THE DRUG ADDICT: INTERGENERATIONAL FAMILY THERAPY AND THE LULAMA PROGRAMME

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CHAPTER 1

INTRODUCTION

1.1 GENERAL INTRODUCTION

The problem of drug use and addiction is continually increasing world-wide. According to statistics the drug problem is taking on "epidemic" proportions in South Africa. However, an estimated figure of incidence and prevalence is at best a matter of speculation (Van der Burgh, 1984).

Despite the severity of the problem, research on programmes of treatment remains insufficient. The Drug Abuse Council (1980) refers to comments made by Hiller and Sheffet in 1975, pointing out that studies done on treatment programmes are comparative in nature and not indicative of reasons for the low success rate of these programmes.

Little or no attention has been given to interpersonal aspects of drug addiction, apart from the influence of the peer group or the approach within certain family orientation self-help groups such as Al-Anon or Family Anonymous (Stanton, Todd and Associates, 1982). Apart from the studies done by the National Institute on Drug Abuse (1974), which indicate that drug abuse is associated with family patterns, little has been done in this regard.

Numerous studies indicate families as an etiological factor in drug abuse (Stanton, Todd and Associates, 1982; Friedman, Utada and Teitelsbaum, 1987). These studies describe patterns within the family which could be the possible cause for the drug addiction.

As the age of onset of drug use and addiction has become lower, the parents (family of origin) have subsequently become more important in the therapy process (Dorus and Hughs as quoted by Kaufman, 1977). Stanton, Todd and Associates (1982) also indicate that the parents of addicts should be included in therapy of the addict.

There is a shortage of information on the techniques that are used in therapy involving the family of origin. As family of origin (intergenerational) therapy is very complex and has many pitfalls, a clear knowledge of the techniques to be used is necessary in order to be therapeutically successful (Stanton, Todd and Associates, 1982). Stanton, Todd and Associates have researched this field widely and have consequently compiled a programme of intergenerational therapy for drug addicts. Research done on this programme indicates that it is more successful than other programmes of treatment for drug addicts (Stanton, Todd and Associates, 1982). In South Africa no programme of this nature has been researched or is available (to the writer's knowledge). The study is thus topical, as the aim is to compile a programme where intergenerational family therapy is incorporated. This programme will be based on the Stanton, Todd and Associates Programme but other theorists of the intergenerational therapy group will also be consulted.

1.2 AIMS OF THE STUDY

1.2.1 GENERAL AIMS OF THE STUDY.

The general aim of this research is to determine the effect of intergenerational family therapy, which is incorporated into the Lulama programme, on the functioning of the drug addict and his/her family of origin. These effects will

be determined by comparing two programmes, the existing SANCA programme and intergenerational family therapy which has been incorporated into the existing programme.

1.2.2 SPECIFIC AIMS OF THE STUDY

The specific aims of the research are to determine the effects of the newly compiled programme, including intergenerational family therapy, on the drug addict and his family of origin. The aspects of the addict's functioning that will be investigated are:

- The addict's level of adjustment; and
- the addict's level of self-actualization.

The aspects of functioning within the family of origin that will be investigated are:

- Communication within the family;
- the satisfaction derived from the family unit by the members of the family;
- the hierarchy in the family;
- the perceived level of health of the family; and
- the perceived strengths in the family.

The relationship of the parents is also important and this study will specifically take a look at the intimacy of the relationship between the parents.

CHAPTER II

REVIEW OF THE LITERATURE

2.1 INTRODUCTION

Chapter II comprises the literature study. Firstly, definitions and descriptions of terms will be given which will be followed by a review of the literature that indicates the connection between family dynamics and drug addiction. The rationale of intergenerational therapy will be explained, and a review of Spark's, Napier's and Bowen's theories will be given. Thereafter, implications of intergenerational therapy on the drug addict will be discussed and the current SANCA programme will be outlined. Finally, the intergenerational family therapy programme will be formulated.

2.2 DEFINITIONS AND DESCRIPTION OF TERMS

2.2.1 FAMILY OF ORIGIN

Hovestadt et al. (1985: 287) say:

> The family of origin is the family in which a person has his/her beginnings - physiologically, psychologically and emotionally. The impact of these premorbidal roots is profound and pervasive and continues to play an important role in the present.

Andolfi and Zwerling (1980, as quoted by Hovestadt *et al.*, 1985) see the family of origin as two adults (parents) and the children born out of this union.

Minuchin (1974, as quoted by De Wet, 1985) says the family of origin is the milieu in which family members develop while experiencing the elements of dependence and autonomy which are present in the family. Williamson (as quoted by Hovestadt *et al*., 1985) adds that few people are aware of the effects of unaccomplished goals, and the problems they have with their parents and grandparents and the consequent effects of this on their behaviour. The family of origin is thus the beginning of an individual - physiologically, psychologically and emotionally. These beginnings in the family of origin have profound effects on people's present behaviour although these people are usually unaware of these effects.

2.2.2 INTERGENERATIONAL FAMILY THERAPY

Spark (1974: 236) sees intergenerational family therapy as:

> The grandparents together with all family members are provided equal opportunity to face and mutually rebalance the unrequited loyalty ties and denied indebtness.

Bowen (1986) sees intergenerational therapy as an aid for the involved family members, to differentiate clearly defined "selves" from the undifferentiated ego mass.

Intergenerational family therapy is thus seen as a way in which the effect of the family of origin is made known to the members of the family and is reduced or changed to a more functional effect.

2.2.3 DRUG ADDICT

The term drug addict can be defined in two ways:

- It can be defined as a person who is dependent on drugs. Here it is important to define drug dependence. According to Miller and Keane (1987: 377) dependence is

  > a state of periodic or chronic intoxication produced by the repeated compulsion of a drug characteristic by (1) an overwhelming desire or need (compulsion) to continue use of the drug and to obtain it by any means, (2) a tendency to increase the dosage, (3) a psychological and usually a physical dependence on its effects, and (4) a detrimental effect on the individual and on society.

- It can also be defined as a person exhibiting certain personality characteristics.

In 1957 Winick (as quoted by Laurie, 1970: 36) says the following:

> The drug addict is a person with certain personality characteristics who happens to have selected this way of coping with his problems for a variety of reasons of which he is usually unaware.

Frankau in 1964 (as quoted by Laurie, 1970) goes further and gives a description of the drug addict. Addicts are described as asocial, inadequate, immature and unstable. They are selfish and self-centered, without any interests in the welfare of others and are only concerned with their own problems. Their major problem is the maintenance of the supply of drugs or the immediate gratification of their desire for drugs. They will resort to any means, unreasonable or dangerous, to satisfy the insistent craving. They do

not develop normal human relationships and are almost without concern for the unhappiness and worry they cause. They lack self-discipline, will-power or ambition, and responsibility is avoided. They have a low threshold for pain and cannot tolerate criticism or frustration. They become outcasts of society and their personal relationships are confined to contrasts with other drug addicts. These people are often very lonely people. For the purpose of this study an addict will be seen as a person with certain characteristics as described by Frankau (1964, as quoted by Laurie, 1970) with a dependency on a drug.

2.3 THE CONNECTION BETWEEN DRUG ADDICTION AND FAMILY DYNAMICS

The connection between substance abuse and family dynamics has received increased emphasis in recent literature. Previous emphasis on individual theories of substance abuse was dominant. What then can be said about the family of the substance abuser? Based on a review of the literature on familial patterns in families with drug-abusing members, a fairly consistent pattern appears evident. The following major aspects have been emphasized: maintenance of the family equilibrium, mourning, achievements, sibling relations, family contact, hierarchical reversal and drug effects.

2.3.1 MAINTENANCE OF THE FAMILY EQUILIBRIUM

Several authors have noted that drug use is essential to maintaining an interactional family equilibrium, which resolves a disorganization of the family system that existed prior to drug taking (Huberty and Malmquist, 1978; Noone and Reddig, 1976, in Kaufman 1985). An example is given in Kaufman (1977:135):

> The addict provides a displaced battlefield so that implicit and explicit parental strife can continue to be denied ... the addict forms cross-generational alliances which separate parents from each other ....

Kaufman goes on to explain that the generational boundaries are diffused, which causes competition between the parents. The drug addict's taking of drugs then leads to a crisis which is experienced as being the only way to get the family together to attempt problem-solving, or to experience emotions.

Maintaining the equilibrium within the family of origin is thus of crucial importance and dependency on a drug could be perceived as a way of maintaining the equilibrium. The equilibrium within a family is often disturbed by: the family life cycle, communication and the parental relationship.

2.3.1.1 Family life cycle

Adolescent substance abuse must be considered in context with the individual and with the family in their life cycles (Levine, 1985). The individual in the adolescent cycle experiences this time as a time of extreme egocentrism, of heightened sexuality and aggressiveness, of reawakened conflicts from childhood, and of a growing need for independence coupled with periods of increased dependence (Blos, 1962; Elkind, 1967, as quoted by Levine, 1985).

The adolescent disrupts patterns of familial interaction by making demands where few had previously been made; and withdrawing where there had previously been high interactional demands. Interpersonal family boundaries, alignments, and functioning become uniquely fluid and labile during this period, generating both old and new and often powerful forces within the family members (Levine, 1985). Parents of adolescents, in addition, are forced

to re-encounter their own sexual conflicts and inhibitions at this time (Skynner, 1981 as quoted by Levine, 1986). Not only are adolescents in the midst of their own most profound identity crisis, but the parent may be in a mid-life crisis and the grandparents in an old-age crisis. The central developmental task - for both the adolescent and the family - is the adolescent's individuation. The adolescent must gradually leave the family and allow the family to redefine itself in his/her absence.

Actual substance abuse is one way in which family dysfunction may become manifest. Some families have special difficulty in dealing with changes, especially changes as far-reaching as those wrought by adolescents. Families of substance abusers tend to be rigidly enmeshed, with blurred generational boundaries, and are characterized by an intensely symbiotic mother-child relationship and an emotionally or physically distant father (compare 2.3.1.2). For many such enmeshed families, adolescent substance abuse can become a "solution" that serves simultaneous purposes. For the family, it preserves rigidity and predictability. Substance abuse prolongs dependency, is associated with a decline in libido and achievement drive, and puts the abuser in the sick role (Levine, 1985). He or she need not individuate, thus the equilibrium of the family is maintained.

2.3.1.2 Communication

Stanton, Todd and Associates (1982) found that communication patterns were more rigid in addict families than in non-addict control families. Mothers tended to dominate the verbal flow and fathers were generally unsuccessful in their attempts to join in dyadic conversations. In an impressionistic analysis of addict interactions, Kaufman (1981, as quoted by Levine, 1985) found them

to be dull, lifeless and joyless, except when mobilized to deal with the child's drug abuse, or when fighting. Communication is predominantly negative - blaming, criticizing, correcting, nagging and screaming. Attention can only be gained by creating a crisis. "Good" behaviour is overwhelmingly ignored, whereas "trouble-making" brings an emotional pay-off and serves as an important stimulant or activating function in the family (Reilly, 1984). The homeostasis is thus regained by the patterns of communication. Reilly (1984) gives examples where the adolescent uses negative behaviour as communication in order to get the parents' attention and restore homeostasis. The adolescent may at times "set himself up" to be caught by police and be punished, by leaving evidence of drug use in plain sight, or by open use of drugs in front of police, teachers of other authority figures.

