope abuse. Findings in this study revealed that individuals of African descent and mainly from rural areas prefers spirituality when faced with most challenges, model encourages parents and their adolescents affected by *nyaope* abuse to seek spiritual assistance from dependable sources. This will assist in the process of treatment, fostering change and creating hope.

6.7.5 Phase 5: Aftercare services

This final phase is added for relapse-prevention purposes. Alike with other substance of abuse, relapse is high with *nyaope* (Mahlangu & Geyer, 2018; Motsepe, 2022; Mpanza et al., 2022; Swanepoel et al., 2016). Aftercare program aims to improve quality of life and prevent relapse after rehabilitation or other treatment programs. This phase will provide an adolescent who abuse substances or *nyaope* with a chance to adapt to everyday challenges and opportunity to address problems associated with abstinence, recovery and relapse. It is important to establish aftercare services for recovering addicts due to the fact that recovery from substances is an ongoing process which is reportedly tedious. It further helps in supporting, guiding, reviewing gains and most importantly preventing relapse.

The current findings indicates that there is high rate of relapse amongst adolescents who abuse *nyaope*. Additionally, adolescents who abuse *nyaope* have psychiatric comorbidities such as Major Depressive Disorders, Anxiety Related Disorders and Antisocial Personality Disorders. These disorders do not necessarily resolve themselves following rehabilitation hence the need for aftercare services that will place

intense focus on underlying conditions. Furthermore, *nyaope* abuse is strongly associated with external Locus of Control (LOC) which was evident in the current study. Hence the high rate of relapse amongst adolescent who abuse *nyaope*. In this phase, parents should encourage and support their children to consult with mental health professionals to resolve underlying condition including assistance with esteem related issues that presents as external LOC. Social work services are essential for basic skills training and monitoring. It was also found that the most overlooked spiritual services are essential during aftercare. This service offers hope, motivation, reduces chances of relapse and achieve remission.

This model presents the significant knowledge regarding early signs and or changes produced by *nyaope*, suitable help available and ways of accessing help in rural areas. This knowledge is essential for early detection and appropriate help-- seeking by parents or caregivers. In this study, most parents demonstrated limited knowledge that caused delays in seeking help and limited knowledge regarding help-seeking pathways. Nonetheless, this knowledge can be provided by Registered Counsellors, Counselling Psychologist and Social Workers during prevention programs such as community campaigns, school-based campaigns and other mental health promotional models. Furthermore, the abovementioned professional can also train Home Based Carers this model in order for them to incorporate it in their daily programs in rural communities.

In summary, the phases of this model are interrelated. This model emphasises the role of parents in curbing the scourge of substance abuse among young people in rural areas. Generally, early identification of substance abuse assists in making informed decision to seek help, which subsequently leads to selection and utilisation of tailor-made services for problem that was discovered. Based on the phenomenological account of parents, aftercare services are significant for managing relapse and maintaining drug free lifestyle. Socio-cultural norms and values such as religion, cultural beliefs, and socio-economic status are important in facilitating as well as hampering the process of help-seeking.

CHAPTER 7: CONCLUSION, RECOMMENDATIONS AND LIMITATIONS

7.1 Introduction

This chapter presents the main conclusions of the study and discusses its limitations. It begins with the overall summary of the study followed the implication the study has on clinical practice, policy, and theory. It also highlights how the findings can translate into recommendations for practice and future research in the area. Lastly, limitations and reflexivity will be discussed.

7.2 Summary of the study

The present study explored the lived experiences of parents with adolescents who abuse *nyaope*. This study was carried out in low socioeconomic communities around the Mokopane area, South Africa. Parents from these rural areas are faced with countless challenges including, among others, unemployment, poor access to social services, and most importantly, raising adolescents who abuse *nyaope*. There is a scarcity of resources to help *nyaope* abusers and their affected family members in the community. The review of the literature on the study has shown a growing trend of cocktail-type drugs similar to nyaope elsewhere including similar problems encountered by parents and families in the present study.