The homeostatic force which controls these patterns of communication in the family is in turn maintained by a set of covert rules (Minuchin, 1974, as quoted by West, Hosie and Zarski, 1987). He also indicates that the boundaries within the family are symbolic of the covert rules. Thus, if the boundaries are not clear, communication is influenced, which in turn influences the homeostasis of the family system. Minuchin (1974, as quoted by West, Hosie and Zarski, 1987) mentions two ways in which the vague boundaries of families may lead to faulty communication patterns:

- Boundaries are diffuse, which represents an over-involved or enmeshed type interaction.

- Boundaries are rigid, which is characterized by a lack of interaction.

Several authors (Friedman, Utada and Morressey, 1987; Madanes, Dukes and Harbin, 1980; Kaufman, 1985; Reilly, 1984) have indicated that these unclear boundaries represent symptoms of family pathology dysfunction and are often found in families with adolescent drug abusers.

The homeostasis in such a family is constantly changing because, as Reilly (1984) noted, there is no consistency in parental rule-making and limit-setting. The parents are not consistent concerning codes of conduct and their enforcement: behaviour which is punished one moment may be ignored, tolerated or rewarded the next. The aim is thus to regain the homeostasis by using communication - verbally or non-verbally - in the family where the homeostasis has been disturbed by faulty patterns of communication.

2.3.1.3 The parental relationship

Drug abuse in an adolescent can also serve other vital family functions. It can help save the parental marriage by distracting troubled parents from marital or personal problems (Reilly, 1984), for example when the parents discover the problem of their drug-addicted child. They disagree about how to handle the problem. The mother may be permissive and sympathetic and the father harsh and authoritarian. The problem of the child's drug abuse diverts them from dealing with their marital problem (Levine, 1985). A related phenomenon occurs when substance abuse serves to pull the father back into the family in order to deal with a crisis related to the adolescent. The adolescent's behaviour prevents the father from over-distancing, and he usually returns to fight with or blame the wife for the adolescent's problem, at the same time putting his foot down with the substance abuser (Swartzmann, 1975, as quoted by Levine, 1985).

Drug abuse can play the key role in regulating marital homeostasis by increasing or decreasing relationship distance and relationship warmth (Reilly, 1984). It can increase affection and bring the spouses closer together or it can push a wedge in between and create more distance, in this way maintaining equilibrium in the family.

2.3.2 MOURNING

Reilly (1984), Stanton (1977) and Coleman and Stanton (1978, as quoted by Levine, 1985) present a dramatic family systems explanation for severe drug abuse. According to these authors, drug abuse is a deliberately acted-out death wish. The family conspires and sacrifices the addict and places him in the position of the unmourned-for ancestor. Levine (1985) points out several facts and observations: addicts have a high death rate; there is a high rate of unexpected premature or traumatic deaths in the families of substance abusers; addiction has often been regarded as the equivalent of suicide; and addicts display a particular fascination with death and related themes.

Reilly (1984) states that parents of drug abusers have themselves sustained serious emotional losses from which they have never fully recovered - death of parents, separations from significant others, rejection by loved ones. Never having completed the task of mourning, their ties to these lost love-objects are frozen in place, thus making it very difficult to transfer their affections to new loved ones such as spouses or children. They avoid the full-blown depression in two ways:

- They attempt to postpone the pain of mourning and deny the feeling of loss by "replacing" the lost loved one with a "stand-in" or "reincarnation". A spouse can be chosen but more typically a child is more easily moulded

into accepting this role assignment (usually the drug abusing child). As long as this child remains at home with the parents, they can feel as if they have never really lost the original love-object he has come to represent. "A sticky nest syndrome results" (Reilly; 1984: 385). The child's striving for autonomy and leaving home triggers immediate sabotage by the family which cannot afford to let him/her go. As Coleman and Stanton (1978, as quoted by Levine, 1985: 81) put it:

> addiction becomes analogous to a slow-dying process and is another example of the way families vest a dying member with special status and view him as symbolic representation of deceased ancestors ... His demise is viewed as sacrificial and noble.

Death is almost the only way that separation between child and parent can take place (Stanton 1977, in Levine, 1985). In this way the parent does not lose the child to others but he/she can have him/her forever.

- The parents deny and avoid their depression by projecting it onto their drug-abusing child. He/she then bears the sadness for them; he becomes their consummate tragedian (Reilly, 1984).

Friesen (1983) adds a third way in which depression is avoided, which is that of unresolved anger towards those in the past who have abandoned or rejected the parents in the family of the drug abuser. This anger is generally repressed and denied, but subconsciously acted out toward the delegated abuser as a form of retribution for the past, as the drug abuser is often a recreated bad object-relationship from the parent's own family of origin. Reilly (1984) states that drug abuse provides a wealth of opportunities for

inappropriate discharge of anger. A young abuser can in a passive-aggressive way spite and rebel against his parents by using drugs; he may be able to embarrass them spectacularly by getting arrested for drug use, possession, or sale. Drug dependency also permits an adolescent to take out his anger against himself in an intrapunitive fashion via a self-defeating and dangerous life style, medical complications, accident proneness, suicidal ideation and behaviour, and overdoses. This allows him to project anger felt towards family members onto outsiders such as the police, dealers, informers, customers, non-abusers, and society in general.

2.3.3 ACHIEVEMENT

Hirsch and Imhof (1975) found that in the families they researched, there were enormous parental expectations for the future drug user or addict. Reilly (1984) found that these expectations subsequently came to play a major role in shaping the child's future. Sometimes too much is expected and love is conditional upon success. This affects the child's life to the following extent:

- the young person in his family constellation is always falling short, re-enacting his own powerless, ineffective, guilt-ridden, depressed family role,

- and the young person will turn to drugs as both a rebellion and an excuse for failure (Hirsch and Imhof, 1975).

These parents are highly orientated to performance as it relates to their own self-esteem and parental pressure. This was felt to be a clinically projected image of themselves growing up in their own homes (Hirsch and Imhof, 1975).

The opposite could also be true. The parents sometimes expect too little (Reilly, 1984). The child is labelled as a failure and he soon learns to accommodate this self-fulfilling prophecy. Drug abuse becomes an integral part of his "never do well" self-image (Reilly, 1984).

2.3.4 SIBLING RELATIONS

There are four common patterns of sibling relations associated with adolescent substance abuse.

In one, the siblings become enmeshed and there may be sibling co-addicts. Here the boundaries are firmly drawn, with the parents over-involved with each other, their own family-of-origin, or personal/professional pursuits, so that the children turn to each other for nurture and engagement (Levine, 1985). Kaufman (1986) refers to these siblings as the "bad" group.

In a second pattern, the generational boundary is breached and an older sibling replaces a parent (often a father) in the triangular relationship with the substance abuser (Levine, 1985). Kaufman (1986) refers to this sibling group as the "good" group and has noted that this older "good" relates to the substance abuser as an authoritarian parent.

In a third pattern the youngest child turns to drug abuse to maintain his/her role as the family baby. This is frequently the child who received the most attention and whose drug abuse keeps him/her from ever abandoning the parental nest. This serves an important function for parents who need to have children around to be over-involved with and/or this prevents them from experiencing strong feelings of emptiness in their relationships with spouses (Kaufman, 1985).

The fourth pattern involves the ecological distribution of roles and statuses in the family. Levine (1985: 7) describes it as follows:

> If one or more siblings have been successful, the substance abuser may avoid competing for similar status, either because all the "good" niches are all occupied or because family maintenance is better served by having him or her be a scapegoat or family problem.

2.3.5 FAMILY CONTACT

The majority of substance abusers maintain close family ties. In 1966 Valiant found that 72% of his sample still lived with their mothers at 22 years: 59% were still living with their mothers or a female blood relative as late as age 30. Valiant (1966, as quoted by Kaufman, 1986) also found that of the 30 abstinent addicts in his follow-up study, all were living independently from their parents. Noone and Reddig (1976) found that of their 323 clients (average age 24,4 years) 72,5% either lived with their families of origin or had done so within the previous year. Goldstein et al. (1977, as quoted by Madanes *et al.*, 1980), reported that addicts usually use their parents' household "as a constant reference point in their lives". In a 1972 survey of 85 addicts it was found that those with living parents, 66% either lived with their parents or saw their mother daily, and 82% saw at least a parent once a week. The average age of these men was 28 years and all had been in the army for at least several months (Madanes, Dukes and Harbin, 1980).

2.3.6 HIERARCHICAL REVERSE

Family subsystems are arranged in a hierarchical fashion, with various members providing direction and support for the family. Most often, support

and direction are provided by the parents (West, Hosie and Zaiski, 1987). Madanes, Dukes and Harbin (1980) found that families of addicts frequently demonstrate a hierarchical reversal (i.e. offspring are equal to or higher in the hierarchy than the parental generation). Hirsch and Imhof (1975) found the addict member in families they studied to be assigned the role of parent - with remarkable consistency the "sick" one is highly protective of parents and siblings, absolving them of any responsibility in the genesis of his addiction. Madanes et al. (1980: 893) comment as follows on the pattern of hierarchical reversal in families with a substance abuser:

> In the families of addicts, the two parental persons and the addict produce hierarchical reversals in which one parental person is placed below the other parental person in the family hierarchy. As a rule, the addict does not place himself above the parental persons when producing hierarchical reversals. The reversal is produced by putting one parental person down in the hierarchy to the level of the offspring ....

This would suggest that the addict is not striving to take control of the family. Concerning the parents, Madanes et al. (1980) say that the parental persons reverse the position of the other parental person in the hierarchy, but never his/her own position. By putting down the other parental person, they seem to be striving for a position of leadership vis-à-vis the other parental person. Further data indicate that both the addicts and the siblings are involved in extreme attachments across generational lines (Madanes *et al.*, 1980).

2.3.7 DRUG EFFECTS

According to Levine (1985) general drugs are associated with effects that can be characterized as intensifiers or "distances". Intensifiers are those substances whose usual psychopharmacological effects are associated with increased motor behaviour, including garrulousness and other forms of social interaction. These substances include amphetamine, cocaine, excessive amounts of caffeine, and the early phase of alcohol ingestion, barbiturates and other central nervous system depressants. Distancers are those substances whose usual psychopharmacological effects are associated with decreased motor behaviour, social withdrawal, absorption into sensory stimuli, drowsiness and eventual loss of consciousness. Such substances include the opiates, most of the effects of alcohol, central nervous depressants, hallucinogens, and sometimes marijuana. It is important to note that marijuana as well as alcohol, the two most widely used substances, have both intensifying and distancing characteristics. L.S.D., mescaline and other hallucinogens, whose effects last 6-18 hours, are often associated with periods of intensification followed by longer periods of distancing.

In families with a substance abuser, intimacy and distance are conflictual issues. The substance abuser is found to use substances to more clearly initiate and demarcate episodes of either closeness or distance. Substance use functions to stabilize, enhance predictability and maintain ongoing patterns of family organization.

In summary then, the following points indicate the connection between drug addiction and family dynamics:

- The maintenance of the family equilibrium.
- Displaced mourning.
- Achievement orientation in the family.
- Sibling relations.
- Family contact which can be enmeshed or rigid.
- Hierarchical reversals.
- Drug effects.

2.4 FAMILY THERAPY WITH SPECIFIC REFERENCE TO INTERGENERATIONAL THERAPY

In the previous section the relationship between drug addiction and family dynamics was indicated. Family therapy is thus strongly advised in the case of drug abuse. Intergenerational family therapy focuses especially on these dynamics and is one of the three schools of family therapy. The other two schools are the structural and the strategic family therapy approaches (Steinglass, 1984 as quoted by Steinglass, 1986).

In the following sections the rationale, and three different styles, those of Bowen, Boscormenyi-Nagy, and Spark and Napier and the implications of intergenerational family therapy will be discussed.

2.4.1 RATIONALE OF INTERGENERATIONAL FAMILY THERAPY

The rationale of intergenerational family therapy, as advocated by Perez (1979) proposes to:

- help family members realize and emotionally appreciate that familial dynamics are intermeshed among all the family members;

- help family members realize that if a family member has problems, these may well be the result of one or more other members' perceptions, expectations and interactions;

- persevere in the therapy until a homeostatic balance has been reached which provides growth and enhancement for each of the members;

- develop full familial appreciation of the impact of the parental relationship upon all family members;

- promote each member's tolerance for frustration when loss, conflict and disappointment are encountered both within and outside the family;

- increase the motivation of each member to support, encourage and enhance each other member; and

- promote the achievement of a parental self-perception which is realistic and congruent with the perceptions of the other family members.

Boszormenyi-Nagy (1974) says the rationale of intergenerational family therapy is that it does not offer an exclusive alliance with any member at the expense of its concern for other members of the same relationship system. Advocacy and the expectation of change are thus extended from one individual or a couple to the entire system of relations in order to create a balance of reciprocity (a dialectical balance of receiving through giving).

Ackerman (Block and Simon, 1982) says mental illness begins and is best conceptualized within the network of family relationships. The family is viewed not just as an external influencing agent, but as the essence of the illness

phenomenon. Ackerman (Block and Simon, 1982) further explains that the main aim of intergenerational family therapy is to intervene in a social group where the members share an identity, a way of life, and the struggle with emotion, and by so doing link the individual to his family environment. Ackerman (Block and Simon, 1982:273) supports this approach when he states:

> It is orientated to the matrix of a sequential series of interdependent, interpenetrating disturbances across time and across the generations.

Ackerman (Block and Simon, 1982) sees family therapy as a method which intervenes directly in the central family relationship processes. Further, the family approach may illuminate multiple levels of disturbed functioning and offer the therapeutic potential of multiple levels of entry. It also imposes crucial responsibility in determining the priorities of using family and other methods of intervention. His only concern is that more consideration should be given to accurate assessment of the effects of interventions on family relationships so that greater control can be exerted.

2.4.2 THE THEORY OF BOWEN

Bowen began his work at Menningers in Topeka, Kansas and at the National Institute of Health in Bethesda, Maryland, outside Washington D.C.. Bowen trained in a psychoanalytic model and began to change to a systems model by exploring the relationships between mothers and their schizophrenic children, in particular to conceptualize the unresolved symbiosis between mother and child. The theory and practice were later extended to emotional

problems less severe than schizophrenia. Bowen came to the conclusion that all symptoms are an expression of a disturbed emotional system (Bowen, 1986).

The Bowen theory involves two main variables (Bowen, 1986):

- the degree of anxiety; and
- the degree of integration of self.

There are several variables related to anxiety or emotional tension. Among these are intensity, duration, and different kinds of anxiety. There are far more variables related to the level of integration of the differentiation of self. This is the main subject of the theory. All organisms are reasonably adaptable to acute anxiety. The organism has built-in mechanisms to deal with short bursts of anxiety. Sustained or chronic anxiety, though, is most useful in determining the differentiation of self. If the level of anxiety is sufficiently low, almost any organism appears normal; and symptom-free. When anxiety increases and remains chronic for a certain period, the organism develops tension, either within itself or in the relationship system, which results in symptoms or dysfunction or sickness.

Bowen developed eight concepts of which the first three (3) apply to the overall characteristics of the family and the other five focus on details within certain areas of the family. These concepts are all in interaction and as such explain the relationship system and its pattern (De Wet, 1985).

2.4.2.1 Concepts of Bowen's theory

- Differentiation of self

This concept is the cornerstone of Bowen's theory. It defines individuals in respect to the degree of fusion or differentiation between the emotional and intellectual functioning (Hansen and L'Abate, 1982). This characteristic is universal and can be used as a way of categorizing all people on a single continuum (Bowen, 1985, as quoted by Bowden, 1986). Differentiation is thus the polar opposite of fusion.

Fusion occurs when an individual intellect is overwhelmed by the emotional system. According to Singleton (1982) fusion can be equated with childishness and emotional immaturity which refers to two aspects: Firstly, the fusion of feeling and thinking, i.e. when objective thinking is overwhelmed by emotionality (The result is then intellectualization or rationalization to justify the acting out of immaturity); and secondly, fusion more commonly indicates the presence or absence of boundaries or the lack of individuality between two or more individuals, as in the concept of symbiosis. This refers to people who 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. "They inherit a high percentage of all human problems" (Bowen, 1985: 362).

Differentiation is the ability to be emotionally controlled while remaining within the emotional intensity of one's family or other emotional system. It is the extent to which one can think objectively about emotionally

sensitive issues (Singleton, 1982). Differentiation would then be the adult or the mature part of the individual's personality. There is thus a relative autonomy between intellectual and emotional systems. In times of stress they are more flexible, more adaptable and less dependent on others and are free of psychopathology.

Bowen (1986) also uses the terms "pseudoself" and "solid self". He sees pseudoself as another label for fusion, in which differences of opinion on important questions create intolerable discomfort and are handled by not telling the other what one really thinks, or by automatically shifting over to the other's point of view or by arguing or debating rights and wrongs. According to Singleton (1982) the pseudoself has a strong inclination to acting or pretending to meet the emotional demands of the interpersonal system for peace and harmony. Bowen (1986) refers to the solid self as the differentiated part of a person in which he/she is clear as to beliefs and convictions about important life issues and goals. These beliefs can be changed as part of a slow internal process of thinking and not in response to the emotional demands to ensure conformity and harmony.

Bowen (1985) explains that when a person is not able to differentiate his emotional and intellectual systems, the person is undifferentiated. If the same happens in a family, it is said to have an undifferentiated family ego mass (Bowen, 1985). Through the concept of differentiation of the self Bowen eliminated the concept of "normal" (Hansen and L'Abate, 1982: 166).

Differentiation has no direct relationship with symptomatology and applies to all human forms of life. The only criticism against this concept is that Bowen never defined the emotional system and the intellectual system.

- Triangles

The concept of triangles evolved from the concept of triads. A triangle according to Bowen (1985), is a three-person-emotional configuration and is the basic building block of the emotional system, whether in the family or any other group. Triangles are formed when fusion occurs between two individuals and this fusion causes tension and anxiety. In order to alleviate this tension and anxiety a third person is temporarily brought into the fusion so that this person can side with one or be against one person in the original relationship. This third person, and the one he/she sides with, fuse until tension and anxiety are created and another third person is involved.

Bowen (1985) indicates that a two-person system may be stable as long as it is calm, but when anxiety increases, it immediately involves the most vulnerable other person to form a triangle. A triangle is thus comprised of a twosome, which is comfortable, and an outsider. In a family the twosome can be the mother and father, and the outsider the child. In times of anxiety the outsider's position is the most desirable and a fusion is formed by one of the twosome and the outsider. According to Singleton (1982) an excessive increase in tension and anxiety will result in the inclusion of a fourth person, which leads to a small network of triangles. The forming of triangles can elaborate to a meta-level where the social syctem is involved in the family system in order to calm the family system. Therapeutically this means that the therapist's greatest task in family therapy is to remain uninvolved in an emotional triangle.

- Nuclear family emotional system

This concept refers to the single generational functioning of the family. Patterns of behaviour between parents and children are re-creations of past generations and will be repeated in following generations. Dating, marriage and reproduction are affected by the two partners' level of differentiation in their respective families of origin. According to Bowen (1985) people pick spouses who have the same level of differentiation. This effectively means that less-differentiated spouses are involved in more emotionally fused marriages, characterized by emotional distancing of one spouse from another, marital conflict, sickness in one spouse and/or projection of the problems onto the children. Hansen and L'Abate (1982) see the nuclear family emotional system as a description of how the tension created by the lack of differentiation is dissipated or distributed within the family so that triangles are formed as a means of reducing this tension.

- Family Projection Process

This is the process through which parental undifferentiation is projected onto the children and it operates within the father-mother-child triangle. The process is universally present in all families to some degree (Bowen, 1985). Hansen and L'Abate (1982) describe the process as starting with anxiety in the mother, to which the child similarly responds with anxiety. The mother then interprets this child's anxiety as being the problem. To continue, they say that the mother may become over-protective or solicitous, gradually establishing a pattern of infantilizing the child. The father usually plays a supportive role in the projection process. He is sensitive to the mother's anxieties and he tends to support her views and

help her implement her anxious efforts at mothering. The process thus has the maternal instinct as its basis (Bowen, 1985).

Stressful or anxious periods during childhood may cause symptomatic episodes. If these periods become sufficiently intense they can result in the child becoming psychotic, especially when the child wants his/her own independence and/or moves away from the parents. The hypothesis is that schizophrenia is the result of several generations of increasing symptomatic impairment, with lower and lower levels of differentiation.

- Emotional cut-off

After having existed as a poorly defined extension of other concepts for several years, this concept was coined by Bowen (Bowen, 1985). Singleton (1982) and Bowen (1985) state that everyone has some degree of unresolved emotional attachment to the previous generation, especially the parents. This concept works on the principle that the lower the level of differentiation the greater the degree of unresolved dependency. The unresolved attachment consists of those parts of the fusion which have not been handled through orderly differentiation. The cut-off consists of denial and isolation of the problem (De Wet, 1985).

The cut-off can happen while they are still living close to the parents or by physically running away, or a combination of both. According to Singleton (1982), whatever the pattern is, the person yearns for emotional closeness yet is allergic to it. Bowen (1985) explains that persons who run away from home and those who stay within the family both have dependencies which, if not met, can be manifested in psychic or somatic symptoms. Those that

stay use intrapsychic mechanisms and develop more internalized symptoms under stress such as psychical illness and depression. Those who run away are more inclined to impulsive behaviour and inability to ever reach a complete level of differentiation. The person is thus not completely in control of his emotional system.