Previous studies on *nyaope* abuse focused on the drug as a relatively new drug of choice among adolescents from low socioeconomic backgrounds. Studies also focused on identifying the ingredients or constituencies of *nyaope* to develop a custom treatment for withdrawal symptoms. Furthermore, the focus of research has been on identifying the trends and effects of *nyaope* on its users. Consequently, this study sought to explore the lived experiences of parents with adolescents who abuse *nyaope* by allowing them to share their experiences regarding their understanding of the contributing factors, the psychological impact, coping strategies, perceived ideal treatment needed, and help seeking pathways.

The findings revealed parents' understanding of the contributing factors of their children's *nyaope* abuse problems. These contributory factors ranged from peer

pressure, social problems, spiritual factors, availability of *nyaope,* and the need to experiment with the drug. In peer pressure, parents revealed that adolescents are influenced by their peers to engage in *nyaope* abuse. Most of this influence occurs in school and sporting activities. These adolescents have also displayed signs of external locus of control where they are easily influenced by the external environment. The results of this current study also indicate that social problems such as divorce, poverty, unemployment, and other social ills are significant contributors to *nyaope* abuse. In addition, the availability and affordability of *nyaope* in townships has been the contributing factor to its abuse. Lastly, the findings on the contributing factors included the spiritual cause. Spiritual attacks in the form of witchcraft and demons are believed to contribute in adolescents to abuse *nyaope*. This understanding of contributing factors is helpful in customising prevention strategies in rural areas and townships.

One of the main findings is the impact of adolescent *nyaope* abuse on parents. Parents relayed the weight of *nyaope* abuse on their emotional, behavioural, physical, and spiritual difficulties. In an attempt to make sense of their experiences, parents presented with blame, guilt, anger, hatred, helplessness, hopelessness, aches, and insomnia. These symptoms worsened medical conditions such as high blood pressure,,, and to some they triggered the diagnosis. The most notable experience is grief, in which parents experience a sense of loss while their children are still alive due to the impact of *nyaope* on adolescents. Parents mentioned that they experience a sense of loss due to the fact that their children could not function in any way.

The study found that parents employ different coping strategies when trying to handle the nyaope abuse problem of their adolescents. These coping strategies are primitive and some are constructive. The findings revealed that they use spirituality, social support, ‘engagement and disengagement' and lastly emotional ventilation. In particular, most of these parents indicated that they had stopped helping their children who abuse *nyaope*. It is also worth noting that most of these parents primarily focused on helping their children and did not realise that they also needed emotional support from professionals. This could have been due to the fact that there are scarce resources (Psychologists and Social Workers) in rural areas.

Findings on treatment sought have shown that parents sought treatment from social services, medical services, rehabilitation service, and finally spiritual services. The findings revealed that there are shortages of social workers in rural areas and townships, there is a significant dependence on methodone medication, and the reliance on Gauteng province for referrals. Furthermore, there is a significant reliance on spiritual services. In such a community, parents and drug abusers struggle to access treatment and generally follow the pathways that will lead to their rehabilitation. Parents are frustrated with the high rate of relapse of their children after rehabilitation programmes and having their children placed on long waiting lists.

One of the significant findings to emerge from this study is the help seeker pathways followed by parents with adolescents who abuse *nyaope*. The results indicate that parents in townships and rural areas will first contact social workers when there are substance abuse related problems. The aim is to be referred to rehabilitation centres. It was found that their second point of contact is medical services to relieve symptoms while waiting for placements in rehabilitation centres. The third point of contact becomes rehabilitation services for treatment. The fourth point of contact becomes spiritual services. This is supported by studies suggesting that when all fails, people seek supernatural intervention. It is significant to note that these pathways are informed by mental health literacy on the part of parents.