- Multigenerational transmission process

The preceding concepts describe the specifics of the process by which levels of functioning, strengths and weaknesses and family patterns are passed down from generation to generation. The Multigenerational Transmission Process describes the functioning of the family projecting process through multiple generations.

In most families, the degree of triangulation of each child with the parents will vary somewhat. The more intense such a triangle, the more the child ends up with a lower level of differentiation than the parents and does less well in life (Singleton, 1982). Bowen (1985) elaborates on this and says that children who are minimally involved with the parents emerge with about the same level of differentiation as the parents. Those who grow up relatively outside the family emotional process develop better levels of differentiation than the parents. There is thus either an up or down movement of the level of differentiation through this process. If one, for instance, follows the child with a lower differentiation through successive generations, one will see a line of descent producing individuals with increasingly lower levels of differentiation. This process might go rapidly for a few generations, then remain static for a generation and then speed up again. Eventually the process produces an individual so deficient in

differentiation that he or she must be maintained in dependent relationships or express severe symptomatology.

Singleton (1982) is of the opinion that in one family system at any given time there can be and usually is both an ascending and a descending scale of functioning. This would depend on the amount of stress between the parents. Bowen (1985) explains that a family that is on a high level of functioning always has the chance of a child moving downward on the scale of functioning and, in turn, a family that is on a low level of functioning can have a child moving upward on the scale of functioning.

- Sibling positions

This concept is based on the work of Walter Toman, who has described 10 basic sibling profiles. According to Bowen (1985) Toman provided a new dimension toward understanding how a particular child is chosen as the object of the family projection process. The degree to which a personality profile adheres to what could be termed "normal", provides a way to understand the level of differentiation and the direction of the projection process from generation to generation. An example is when the oldest child turns out to be more like a youngest. This serves as strong evidence that he was the most triangled child. One is then able to make predictions based on these sibling positions and Bowen (1985: 385) concludes that:

> ...no single piece of data is more important than knowing the sibling positions of people in the present and past generations.

- Societal regression

This concept proceeds in logical steps from the family, through increasingly larger social groups, to the total society. The societal concept postulates that the same processes in the family also evolve in society. Bowen (1985) says that people are living in a time where chronic societal anxiety is increasing, and that they respond to this in an emotional way. They make emotional decisions in order to decrease the anxiety. These emotional decisions result in symptoms of dysfunction which restart the whole process again, in turn increasing rather than decreasing the problem.

According to Bowen (1985) within society, as within the family, a cycle keeps repeating itself, going from where the intellectual system is used to where the emotional system is used.

2.4.2.2 Therapeutic goals

The basic goal of therapy is to assist each patient towards a better level of differentiation of self, which would mean that the patient is emotionally controlled within the family system. Bowen (Singleton, 1982) sees the therapist as an individual who is interested but neutral, thus calm and objective. The therapist must be independent from the emotional system in the family, so much so that dependence on the therapist is discouraged. These statements make therapy sound simplistic and easy, but this all has to be understood in terms of the previously described eight concepts (Singleton, 1982).

Therapy, according to Bowen (1985), proceeds in two stages, an evaluation stage and a stage where the family of origin is directly engaged.

2.4.2.2.1 Evaluation stage

This stage consists of two parts:

- the gathering of information: and
- teaching.

- The gathering of information

History-taking is imperative in this theory. The understanding of how a family works or where it fails is obtained through prolonged, painstaking history-taking. This is then transferred to the family genogram. All the details of past family happenings, attitudes, personalities, habits, deaths, traumas, separations and divorces are diagrammatically traced through the shorthand of genogram-making. In this way one is able to determine the behaviour patterns of this generation and generations before them and how they deal and have dealt with anxiety. One gathers information in such a way that one has clarity on all the concepts in this family (triangle, emotional cut-off, etc.). A genogram becomes the continuous basis of referral and reference to understanding the family, and how the symptom has developed over a period of time (Hansen and L'Abate, 1982).

Hansen and L'Abate (1982: 171) see diagnosis also as a part of gathering information:

> Diagnosis is related to an understanding of the degree of anxiety and dysfunctionality in the system.

The degree of dysfunction is indicated by the psychiatric level pinned on the identified patient. Psychiatric terminology is used freely.

- Teaching

  According to L'Abate and McHenry (1983), this part is aimed at giving a basic overview of Bowenian theory to engage the thinking system. The individual is made aware of triangles, patterns and toxic issues in the family of origin, so that he/she can become more objective about his/her own self. This increases the individual's sense of flexibility of choices and range of behaviours which are not instinctively present in the emotional system.

  Teaching is often presented through dialectical lecture, or as examples of experience (Singleton, 1982).

2.4.2.2.2 A stage where the family of origin is directly engaged

The aim of this phase is to change the relational patterns which currently exist in the family and promote basic differentiation. During this stage, when one person begins to function more independently, the system will react characteristically and become unstable and react in what Boszormenyi-Nagy and Spark (as quoted by L'Abate and McHenry, 1983) term the togetherness - preserving moves. These moves create anxiety and cause the member to think emotionally and not rationally. It is then the job of the therapist to predict these events so that this member can anticipate this and respond rationally. Hall (1981, as quoted by L'Abate and McHenry, 1983) makes the statement that tension can promote differentiation because rigid patterns are unbalanced and no longer operable. Differentiation is thus made easier when the member is

objective and keeps an emotional distance when reacting to other members of his/her extended family.

Bowenian therapy is not directly focused on symptom relief. The focus falls on the past and how the past affects the functioning of the family. This information is used to motivate members to strive for a higher level of differentiation.

2.4.3 THE THEORY OF BOSZORMENYI-NAGY AND SPARK

Family system theorists have long been aware of the nature of interlocking physical, emotional and existential bonds between nuclear and extended family members. Bowen (1986) focusses on the differentiation of self in the marital, parental and extended family relationships to get out of the amorphous "we-ness" of the intense, undifferentiated, family ego mass. Boszormenyi-Nagy and Spark (1973) introduce a dialectical perspective on family theory that revolves around concepts of loyalty, justice and the balance of merits. These concepts include but go beyond the individual and his unmet dependency needs (Spark, 1974).

A discussion of Boszormenyi-Nagy and Spark's (1973) theory, divided into five parts, follows. Firstly, the dialectical theory of relationship, secondly, obligations, thirdly, loyalty, fourthly, the children in the inner world of the family and fifthly intergenerational family therapy techniques.

2.4.3.1 Dialectical theory of relationships

2.4.3.1.1 The dialectical theory

Boszormenyi-Nagy and Spark (1973) propose that the understanding of the structure of a relational world requires a dialecticalal rather than a monolithic way of thinking. According to dialecticalal thought, a positive concept is always viewed in contrast with its opposite, in the hope that their joint consideration will yield a resolution through a more thorough and productive understanding (resolution). According to the dialectical law, movement in one direction causes pull and eventual movement in the opposite direction

> dialecticalal resolution is never a bland, gray compromise between black and white, it is living with live opposites (Boszormenyi-Nagy and Spark, 1973: 19).

Boszormenyi-Nagy and Spark (1973) thus say that the dialectical law anticipates life's basic unpredictabilities to introduce challenges to any equilibrium. The qualitatively new event will upset the whole principle of equilibrium, instead of simply moving its balance from one homeostatic phase to another. By adding a necessary new component, the imbalance that exists now will lead to a new balance later. The false and mundane are valuable as they dispel stagnation. Injury and unfairness, which lead to imbalances, are again balanced through restitution. The spontaneity of autonomous motions of individual members creates new imbalance and new injustice which, if recognized and faced, lead to richer, safer definitions of freedom and concern among other members. The prevalence of movement over stagnation is the essence of a dialecticalal view of family relations.

According to Boszormenyi-Nagy and Spark (1973) the deepest human understructure of relationships consists of a hierarchy of obligations. There is a constant give-and-take of expectation between each individual and the relationship system he/she belongs to. We thus constantly oscillate between posing and discharging obligations. The balance between obligations and fulfilment of obligations constitutes the justice of the human world. A variety of everyday human and clinical situations can illustrate the relational dynamics based on dialectical reasoning, such as the conflict between overt and covert expectations and the antithetical relationship between individuation and family dynamics.

2.4.3.1.2 Relational boundaries

One of the most important aspects of the relational dialectical pertains to the concept of intergroup boundary between us and them. Ontologically "they" creates "us" as a meaningful and purposeful entity. We may wish them to leave, to get out of our way, but without them we lose purpose and meaning. In other words we might resent them, but we need them. The internal identity of the in-group is inseparably connected to the boundary of otherness towards the out-group (Boszormenyi-Nagy and Spark, 1973).

Family life has to obtain mastery of subgroup antithesis rather than hope for an absolute. In family life the differentiation, individuation and ultimately the separation of children, adolescents and young adults create the meaning of parenthood.

Psychologically, one could conceive the boundary that separates the in-group from the out-group, according to Boszormenyi-Nagy and Spark (1973), as:

- cognitive: knowing that we are different;
- effective: feeling that "we" belong together as separate from "them"; and
- by nature of action: assessing what "we" do for "them" and what "they" do for "us".

Boszormenyi-Nagy and Spark (1973) are concerned with loyalty and with the justice of the human order, and stress the third, the factual give-and-take aspect of boundary. This refers to the way parents give to their children, and receive from their children - in this way the gap of generations is both maintained and bridged by actions and attitudes.

The balance of intergenerational attitudes constitutes an important criterion of family health. Ideally, parents should be comfortable in accepting their children's dependency. They should be comfortable in accepting the child's need for nurture, guidance, and correction. Sometimes the parents feel exhausted, depleted and exploited and at such times the parent may unwittingly ask the child for trust, support and reward. Usually the child is able and happy to repay the parent for the care and support received. Boszormenyi-Nagy and Spark (1973) refer to this phenomenon as parentification. On a temporary level parentification of a child is a normal part of family life and a vehicle for the child's learning how to be responsible.

Vicariously fixed, compliant role performance among family members constitutes a family system which blocks and postpones rather than resolves old accounts. An example is when parentification takes place and there is a reversal in positions that becomes a rule and not just the exception. The child is overburdened with demands for responsibility and he/she becomes a spe-

cialist in dealing with infantile adults while becoming developmentally depleted as a child in his/her own right (Boszormenyi-Nagy and Spark, 1973).

Adolescence exemplifies the dialecticalal contra-position of the generational differential (Boszormenyi-Nagy and Spark, 1973). The adolescent is both childish and adult-like, he/she is neither child nor adult. Through the experience of being on the child side of the adult-child differential, the adolescent gradually learns how to be on the adult side of the boundary toward someone in a position junior to him/her.

2.4.3.2 Obligations

An obligation is defined by the Oxford English Dictionary (1989: 647-648) as:

> The fact or condition of being indebted to a person for a benefit or service received; a debt of gratitude.

Boszormenyi-Nagy and Spark (1973) consider the deepest human understructure of relationships to consist of a hierarchy of obligations.