7.3 The study contribution: The adapted nyaope-help-seeking model

The current study aimed to explore the lived experiences of parents who abuse *nyaope* in order to develop a help-seeking model. The phenomenological account of parents with the help of the existing help-seeking model led to the adoption of a five-phased research-informed help-seeking model for parents with adolescents who abuse *nyaope*. The model was adapted from different models with three- and four-phased help-seeking model by Cauce et al. (2002) and modified based on the phenomenological account of parents in the current study. The current study proposed the following phases to follow for help-seeking; 1. Problem recognition, these phases help parents identify early signs and symptoms such as poor hygiene, compulsive theft, sleep disturbances, mood swings, and lack of energy; 2. Decision to seek help; these phases help parents with mental health knowledge to seek help 3. Service

selection; the phase serves to guide parents with the available source of services 4. Service utilisation; this phase encourages and depicts the importance of using mental health services and spiritual services. Lastly, 5. Aftercare services, this phase is a unique phase in the current study which serves to amplify the importance of ongoing assistance after rehabilitation services.

7.4 Implication of the study findings

The implication of this study on theory, research, policy, and clinical practice will be thoroughly discussed in this section.

7.4.1 Implications for theory

7.4.1.1 Bowen Systems Theory

The results yielded a clearer understanding of Bowen Family Systems Theory, which contends that when a member of the family becomes dysfunctional due to addiction or any other illness, they consequently cause the dysfunction of the entire family system. Parents were found to be the most affected when their children had addiction problems (Brown, 1999; Bowen, 1976). According to this theory, individuals with low levels of differentiation are less flexible, less adaptable, and more emotionally dependent on those around them. They are easily stressed into dysfunction, and it is difficult for them to recover from dysfunction. Brown (1999) presented an analogy of ‘knee jerk reaction’ to describe a fused relationship and how it responds to crises or perceived demands of another person in the family system. The fused relationship is commonly evident between the parent and the affected child in the family. The current findings of this study are in line with this theory more especially regarding the contributory factors. It was found that family systems contribute significantly to the abuse of *nyaope.* Furthermore, it also relates to the degree of engagement between a parent and the child who is affected by a problem or defected (Brown, 1999).

7.4.1.2 Afrocentric theory

In the current study, the researcher adopted Afrocentricity as a lens to view the lived experiences of parents raising with adolescents who abuse *nyaope*. This theory was developed by Molefe Asante and has been used to conceptualise mental illness, mental disorders as well as social ills within different societies in Africa and the diaspora. This theory conceives that disharmony between the spiritual and physical sphere may lead to suffering or diseases. It further acknowledges that individuals can cast a spell on others in order to cause suffering or disease. This conceptualization further contends that suffering or diseases that comes as a result of spirituality, treatment should be spiritually inclined. The findings in this study relates to the causal factor of diseases and suffering. Parents reported that they believe that their children were bewitched hence they abuse *nyaope*. These findings relate to local studies (Mafa & Makhubele, 2020; Mahlangu, 2016; Khumalo, 2016; Masombuka & Qalinge, 2020)

7.4.1.3 Biopsychosocial model

The Bio-Psychosocial model (BPS) and the findings on contributory factors to *nyaope* abuse were supported by this study. Skewes and Gonzalez (2013) indicate that the BPS model conceptualised peer influence as a contributory factor to substance abuse because peers influence adolescents' values, attitudes, and behaviour in multiple domains, including substance abuse. Having a peer group that uses substances is a strong predictor of adolescent substance use. It is believed that when adolescents associate with peers who hold socially deviant attitudes and beliefs, the risk of substance use increases. This finding suggests that South African teenagers remain at a risk of using *nyaope,* more so, teenagers coming from broken families, those suffering from mental health problems or with high levels of external locus of control. The latter is even more worrisome considering that teenagers are generally peer-group oriented in their identity search.

7.4.1.4 Stress Strain Coping and Support (SSCS)

The findings in this study revealed that parents utilise the technique called 'engaged and withdrawn' as a coping strategy. This implies that parents cope with their

challenges through engagement, which includes reprimanding, whipping and assisting with help-seeking. Subsequent to that, they also cope through withdrawing from helping and assisting, which is like 'giving up'. Parents adopted multiple coping approaches, including 'engaged and withdrawn'. In this study, the majority of parents utilised engagements with the addict which involved vigilance, talking to the adolescents about their drug abuse, setting rules and punishments to limit the adolescent's drug abuse. Withdrawing, on the other hand, was evident in the way the parents disengaged from the adolescent. Similarly, research by Jackson et al. (2007) showed that parents would disengage from their adolescents as a last and desperate attempt to cope. This is where parents would give up and decide not to involve themselves at all.