The dynamics of loyalty and obligations of family systems include, but supersede, the dynamics and functioning of an individual. Inherent in all close and meaningful relationships are the fundamental elements of giving and receiving; of being treated fairly or unjustly; of taking without repaying; or receiving with no possible way of giving back. Martyrdom or over-giving and permissiveness, scapegoating and parentification, are illustrations of non-balancing or non-mutual reciprocity within relationships (Boszormenyi-Nagy and Spark, 1973).

The roots of a child's obligation to his family that raised him may not always be easy to trace and may go back several generations and lie beyond the knowledge of those living. However, there is no doubt about an underlying obligation framework which binds a family together. The larger the extended family, the wider the range of possible emotional benefits for the members, but also the larger the scope of the hierarchy of obligations (Boszormenyi-Nagy and Spark, 1973).

Detailed records of the subjective justice of the human world are more closely kept, and linger for a longer time in the invisible patterning of family relationships than in any other group, probably because families are concerned with the production of offspring. This is a reversible act, a long-term goal, with far greater ethical consequences than any other individual human function. The child's individual accounting of obligations colours his experience, feelings, thoughts and wishes. They are retained in his memory and symbolically elaborated in his conscious and unconscious thought processes. The negative outcome of the accounting of obligations, or denied or minimized repairment is the emergence of guilt feelings. A positive outcome results in a sense of trust (Boszormenyi-Nagy and Spark, 1973). A sense of trust can be achieved within the family if it has a relatively comprehensible rules system and criteria for obligations and permissible individual autonomy.

An imbalance concerning the equity of merits (obligations), or exchange of benefits between two or more partners in relationships, registers subjectively as an exploitation by the other. Such relationships according to Boszormenyi-Nagy and Spark (1973) stimulate feelings of guilt and perpetual indebtedness. They produce immense feelings of despair because it is then felt that family accounts can never be settled, neither through emotional interest and concern

nor by concrete action. Survival can only be maintained by finding substitute ways for repaying benefits received from the parent. Acts of rebellion or escape through separation never fully resolve a child's predicament. These, Boszormenyi-Nagy and Spark (1973) point out, lead to even deeper guilt-burdened obligations. This guilt-bound, loyalty-trapped child, owes the parent:

- the symptom, e.g. drug addiction;
- no change, e.g. remaining an addict: and
- no mixing with outsiders.

In summary, Boszormenyi-Nagy and Spark (1973) indicate that the repairing and repaying of obligations resolves itself in the dialectical of normal parenting and through this the parent, as well as the child, is motivated by the entire family network of obligations.

2.4.3.3 Loyalty

2.4.3.3.1 The nature of loyalty

The concept of loyalty is an important one for the understanding of family relationships. It can have many meanings, ranging from an individual, psychological sense of loyalty, to national and societal codes of civic allegiance. Etymologically the word loyalty points to the French root "loi" or law and thus implies law-abiding attitudes (Boszormenyi-Nagy and Spark, 1973). The Reader's Digest Dictionary (1987: 912) defines loyalty as:

> Feelings of devoted attachment, affection, or duty.

Boszormenyi-Nagy and Spark (1973) see a group as members who have a shared loyalty to the principles and symbolic definitions of this group. Examples of groups with shared loyalty are, for instance, national loyalty which is based on cultural identity definition, common territory and shared history; and the biological existential basis of family loyalty consisting of bonds of consanguinity and marriage. Members are loyal, but in order for them to be so they must internalize the spirit of the group's expectations, so that the member can be subjected to both internal expectations and internalized obligations.

Loyalty commitments are like invisible, but strong fibres which hold together complex pieces of a relationship in families and in the larger society. Each person maintains a bookkeeping of his perceptions of the balance of the past, present and the future. Boszormenyi-Nagy and Spark (1973: 39-40) make the following comments in this respect:

> What has been "invested" into the system through availability and what has been withdrawn in the form of support received or one's exploitative use of others remains written into the invisible accounts of obligation.

Ultimately loyalty in a family will depend on each individual's position within the justice of his/her human world, which in turn constitutes a part of the intergenerational family accounts of merits.

Origins of loyalty go back to various sources. According to Boszormenyi-Nagy and Spark (1973) loyalty-structuring is determined by the history of the group, the justice of its human order and its myths. Each individual's extent of

obligation and his style of compliance is co-determined by the particular member's emotional set and by his merit position in the multiperson system. Its origins are typically dialectical in nature and usually connected with the raising and training of children. The adult is eager to impart his own normative value-orientation to his child. The parent becomes the creditor while the child becomes the debtor. The child will eventually have to settle his debt in the intergenerational feedback system by internalizing the expected commitments and by transmitting them to his own offspring. Each repayment of reciprocal obligation will raise the level of loyalty and trust within the relationship (Boszormenyi-Nagy and Spark, 1973; Spark, 1977). In families the most fundamental loyalty commitment pertains to the maintenance of the group itself. The more rigidly the child is tied to his parents with invisible loyalty commitments the more difficult it will be for him to leave the family and start new relationships (Boszormenyi-Nagy and Spark, 1973).

Loyalty conflict is intrinsic to any family life. All individual assertiveness is a challenge to the shared family loyalty. New responsible peer engagements of marriage often cause more conflicting loyalties. Boszormenyi-Nagy and Spark (1973) postulate that marital conflict is often due to unresolved loyalty towards the spouse's family of origin and his/her loyalty to the nuclear family.

Reliable ways of measuring the extent of loyalty commitments do not exist due to a lack of understanding of its main dimensions (Boszormenyi-Nagy and Spark, 1973).

2.4.3.3.2 Types of loyalty

Boszormenyi-Nagy and Spark (1973) distinguish six different types of loyalty.

- Original loyalty

  Unresolved loyalties to the family of origin are termed original loyalty and these have to be overcome in marriage. This is also called primary loyalty.

- Invisible loyalty

  These are loyalty commitments or obligations which have been denied.

- Horizontal loyalty

  These are loyalty commitments or obligations which are owed to one's mate, sibling or peers in general.

- Vertical loyalty

  Vertical loyalty commitments are owed to either a previous or subsequent generation

- Negative loyalty

  This is loyalty that is based on negative acts. An example would be a witch or traitor (in the family). This traitor can only relate to his family of origin through being a bad object. The dialogue will lack positive exchanges, and even negative exchanges will take the form of omissions rather than commissions.

- Split loyalty

  This is rejection of one person simultaneous to devotion to another. This can be the cause of great psychic pain and a frequent cause of intense jealously, for example a mother may hurt her child by showing devotion toward strangers in the child's presence.

2.4.3.3.3 Intergenerational structuring of loyalty conflicts

Boszormenyi-Nagy and Spark (1973) indicate that as generation follows generation, vertical loyalty commitments keep conflicting with horizontal ones. The establishment of new relationships, especially through marriage and the birth of children, raises the necessity for new loyalty commitments. The more rigid the original loyalty system, the more severe the challenge for the individual. All members face new demands for adjustment. Adjustment, according to Boszormenyi-Nagy, does not mean a final resolution, a closing of a previous phase, but a continuing tension to rebalance old but surviving expectations with new ones.

Boszormenyi-Nagy and Spark (1973) see instances of developmentally required transitions of loyalty as linked to the following expectations:

- Young parents have to shift their loyalty from their families of origin towards each other.
- They owe a redefined loyalty to their families of origin.
- They owe loyalty to the children born out of their relationship.
- Children owe a redefined loyalty to the parents and the older generation.
- Siblings owe loyalty to one another.
- Blood-related family members owe avoidance of sexual relations among themselves, while nevertheless relating affectionately to one another.

- Fathers owe support to their nuclear families while continuing to owe support to their ageing or incapacitated parents and relatives.

- Mothers owe homemaking and child-rearing care to their nuclear families but are expected to be available to their family of origin as well.

- Family members owe a solidarity in how they behave towards friends and strangers, but they also owe good citizenship to society.

- All members owe loyalty to the maintaining of the entire family system, but they should be prepared to accommodate new relationships and consequent changes to the system.

Loyalty, a key concept in this theory, has been described as a motivational determinant which has self-other dialecticalal and multipersonal, rather than individual, roots. The invisible loyalty consists of consanguinity, maintenance of biological life and family lineage on the one hand and earned merit among members on the other (Boszormenyi-Nagy and Spark, 1973).

2.4.3.4 Children and the inner world of the family

What is being learned and developed in the early phases of childhood in the relationship between parents and children is a capacity for mutual trust and loyalty commitments based on the laws of reciprocity and fairness. The child needs a life space of his own, to play and to learn, to get permitted to be a child. In a healthier family, coexistent loyalty to one's family of origin and one's nuclear family is more aptly balanced. Three levels of need exist and must be balanced; firstly that of the ageing parents; secondly, that of the self and the marital partner; and finally, those of young children. In pathogenic family

systems, excessive psychic loyalty to one's family of origin is unconsciously maintained, at great cost to the marital partner and to the children (Boszormenyi-Nagy and Spark, 1973).

Boszormenyi-Nagy and Spark (1973) explain that adults who have not adequately worked through their emotional separation and guilt feelings may remain unconsciously overcommitted and loyal to their families of origin. Their children may then be used as substitute objects of gratification for the parents' unmet dependency, aggressive or sexual needs. The parents may even attempt to pay off their indebtedness to their own parents by martyr-like, guilt-producing giving to their children. These children are not permitted to be children, to pursue and gain mastery over their interests and work. They are overburdened with adult-like attitudes, which interfere with and disrupt their growth. The result of this imbalance, as indicated by Boszormenyi-Nagy and Spark (1973), is children with depression, learning and behavioral difficulties, psychosomatic illness, accident proneness, suicide and battering. The child is in a complex dilemma: he is unable to be a child because he must repress or deny his own needs. He must try to postpone his own course of growth and development. His loyal attempts to meet his parents' needs are met with ambivalent responses because he cannot totally replace the grandparent and undo the original injustices done to the young parents. However, unless the parents' needs are met, they are emotionally unavailable to their children (Boszormenyi-Nagy and Spark, 1973).

In pathogenic families, one or both adults and all the children are assigned and assume inappropriate generational and sexual roles and stereotyped characteristics (Boszormenyi-Nagy and Spark, 1973). These will be discussed below.

2.4.3.4.1 Parentified children: the family worrier

Children are increasingly loyal and will assign themselves as physical and psychological guardians to one or both parents if they sense insatiable, unmet needs for comforting. These are parentified children.

An example is a young daughter that cannot attend school since she accepts overburdening emotional responsibility as well as the physical care of siblings because of the mother's underlying depression and the father's emotional unavailability. The mother's continuous hypochondriacal complaints keep the children in a constant state of anxiety. Their hyperactivity and tenseness are a reaction to her complaints of pains and illness and fears about dying. Eventually, such a mother manages to ensure that at least one if not all of the children never leave her alone.

2.4.3.4.2 Aaggressive or scapegoated children

This is when one or more children in a family are described as uncontrollable aggressors who cannot be managed by their parents. Often they come into conflict first with the school authorities, and then the law. Their behaviour within the family may or may not cause overt difficulties. The essential cause of such behaviour is found in the underlying conflicts and tensions within the family system and is an absolute indication of family exploitation.

2.4.3.4.3 Children as sexualized partners

Another form of the "bad" child role is enacted by children through delinquent sexual behaviour within or outside the family. Seductive, incestuouslike relationships or overt incest is frequently found in severely disturbed families.

Children of the same or opposite sex are used as a substitute for a marital partner. In many instances, sexual relations between the marital pair occur infrequently or have discontinued altogether. When incest occurs in a family it indicates the lack of generational and ego boundaries in all members. In such instances, a child is not perceived as a child, but as an object, to be used and exploited for dependent and retaliatory motivations and for narcissistic self-gratification. The child accepts such a role because of an unconscious, collusive loyalty expectation. To act otherwise might result in psychological loss or non-survival of one or both parents.

2.4.3.4.4 The family "pet" child

Another category of family role assignment is one in which families describe a child as perfect or ideal. The pet is described as the carefree or non-symptomatic child, as he/she causes no overt trouble. These children may act clown-like, do silly annoying things, or tease, but it is never done with serious intent to hurt or make anyone angry. They are rarely taken seriously. It is as if these children exist to bring the family lightness and laughter. This child's goodness is often used as an example/model against the siblings who express hostile feelings. This child is rarely brought for treatment. In reality there is no real position for him in the family, he is in a sense a non-person, and his sense of worth or importance is very minimal. His needs and inner feelings are negated, denied, minimized and disconfirmed. His underlying self-esteem is poor, and he constantly yearns for a place within the family. These children's social life capacity may be minimal. The pet child may later move into the role of parentified child as an older sibling leaves the home. The result is sadness and depression in the child.

Each of these roles seems also to have definite functions in the family (Boszormenyi-Nagy and Spark, 1973).

- Children as referees or judges

  Children in the family are used by parents to referee their fights, to take sides or to stop fights.

- Lack of sexual identity: Seduction of children

  If the parents' sexual relationship is problematic, one or all children are forced into the role of a sexualized child, causing confusion for parents and children about their own sexual identity.

- Depression in children and parents

  This is when children are forced into the parentified role and they experience feelings of depression for they carry the burdens and worries of their parents, because of the parents' depression.

- Homicidal and suicidal threats to parents and children

  Homicide or suicide reveals the individual's extreme despair, loss of ego boundaries, lack of control and feelings of worthlessness, regarding the self and significant objects. This highlights a seriously unbalanced state of justice and obligations in family relationships. These threats can create guilt feelings and an atmosphere of terror for all family members.

- The enemy-ally syndrome

  These children are used as mediators or family rescuers, in order to prevent homicide, suicide or fights between parents.

- Children as captive objects

  Some marital pairs form such a fused or symbiotic relationship, speaking and acting for each other, that they create an emotionally tight island as far as the children are concerned. The parental relationship appears "insulated" and the children's emotional demands and needs are experienced as an "intrusion". Through their loyalty children remain in a captive state - becoming more and more demanding of recognition.

- Children as sacrificial objects

  The parents of these children are caught in a negative loyalty bind, experiencing a lack of trust and love from their families of origin, and are unable to transfer sufficient trust and loyalty to the marital partner. The child is then used as a sacrificial object. The child is then made to carry the badness so that the parents can now see the good in themselves and love themselves as they wished to be loved.

2.4.3.5 Intergenerational family therapy techniques

According to Spark (1974 and 1977) the reason for intergenerational family therapy is that this therapy can lead to the working through of unfinished business between parents and grandparents, also between siblings, and consequently create structural as well as symptomatic change in the family system. Spark (1974 and 1977) sets out the techniques used as follows:

- When it becomes evident to the young adults in the course of family treatment that the relationship with one or both families of origin needs exploitation and improvement, the grandparents can become an active and immediate part of the treatment process, whether physically present or not.

The choice as to whether the grandparents do or do not attend sessions is left to the parent and grandparent

- After working through much anxiety, fear and other resistances some families do eventually bring grandparents into the sessions, while others refuse even to extend an invitation.

- Spark also believes that improvement can occur even if the grandparents are not present at the session, although direct inclusion in sessions provides in vivo learning for the family members.

- The family therapist must help the parents convey to the grandparents that the purpose is not to use either generation as a destructive target for the other's hurt, disappointment and angry feelings.

  It should always be made clear that the family is free to arrive for any session in any combination of persons.

- In parent-grandparent sessions there is usually a polite, but tense phase initially. This usually consists of:

  - The therapist explaining the reason and rationale of the session; and

  - the establishing of rapport.

- Following this phase is a phase where there may be some degree of disappointment, bitter recrimination about past injustices and a seeming impasse may ensue. In some cases a defensive protectiveness blocks meaningful exchanges. The intention is to move out of the "blame

syndrome" to a deeper level of reciprocal discussion between the generations.

- The therapist encourages the grandparents to share information about their lives.

- The information that is shared usually has a painful effect attached to it, but this is often a moving experience for both generations.

This therapeutic process as Spark (1974 and 1977) indicates, enables a new phase of identification to begin between the generations and may replace old, deprived or distorted aspects of their relationship.

2.4.4 THE THEORY OF NAPIER

Augustus Napier started as many therapists start, doing individual psychotherapy. Through experience, Napier discovered the power of the family system, which was capable of totally exceeding individual work. This was evident when after seeing a patient "recover" he would witness all the progress undermined by the family; or would treat a scapegoat child "successfully", only to find another child in the family dragged into the role. He found this learning process about the family system powerful and painful (Napier and Whitaker, 1978).

Every family is a miniature society, a social order with its own rules, structure, leadership, language, style of living and "Zeitgeist". Its organizational pattern has been established over many years of living together and the roots of its present experiences go deep into the unique link with history (Napier and

Whitaker, 1978). This organization is unique, meaningful and irreplaceable for the family, and its establishment over the years is very painful.

This organizing starts with an individual's choice of marital partner, which is the most important choice, as the marital choice represents an attempt at growth (Napier, 1978, as quoted by Napier and Whitaker, 1978). This is an attempt to add new information to the models in the separate families of origin and an attempt to disrupt the patterns in each family. The author maintains that individuals, in choosing a partner, take unconscious account of very complex trends in their own and in their prospective partner's family of origin. The effort at growth is usually accompanied by a great deal of conflict. Napier (Napier and Whitaker, 1978) further assumes that this determination and desire to expand, integrate and grow, is universal and that the family which enters psychotherapy is one in which this natural process has become blocked.

Napier (Napier and Whitaker, 1978) identifies six patterns of behaviour that are characteristic of families. These patterns are all interrelated and can be evidenced in the way they relate to one another, the way they sit, the way they talk to each other, their tones of voice and the assumptions they hold about life.

2.4.4.1 Behaviour patterns of families

Napier (Napier and Whitaker, 1978) distinguishes the following six patterns:

- Stress

  Napier (1978) points out that all families have to live with stress, but those families which come for treatment have much more than their share. The

stress in these families is often evidenced in their tense posture, the vigilant defences which are maintained, the faces which are worn and tired and the voices which lack energy and are discouraged. Napier defines several general categories of stress (Napier and Whitaker, 1978).

Firstly, the normal wear and tear of everyday living. These are the normal day-to-day stress events like going to a stressful job, worrying about the mortgage or pulling a muscle when straining to lift a sofa. Secondly, there is acute situational stresses. These are predictable crises experienced by everyone at specific times in life. A serious illness, a job change, a move to a new city, the death of a family member - all involve coping with a life suddenly altered by new circumstances. Thirdly, there is interpersonal stress. This involves conflict and disunity between people who are normally expected to co-operate with one another. Rather than cope with life's innumerable practical problems and minor emergencies, people often make war with friends, fellow employees and family. The schisms within the family can be the most complex and mysterious because they are often related to events that took place in previous generations, the emotional residues of these events being passed down as part of the family's heritage. It may seem strange to think that a family's sense of identity may be tied to maintaining certain patterns of conflict, but just as children learn values and facts from their parents, they can also learn emotional patterns of conflict. Fourthly, there is intrapersonal stress. This is the person's war with himself. Conflict within the individual does not begin there, it is the product of external pressure which the person internalizes.

Family relationships are so crucial and are often so threatened that solving the schisms, especially on an interpersonal level, has the highest immediate priority (Napier and Whitaker, 1978).

- The positive feedback spiral

Napier (1978, in Napier and Whitaker, 1978) says that any system has a degree of stability and balance, a homeostatic level which is the family's usual pattern. The system needs information on how it is doing in maintaining that pattern or balance. This, Napier (Napier and Whitaker, 1978) says is done by using positive and negative feedback.

The positive feedback spiral occurs when only positive feedback is received. Interludes where there is a balance in the system are very rare. The stress becomes more and more polarised and escalates to a level where the whole system is threatened (Napier and Whitaker, 1978).

- Triangulation

This is based on what Jay Haley has called the basic problem in emotional disturbance: the triangle. In almost every instance of "symptomatic" behaviour, Haley finds a simple, sad, but common story. He finds that two parents are emotionally estranged from each other, and in their terrible isolation they over-involve their children in their emotional distress (Napier and Whitaker, 1978). Napier (1978, as quoted by Napier and Whitaker, 1978), concludes that the identified patient - the child - is the victim of the family stress. The parents use this child as a family scapegoat or a whipping boy. The child agrees to suffer openly the stress of the entire family, in order to keep the family stable. According to Napier (1978, as

quoted by Napier and Whitaker, 1978), the parents of these children are simply too frightened to face each other, as they cannot cope with the implications of an open war between themselves, manifested for example, in divorce. These children then grow up disturbed and repeat the same pattern in their own families. This has also been described by Bowen as his second concept - Triangles (see 2.4.2).

- Blaming

An integral part of the family agony is its fascination with finding someone to blame. Blaming, as Napier (1971) explains, is a very powerful process, the members not only hurling accusations at someone else, but defending themselves in turn. Each feels powerless, victimized, the one person sees the other as the one in power, the one who controls his fate. Each reveals an intense awareness of the other person, but a profound lack of awareness of the self. They are not aware of their own feelings, nor do they recognize their own potential for action and change. They find it hard to talk about themselves, and they can't even consider the possibility that they themselves can be different. They always see the other person. It is that person they can talk about and it is he who must change.

The importance of blaming is made clear in the following explanation given by Napier (Napier and Whitaker, 1978: 86):

> We are talking about much more than a perceptual problem based on misunderstanding, however the trouble is far more serious. Perception of the other is rooted in experience of self, and the limitations the family members have in seeing one another as truly

human are really limitations in self-experience. We can't teach people intellectually to see one another differently. First, they must experience themselves differently.

- Diffusion of identity

The problem family is likely to have a tense, difficult kind of relatedness in which no one member is free to be autonomous and independent. Napier and Whitaker (1978) describe it as a family-wide symbiosis which inhibits the individuality of every member. The family's spontaneity, its creativity, its very liveliness is compromised again and again in the interest of pleasing one another and keeping the peace.