This coping strategy was supported by the SSCS model, which presents the coping strategies used by AFMs. This model indicates that parents use multiple coping strategies, such as observing the adolescent's behaviours, talking to the adolescent about his/her drug abuse and setting rules and punishments to limit the adolescent's drug abuse. As a last and desperate attempt to cope, the parents also indicated that they had become withdrawn from the adolescent, which was also reported by Jackson et al., (2007) in their study of parents' experiences of adolescent substance abuse. The SSCS model summarises this coping strategy as: putting up, withdrawing, and standing up.

7.4.2 Implications for future research

Empirical research is important for the development and modification of evidence-based strategies in managing *nyaope* abuse which has become a national pandemic. This study noted that South Africa has limited research on lived experiences of parents with adolescent abuse and research of treatment modalities. The findings in this study hold implication to research on spiritual causal factors. There is scarcity of research focusing on spiritual causal factors in South African population. Further research should include spiritual and traditional healers regarding the conceptualisation of substance abuse. Thus, it will guide the holistic and or integrated treatment model for *nyaope* abuse.

7.4.3 Implications to policy

The importance of prioritising policies that consider the experiences and needs of parents and *nyaope* abuse cannot be overemphasised. There should be well designed policies that magnify rather than minimise support of the families that have children who abuse *nyaope* and /or substances in general, as this can lessen the burden of *nyaope* abuse on families. While the policy context might not be considered an appropriate space to unpack the implementation of family-focused interventions, it is nevertheless an important strategy in the efforts towards prioritising families and implementing remedial programmes and interventions against drug abuse.

In view of the findings of this study, a strict policy on drug monitoring at schools and curriculum and/or programmes that discourage the use of *nyaope* is a necessity. It has also been found that places where adolescents engage in extra-mural activities (dance groups and soccer) contribute to the use of *nyaope* abuse. Therefore, law enforcement agencies should be encouraged to monitor those areas and enforce strong policies that forbid any substances at school and sporting facilities. *Nyaope* should be criminalised and other related substances should be prohibited in public spaces and if the prohibitions are violated, a harsh punishment should be meted on the transgressors. A policy that endorses the integration of western medicine, traditional medicine and spiritual services should be developed and practiced in rural communities. The White Paper on Families and a Drug Master Plan should be implemented and practiced to the entire rural communities of Limpopo Province.

In lieu of the findings, a strict policy on drug monitoring at schools is important to reduce and/or ultimately stop the availability and use of *nyaope*. This monitoring should include the presence of law enforcement agencies such as the South African Police Services (SAPS) at schools. The curriculum at school should incorporate and enforce lessons, curriculum and/or programmes that discourage the use of *nyaope*. It has also been found that places where adolescents engage in extra-mural activities (dance groups and soccer) contribute to the use of *nyaope* abuse. Therefore, these places also require vigilance from the SAPS. Furthermore, the process of criminalisation of *nyaope* should be accelerated to reduce the increased usage of this drug in rural areas.

7.4.4 Implications to clinical practice

The findings of this study have several implications to clinical practice. A mental health professional practising in South Africa should consider the spiritual causal factor as part of contributing factors to *nyaope* abuse, which will help provide informed intervention and make informed referrals. This is in line with calls made by other scholars who encouraged South African mental health practitioners to be culturally sensitive and implement culturally informed modalities to treat mental health-related challenges.

The results of this study encourage South African mental health professionals to approach care parents who report to consultation rooms seeking help on behalf of their children. Based on the finding from this study, it is important to detect or investigate emotional difficulties on the part of the parent. These emotional difficulties affect how these parents cope and support their affected children, as well as other family members. Parents mainly resort to withdrawal as a coping strategy due to the lack of services.

The findings further revealed the disintegrated approach to nyaope treatment and frustration on the help-seeking pathways. Mental health professionals are disjoint when treating *nyaope* abuse, which compromises prognosis. The disintegrated programmes include medical services that occur separately in rural areas, aftercare services that are offered selectively and separately by social workers, rehabilitation services that do not include parents, and spiritual services. This contributes to the high rate of relapse and leads to a poor prognosis.