In such families you don't have separate persons, there is a conglomerate person, the family. Instead of the members controlling the family, they are rigidly controlled by their roles within the family system. The family rules them with a steel hand. This symbiotic togetherness which Napier (1978) comments on, is probably a response to stress, but this symbiotic togetherness also creates a stress of its own as it threatens the individuality and autonomy of the family members. Bowen (c.f. 2.4.2) refers to this symbiotic togetherness as "stuck togetherness" or fusion. This loss of identity creates fear and conflict, and is one way of developing dependence on the family (Napier and Whitaker, 1978).

The conflict escalates and by the time the family enters treatment every one of its members is usually crying out about being intimidated by someone. The family members are not intimidated so much by each other as individuals, as by their mutual need for each other. It is the relationship

that intimidates them. It is the family itself from which they beg freedom. The solution does not simply lie in attaining freedom from the family with its false unity. The members usually experience a frustrating combination of personal isolation and claustrophobic restrictiveness. They do not enjoy either the freedom of genuine separateness or the exhilaration of real intimacy:

> They suffer a seemingly unending purgatory of solitary imprisonment in a family that they love but cannot fully enjoy. (Napier and Whitaker, 1978).

- Stasis

The family members have a great fear of losing one another, but there is a greater fear than that - the fear of immobility and stasis, which is really the fear of death. The consciousness of death is a crucial family dynamic (Napier and Whitaker, 1978).

An example is a couple who have moved further and further away from each other as time has passed. Yet their emotional feelings are not distant, they are closer - as with every passing year their investment in each other is greater and their total feeling about each other becomes more intense. Napier (1978, as quoted by Napier and Whitaker, 1978) explains that this is a fault in the model of intimacy learned by the respective partners from their family of origin. Napier (1978, as quoted by Napier and Whitaker, 1978: 88) continues:

> They learnt early and well to set their 'emotional thermostat' low, and when emotional pressures begin to build up in their marriage, the only alternative allowed them by their family models was to cope with these tumultuous feelings by creating emotional distance.

The couple create emotional distance between themselves, but what they felt for each other doesn't disappear. The child becomes the expressive agent for the couple, becoming the provoker, mediator and messenger to the outside world. The child represents life or change in stasis and the couple represents death, or non-change in stasis. They fight a war against each other: the one faction, the child, crying for freedom and searching wildly for life; the other, the parents, fighting against the first, the child, saying that it should stop and be quiet (Napier and Whitaker, 1978).

In summary, Napier (1978: 93) says these dynamic patterns are very important in psychotherapy and describes dealing with these patterns as extremely difficult. The reason he gives for this is the complexity and the interwovenness of all these patterns. He sees psychotherapy as:

> ... not unlike trying to untangle a ball of yarn that had been played with by a mischievous cat for a very long time.

2.4.4.2 Therapy method by Napier

The aim of these sessions is to facilitate growth. Napier sets it out as follows (Napier and Whitaker, 1978):

- Al members "living under the same roof" are expected to attend therapy. This includes, for instance, the grandmother and other siblings. Secondary

groups such as neighbours, grandparents and family may be included later, on a voluntary basis.

- The problems encountered by a person, such as drug addiction, are redefined as family dilemmas. It can be put to the family that not only does the addiction affect the person addicted, but it also affects the other people in the family such as the parents and other siblings.

- In the initial phase of therapy, the therapist structures therapy by asking questions, establishing rules and procedures for working, encouraging the family to initiate, watching the way members communicate, looking for new alternatives and suggesting them to the family.

- During the second phase of therapy, the therapist changes his/her approach, demanding that the family assert itself. Greater emphasis is placed on the family's own initiative as this is essential for a successful outcome. The family, through this, is forced to discover its own power to change. An example would be the therapist withdrawing him/herself, forcing the members of the family to start relating to one another.

- The therapist at this stage becomes involved with the family as they take more risks, for instance, one member of the family doesn't arrive for therapy as unconsciously "arranged" by the family. This creates a moment where therapeutic changes occur, which Napier calls the therapeutic moment. The therapeutic moment is highly variable and it is difficult to generalize, except that the therapist finds something extremely significant in what is happening in the family and reacts strongly and personally. In a case experienced by Napier and Whitaker (1978) the therapeutic moment

was when Don, the son, and Whitaker had a physical fight because of Don's arrogant attitude. The moment can be loving, humorous or angry, but is always intense. In this case it was motivated by anger. Whitaker took over for the parents, and indicated to the parents how to stand up to Don's arrogance. Whitaker was over-involved and became angry when Don made some arrogant statements directed at him. In not tolerating Don's attitude Whitaker served as a model to the father who imitated this behaviour with great success. The aim is thus for the individuals in the family to start to see themselves, not the family, as a unit. They must become individuals.

- The individuals become aware of themselves and their conflicts with their family of origin. This is then discussed and on occasions the grandparents are asked to come into therapy on a voluntary basis. A good example is a patient who had come to realise that he was needed by his parents to keep their relationship going. He was manipulated to get involved in this battle and this made him feel very angry and helpless. His parents were then asked to join in therapy to try and solve these conflicts.

- Conflicts are resolved and as therapy moves towards becoming increasingly more individual, family therapy is ended. This decision is taken by the therapist in conjunction with the family.

Napier (1978) states clearly that for therapy to be successful the family must desire change and the therapist must want them to change.

In conclusion, the theorists discussed above all agree that parents and grandparents affect the functioning of their children and grandchildren. They

indicate that when families and their members are undifferentiated, problems occur. The theorists disagree in terms of the way this undifferentiation is manifested in the families. Bowen (1986) sees the basis of undifferentiation as caused by triangles (see 2.4.2), while Boszormenyi-Nagy and Spark (1974) (see 2.4.3) see the basis as caused by loyalty obligations. Napier (1978) (see 2.4.4) sees both triangulation as well as loyalty obligations as the basis of undifferentiation.

In their therapy they use different methods but their aim is to differentiate the family members from the family unit.

2.4.5 THE IMPLICATION OF INTERGENERATIONAL FAMILY THERAPY FOR DRUG ADDICTION

Stanton, Todd and associates (1982) reported that intergenerational family therapy can be effective in reducing drug addiction. Hirsch and Imhof (1975) came to the conclusion that intergenerational family therapy cannot be seen as "the" answer to drug addiction but they see it as having merit and viability as a treatment modality as the results that they have obtained are very encouraging.

Kaufman (1985) discusses the results of various studies:

- Silver, Panepinto, Arnon and Savaine (1975) have found that 40% of women in their programme became drug-free, while the employment rate in men increased from 10% to 55%.

- Hendricks (1971) found that addicts who had undergone family therapy were twice as likely to stay in therapy than those that did not have family therapy.

- Stanton (1980) noted that out of 68 studies on the efficacy of the family therapy of drug abuse, only 14 quantify their outcome. Only six gave comparative data with other forms of treatment. Four of these six showed family therapy treatment as superior to other modes.

As indicated earlier (see 2.3) many family factors are involved in drug abuse which is a justification that this style of therapy, intergenerational family therapy, should be very successful. Although little data is available to indicate the success of intergenerational family therapy above other methods, it is seen as an important part of therapy and results to date are very encouraging (Kaufman, 1985).

Various other therapeutic techniques were developed for intergenerational family therapy by various other authors. These include polar sculpture (Hawkins and Killorin, 1979), griefwork (Reilly, 1984), role reversals (Hawkins and Killorin, 1979), structural techniques (Roberts, 1982), I statements technique (Gordon, 1975). These techniques will not be elaborated on as all the techniques used in the study will be discussed in detail in the next section.

2.5 DRUG ADDICTION PROGRAMME

Many types of treatment programmes are currently being implemented worldwide (Igbinovia, 1976; Steer, 1983; Kaufman, 1977). As mentioned previously (see 1.1) no programme of this nature has been researched or is available (to the writer's knowledge) in South Africa. In South Africa two modes

of treatment are currently being used - outpatient and in-patient treatment (SANCA, 1988).

As previously indicated (see 1.1) this research centres around in-patient treatment, which can be short-term over 4 weeks - or medium-term - over 3 months. The mode of treatment which is investigated in this research is short-term in patient treatment with the focus on the programmes which are followed during this time. Two programmes; the current Lulama Programme and the Lulama Programme where intergenerational family therapy has been incorporated are compared in order to determine the effect of the intergenerational family therapy programme on the drug addict and his family of origin (see 1.2). A short description of both programmes will be given in this section.

2.5.1 LULAMA PROGRAMME (SANCA)

The information on the Lulama Programme given below was obtained from conversations with the deputy director of Lulama, Mr. D. Davidson.

The Lulama Programme entails 4 weeks in-patient treatment in a therapeutic community, with the aim of rehabilitating the drug addict to the extent of enabling him/her to:

- be open to the possibility of a relapse and therefore to identify high risk situations and conditions in his/her life;

- learn alternative coping strategies for dealing with the high risk situations,

- gain a sense of efficacy in the use of those alternative coping skills; and

- modify defective thinking styles, thereby enhancing the achievement of the first three goals and creating an infrastructure for the processing of novel problematic experiences, for example teaching the patient how to think and not only what to think.

Before being admitted the patient is assessed by a social worker to ascertain suitability for treatment within the therepeutic community of Lulama. The patient, if suitable, is then admitted on Friday at 8 am and issued with a list of basic rules together with a general information file concerning all matters pertaining to the functioning of Lulama. Each patient is then assigned an individual therapist who deals with that person's family/significant others and any issues the patient is unable to work through within the group context.

There is a strong emphasis on group work and the group serves as both the context and the means for treatment.

WEEK 1

This week is seen as the settling-in week in which the members of a group get acquainted. The group is split up into dyads, which are given time to gather information about each other. They then rejoin the group and introduce each other. The next step is to discuss the beliefs each member has about drugs, such as the belief that they help a person to relax. The relapse flow chart (see Appendix 1) is explained and a discussion follows. The most important aspect of week one is the formulation of treatment goals by the patient, and the encouragement to verbalize these goals to other members of the group. Together the group tries to identify the seven high risk situations (see Appendix 2) which could lead to a relapse.

At the end of this week every individual is evaluated to assess the progress that he/she has made. This is done by giving the person 14 imaginary situations covering the seven high risk situations. The person has to respond in writing how he/she would cope in each situation. If the progress is not satisfactory the person is asked to repeat week one. If progress is satisfactory he goes on to week 2.

WEEK 2

During this week the individuals are taught the three core techniques for dealing with high risk situations. They are taught problem-solving, behaviour rehearsal and cognitive restructuring. The rest of this week is used to practise using the core techniques to cope in the following high risk situations:

- negative emotional states. Relaxation procedures are taught to enable a person to cope;
- interpersonal conflict; and
- social pressure.

In each case a situation is created in which the individuals are taught to cope through role-play (within the situation).