7.5 Recommendations of the study

The current study aimed to explore the lived experiences of parents with adolescents who abuse *nyaope*. The following recommendations are made following the study findings and implications expounded in the previous sections. Some of the findings of this study are consistent with those of previous studies. However, this study broadens the scope by probing the lived experiences of parents with adolescents who abuse *nyaope,* an area that remains largely under-researched. Therefore,

- It would be interesting to focus on exploring the coping strategies used by parents with adolescents who abuse *nyaope* and to further explore its efficacy. This would help professional and affected members access evidence-based coping strategies that could be documented from future studies. The project would also look for ways to establish reliable support groups and their benefits in rural areas.

- Considerable more work will need to be done on help-seeking pathways for families with children suffering from addiction in rural areas of South Africa. Exploring the pathways to seek help helps identify probable levels of mental health literacy in communities.

- Studies should explore the viability of relevant existing policies (White Paper on Families; Drug Master Plan) and Acts (treatment and prevention of substance abuse act) in rural areas. Rural areas are underresourced and most of these policies seem impossible.

- More research should go into preventive, treatment (rehabilitation), and support programmes for caregivers. In this area, research should further explore strategies for integration of western medicine, traditional medicine, and spiritual services. This would help addicts and offer considerable support to affected family members. The ultimate goal should be to develop a community and family-orientated approach to substance-related problems.

- It would be interesting to conduct an experiment with methodone, which is the drug used for withdrawal symptoms of substances, including *nyaope*. Parents are spending a lot of money on methodone, yet there are few studies on its efficacy in treating withdrawal symptoms from *nyaope*. Further experiment.

- A future study that establishes the applicability and efficacy of the new research-informed model would be interesting. This study should focus on testing the model in rural areas.

7.6 Limitations

There are several limitations that were noted when conducting the study. Although the current study met all the principles of phenomenological study, the data of 11 participants could be perceived as relatively small. Thus, it would be beneficial to access a larger population for further investigations of the lived experiences of parents with adolescents who abuse *nyaope* and the study should be geographically decentralised. This would allow for the generalisation of findings to other settings (countries and provinces) since the data were small and focused only on the rural part of the Limpopo Province. Although there was a second phase of data collection, not all planned follow-up interviews were conducted due to lack of accessibility of some participants which might have compromised the intended quality of data. Be that as it may, the researcher acknowledged as part of IPA that he took an active role in the research as well as the interpretation of the findings. Transparency has also been achieved through reflexivity, outlining of the procedures and presentation of the transcript extracts to allow readers to reflect and consider alternative views.

7.7 Reflexivity

The process of the current study has been extremely challenging. This is precisely due to the fact that I was engaged in qualitative research (more specifically hermeneutic phenomenology) which I was a novice and focused on the topic of *nyaope* abuse among young people where I had to uncover the intense emotional experiences of parents. The experiences of these parents made me develop an emphatic stance during the data collection and analysis process. On the contrary, I personally experienced a rewarding feeling as a result of the knowledge and research skills that I have greatly increased.

7.8 Conclusion

The study of *nyaope* abuse and the lived experiences of parents with adolescents who abuse *nyaope* is emotive but imperative in a South African context. South Africa is grappling with the devastating scourge of *nyaope* abuse with no visible potential for decline. The current study has approached the scourge from the lens of primary caregivers with the aim of establishing a family-orientated approach to kerb the challenge. The results suggest a holistic approach to stop the rapid increase in *nyaope* abuse. The five-phased help seeking model will assist rural communities and townships in primordial prevention and early identification of problem for swift and prompt intervention. Therefore, it is imperative for future studies to further zoom into this subject and test the model presented in this study.

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ANNEXURE 1: ETHICAL CLEARANCE LETTER

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TURFLOOP RESEARCH ETHICS COMMITTEE

ETHICS CLEARANCE CERTIFICATE

MEETING: 06 February 2019

PROJECT NUMBER: TREC/01/2019: PG

PROJECT:

Title:	A phenomenological study of parents with adolescents abusing nyaope in Mokopane, South Africa.
Researcher:	T Ramulwela
Supervisor:	Prof T Sodi
Co-Supervisor/s:	Dr M Makgahlela
School:	Social Science
Degree:	PhD in Psychology

PROF P MASOKO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

Note:

i) This Ethics Clearance Certificate will be valid for one (1) year, as from the abovementioned date. Application for annual renewal (or annual review) need to be received by TREC one month before lapse of this period.

ii) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee, together with the Application for Amendment form.

iii) PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

Finding solutions for Africa

ANNEXURE 2: LANGUAGE EDITOR

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25 July 2023

TO WHOM IT MAY CONCERN

This letter serves to certify that I have edited a doctoral thesis titled: **A PHENOMENOLOGICAL STUDY OF PARENTS WITH ADOLESCENTS ABUSING *NYAOPE* IN MOKOP ANE, SOUTH AFRICA** by **TAKALANI VINCENT RAMULWELA.** A version of the manuscript with the evidence of my editorial interventions has been sent to the authors and is available upon request.

Unless tampered with prior to your reception, I trust you will find the editing quality in order.

Best regards

Sebola, M

_____

DR. MOFFAT SEBOLA

ANNEXURE 3a: INTERVIEW GUIDE (English Version)

Objective	Interview questions
1. To investigate the parents' understanding of the contributory factors and psychological impact of their adolescent child's *nyaope* abuse problem.	a). In your opinion, what do you think are the causes of your child's *nyaope* abuse?
	b). Could you explain to me the psychological impact of the *nyaope* abuse problem in your child?
	c). Do you understand your child's problem in detail?
2. To identify and describe the strategies used by parents to cope with the *nyaope* abuse problems of their adolescent child	d). Could you attempt to identify and describe the coping strategies that you used throughout the beginning of your child's *nyaope* abuse problem?
3. To determine the parents' views regarding the treatment that their adolescent child is receiving or should receive;	e). Kindly share your views regarding the treatment that your child is receiving or should receive?
4. To determine the help-seeking pathways that the parents have followed to manage their adolescent child's *nyaope* abuse problems.	f). Kindly share the help-seeking processes/pathways taken in order to assist/manage your child's *nyaope* abuse problem?

ANNEXURE 3b: INTERVIEW GUIDE (Northern Sotho Version)

Nepo	**Dipotšišo tša poledišo**
1. Go nyakišiša gore naa batswadi ba tseba mabaka ao a tlišago mathata a tšhomišo bašaedi ya seokobatši sa nyaope	a). Go ya ka lena, ke eng seo se hlohleletšago ngwana wa lena go šomiša bašaedi seokobatši sa nyaope?
	b). Naa le kwešiša bothata bja ngwana wa lena ka botlalo?
2. Go hwetša kamego ya lapa le ya menagano ya batswadi yeo e tlišwago ke mathata a tšhomišo bašaedi ya seokobatši sa nyaope	c). Ke kgopela le ntlhalošetšeng gore naa tšhomišo bašaedi ya seokobatši sa nyaope ka ngwana wa lena e le ama bjang monaganong?
3. Go hlatha le go hlalosa maano ao batswadi ba a šomišago go phela ka mathata a tšhomišo bašaedi ya seokobatši sa nyaope ke bana ba bona bao ba lego mahlalagading	d). E ka ba ke mekgwa efe yeo le e šomišitšego go phela le ngwana wa lena go tloga mola a bago le mathata a tšhomišo bašaedi ya seokobatši sa nyaope?
4. Go hwetša maikutlo a batswadi mabapi le kalafo yeo ngwana wa bona yoo a lego mahlalagading a e humanago goba a swanelago ke go e humana	e). Naa maikutlo a lena ke afe mabapi le kalafo yeo ngwana wa lena a e humanago goba a swanelago ke go e humana?

5. Go hwetša mekgwa ya go kgopela thušo yeo batswadi ba e latetšego go laola mathata a tšhomišo bašaedi ya seokobatši sa nyaope ka ngwana wa bona	f). Ke mekgwa efe ya go kgopela thušo yeo le e latetšego go laola mathata a tšhomišo bašaedi ya seokobatši sa nyaope ka ngwana wa lena?

ANNEXURE 4a: PARTICIPANT CONSENT LETTER AND FORM (English Version)

Department of Psychology
University of Limpopo
Private Bag X1106
Sovenga
0727
Date_____

Dear Participant

Thank you for showing interest in this study that focuses on the lived experiences of of parents with adolescents abusing *nyaope* in Waterberg District. Your responses to the interview will remain strictly confidential. The researcher will attempt not to identify you with the responses you give during the interview or disclose your name as a participant in the study. Please note that your participation in this study is voluntary and you have the right to withdraw from participating at any time should you wish to do so.

Kindly answer all the questions as honestly as possible. Your participation in this study is very important. Thank you for your time and cooperation.

Kind regards

_____ _____

Ramulwela T.V. Date

Doctor of Philosophy Student

_____ _____

Prof. T. Sodi Date

Supervisor

ANNEXURE 4b: PARTICIPANT CONSENT LETTER AND FORM (Northern Sotho Version)

Department of Psychology
University of Limpopo
Private Bag X1106
Sovenga
0727

Letšašikgwedi _____

Mohlomphegi

Ke leboga kgahlego ya lena go kgatheng tema nyakišišong ye ya go lebelela maitemogelo a batswadi ba go ba le bana bao ba lego mahlalagading ba šomišago bošaedi seokobatši sa nyaope seleteng sa Waterberg go la Afrika Borwa. Go kgatha tema ga lena poledišanong ye e tlo ba thopa. Monyakišiši o tla leka ka mešegofela go se phatlalatše tshedimošo yeo e ka hlathago go kgatha tema ga lena nyakišišong ye. Le tsebišwa gore go kgatha tema ga lena ke ga boithaopo, le na le tokelo ya go ikgogela morago nako efe kapa efe.

Le kgopelwa go araba dipotšišo ka moka ka botshepegi. Go kgatha tema ga lena go bohlokwa ele ruri. Ke leboga nako le tšhomišano ya lena.

Wa lena ka potego

_____ _____

Ramulwela T.V. Letšašikgwedi

Moithuti wa Kgrata ya Bongaka ya Filosofi

_____ _____

Prof. T. Sodi Letšašikgwedi

Supervisor

ANNEXURE 5a: CONSENT FORM (English version)

Consent form

I_____ hereby agree to participate in a doctorate's research project that focuses on the lived experiences of of parents with adolescents abusing *nyaope* in Waterberg District.

The purpose of this study has been fully explained to me. Furthermore, I understand that I am participating freely and without being forced in any way to do so. I also understand that I can terminate my participation in this study at any point should I wish to do so and that this decision will not affect me negatively in any way.

I understand that this is a research project, whose purpose is not necessarily to benefit me personally. I understand that my details as they appear in this consent form will not be linked to the interview schedule and that my answers will remain confidential.

Signature: _____
Date: _____

ANNEXURE 5b: CONSENT FORM (Northern Sotho Version)

Nna _____ ke dumela go kgatha tema nyakišišong ye ya kgrata ya bongaka yeo e lebelelago maitemogelo a batswadi ba go ba le bana bao ba lego mahlalagading ba šomišago bošaedi seokobatši sa nyaope seleteng sa Waterberg go la Afrika Borwa.

Ke hlaloseditšwe nepo ya nyakišišo ye ka botlalo. Godimo ga fao, ke a kwešiša gore ke kgatha tema ka boithaopo ntle le kgapeletšo. Ke a kwešiša gore nka ikgogela morago nako efe kapa efe ntle le go angwa gampe.

Ke a kwešiša gore nepo ya nyakišišo ye ga se go tlo hola nna. Ke kwešiša le gore tshedimošo ya ka yeo e lego mo godimo ga foromo ya tumelelo e ka se tswalanywe le diphetolo tša poledišano ya rena le gore diphetolo tšeo e tla ba sephiri.

Mosaeno: _____
Letšatšikgwedi: _____