WEEK 3

Week three is a continuation from week two and the role-playing of the other four high risk situations is continued. This includes:

- interpersonal evaluation;

- craving and sensation-seeking and testing personal control;

- negative physical states; and

- abstinence violation affect.

WEEK 4

The aim of week four is to teach the individual to be able to identify relapse warning signs (see Appendix 3) to remain drug-free. The individual is taught that one "builds up to drugging or drinking" and the individual is taught that keeping all the tension inside oneself is not the appropriate way of coping. By sharing one is enabled to stay in control.

The treatment is then terminated by wishing each other good luck and giving positive feedback about what each has achieved in the four weeks.

This programme also includes a family programme which is not compulsory. This group is run every Monday afternoon and aims to:

- educate family/significant others on the issues and facts relating to drug dependence, the specific drugs and the process of recovery;

- provide family/significant others with a support system to assist them to both gain insight and deal with the problem;

- provide family/significant others with the opportunity to get involved in the treatment programme and to meet staff and other patients;

- provide a means for patients and family/significant others to explore and repair relationships and provide a better understanding on both sides for each other;

- pave the way for intensive family therapy on a more individual basis; and

- provide an opportunity for the therapeutic team to observe family interaction in another context.

This programme is mainly aimed at improving an addict's coping skill and includes some introductory work with the family and significant others. This programme, however, does not include any form of family therapy. The Lulama Programme, with the Intergenerational Family Therapy Programme, aims eventually to accommodate this facet of treatment. A short description of the intergenerational family therapy facet of that programme will be given.

2.5.2 THE INTERGENERATIONAL FAMILY THERAPY PROGRAMME

In compiling the intergenerational family therapy programme, the theoretical orientations of Bowen, Boszormenyi-Nagy and Spark, and Napier (see 2.4 to 2.4.4) have been used. The aim of this programme would be to complement and not imitate a specific method of therapy developed by any particular author. The proposed programme aims to incorporate the above authors' basic therapeutic approaches and is supplemented by various techniques from other authors.

The programme consists of 8 sessions with the addict and both his parents. The intergenerational family therapy is divided into four phases which run concurrent with the Lulama (SANCA) Programme (see Chapter 3). Phase one

is the initial evaluation phase, phase two is the working phase. The third phase consists of the final evaluation with the fourth and final phase following as the termination phase. Phases one and two will run consecutively during two sessions weekly. There will then be a break of one week and phases three and four will follow. Phases three and four will be done in one week. The programme from phase one to and including the final phase has a duration of six weeks.

The contents of each phase is as follows:

2.5.2.1 The initial evaluation phase

This phase will consist of two sessions.

- **Session One**

The aim of this session will be firstly to introduce the programme to the family and especially to stress the time limit of the ~~programme~~; secondly, to take a brief family history in order to compile a genera (see 2.4.2.1.1); and thirdly, to take a brief history of the drug-taking pattern. The rationale of this session is not only to establish rapport with the family but also to gain information to establish the contents of the programme. The duration of this session is an hour and thirty minutes.

- **Session Two**

This session is used for the administering and completion of the test battery. The duration of the session is two hours and thirty minutes.

2.5.2.2 The working phase

This phase consists of four one-hour sessions with the drug addict and both parents, and aims at making the family aware of their problems and leading them towards the solution of these problems.

- **Session One**

This session consists of three parts:

Firstly, the description of terms where the following terms will be explained briefly:

- triangle (see 2.4.2 and 2.4.4);

- differentiation of the self (see 2.4.2);

- family projection process (see 2.4.2);

- emotional cut off (see 2.4.2);

- loyalty (2.4.3.3); and

- obligations (2.4.3.2).

The description of terms is used to assist the family in becoming more aware of the processes within the family. This awareness is used by the family to work through and change existing processes which lead to and maintain the drug addiction. This concurs with Bowens' therapy (see 2.4.2.2.1).

Secondly, the addict as well as the parents, is asked to give "I" messages. This is a technique described by Gordon (1975) in Parent Effectiveness Training (PET), and was used because the technique is easy to understand and fast to learn. The aim of these "I" messages is to get the members to talk about themselves without an emotional debate and to get to know each other. The rationale of this technique is to get the family to realize that each member is an individual and not just a part of the family ego mass. Bowen (see 2.4.2) and Napier (see 2.4.4) view this as the most important part of therapy. The members are asked to communicate by starting a sentence with "I", followed by a feeling which is then explained in terms of what it is the other did to make him feel that way. For example:

"I am unsure because you change the rules so often".

Thirdly, griefwork has to be done in some of these families. In some families parental losses lead to projections, identifications, and displacements that contaminate the family system because they have not been mourned (Reilly, 1984). The parents, as well as the addict, have to be made aware that they are confusing birth with reincarnation and its tendency to collapse the family of procreation back into the family of origin. The rationale behind griefwork is enabling parents to let go of the young addict so that separation and individuation can take place. Through the genogram the therapist determines whether such losses have occurred and, if so, griefwork has to be done. The goal is then to help parents belatedly to complete their mourning in relation to their own lost ones. In concurrence with therapy by Boszcormenyi-Nagy and Spark (1973) (see 2.4.3.5) they are encouraged to express previously blocked emotions such as guilt, abandonment, disappointment and anger, and to

gradually move on to a resolution involving acceptance, forgiveness, tenderness and hope.

If there have been no losses or losses have not led to projections, identifications or displacements, griefwork is not necessary and this part of this session is left out. Instead the family will concentrate on and practise more "I" messages and then continue with session two.

- **Session Two**

In this session the focus will be on a technique by Hawkins and Killorin (1979) called polar sculpture.

The family has in the previous session learnt how to express themselves as separate from the family egomass. They also have an academic knowledge of what the family system looks like and how it operates. This technique is used here to strengthen what the family now knows with a more concrete illustration. This will make it possible for the family to see where the problems lie within the family system and in turn, it gives them more definite structures to work with in order to achieve a more balanced system which can allow separation and individuation. This technique has been chosen because it elicits such strong emotions and thus makes it a very powerful technique which almost forces the whole family to look at what is going on in the family. The technique makes it extremely difficult for any member of the family to ignore the events within it.

Hawkins and Killorin (1979) uses the technique with two empty chairs placed in the middle of a room. In this research however, the original technique of using two empty chairs has been changed. Instead of using empty chairs the parents of the addict will be seated on these chairs. The addict is instructed to

walk around in the space surrounding the chairs. He is asked not to speak, but to pay careful attention to his emotions as he moves around. The addict is encouraged to test all areas of the space such as behind, beside, in front of, near to and faraway, also any posture like lying down, sitting or standing is tested. The addict is then encouraged to rest in a spot and position where the person feels that it is the right spot and feels at ease. The addict and both parents will then be asked how they felt during the exercise and how they reacted to the placement and position the addict ended with. The most important part of this technique is that different members draw on how the addict came to this placement and position and what it means to every member. A summary of the above discussion will then conclude this session.

- **Session Three**

During this session two techniques are used, namely role reversals and emphasizing the positive. Role reversals were used to re-enforce the work done in the previous sessions and to again place the pressure on the family to face the problems within it. This serves as motivation to continue therapy and to prepare a solution to the family's problems. Emphasizing the positive follows preparing the family for the possibility of change.

The first technique, role reversal, is a technique used by Hawkins and Killorin (1979). This technique is used as previous research (Hawkins and Killorin, 1979) indicated the effectiveness of the technique when used as a way for members of families to express how they perceived the other members of the family. The aim of this technique is to allow members to express how he or she perceives the other members' needs - to express some of the secrets that the non-verbal communication reveals. The rationale is that as the members get to

know each other better they gain understanding of the behaviour of the other members, towards him, her or the situation. It is the start albeit in a negative way of acknowledging that each is a separate entity.

The addict is asked to imagine that he is one of his parents. He is encouraged to sit as the parent would, to arrange body and mannerisms in a similar fashion and to talk as the parent would. He is asked to, as far as possible, become a parent. The addict is asked to identify himself as the parent by saying "I am" (parent's name), "mother/father of" (addict's name). The addict is then asked to complete the following sentences:

- always said ...
- I never talked about ...
- I felt ...
- I wanted ...

All three of the members of the family are in the room when this technique is used.

After being one parent the addict is asked to be himself, deroling by saying "I am" (addict's name), "son of" (parent's name). Both parents are involved in this programme and are asked to reverse their roles with their son. One parent, the parent that was not chosen by the addict first, is asked to imagine that he/she is the addict. The reversal is obtained by stating "I am" (the addict's name), "son of" (parent's name). The same sentences have to be completed as by the addict. Deroling is again completed by saying "I am"

(parent's name), " parent of" (addict's name). The same procedure is followed for the other parent.

The second technique, emphasizing the positive, used by Reilly (1984) is used to reveal a tense situation, which might possibly lead to positive reframing and/or relabelling, so that change can take place in the family system. The technique was used as the researcher felt comfortable about using this technique to get the family system to act and not only to talk about what was wrong with the family system. The family is asked to enumerate what they like about each other, an unusual technique, as the family is usually more ready to list the mutual recrimination. Reilly (1984) explains that the family's attendance, expressions of anger and criticism are interpreted as their underlying affection, caring and concern for one another, that the emphasis is on change and not blame. The family is requested to identify how the family relationships might improve, they are retrained to recognize and reinforce positive behaviour.

- **Session Four**

A technique developed by Roberts (1982) to treat conduct disorders in adolescents and young adults will be used in this session. This follows the previous session where problems in the family are pointed out to them as they are prepared for change. This technique is the first actual change that is introduced to the family. The aim of this structural technique is to move the parents to agree on a set of rules which they can apply at home, with a definite set of reactions such as punishments, if rules are not abided by. This structural change is used to facilitate corresponding structural rearrangements in the family, to remove the addict from the triangling position between his parents.

The addict is also reminded of his appropriate position in the family hierarchy and helped to make the appropriate changes in his behaviour.

This session then comprises both a separation of the addict from the parents and his treating them separately. In this research only one session will be held as the time limit prevents more intensive work.

The working phase of this programme is designed to help the family with change. Change, though, is a very threatening experience and often families resist change. Also, families are often not even aware of problems within the family. In this working phase every technique is used in such a manner that it first aims to make the family aware, and through awareness guide them towards change. The less threatening techniques are introduced first and as the rapport and trust between family and therapist increase, more threatening techniques are introduced. During this phase therapy moves from a family therapy to a more individual therapy. This is in concurrence with therapy done by Napier (1978) (see 2.4.4.2). Therapy is also done to stimulate movement from an ego mass to a more individual level, which is the primary aim that Bowen (1985) (see 2.4.3) has in his therapy.

2.5.2.4 The final evaluation phase

This phase constitutes one session of two-and-a-half hours for the administration of the test battery to determine objectively what changes have occurred in the family.

2.5.2.4 The termination phase

This phase is the last phase and comprises one single hour session. In this session the course of treatment is summarized, the gains made by the family are reviewed and reinforced. The therapist expresses the view that the family has made good progress in therapy and that they can continue on their own. The therapist at this stage gives the family a referral should they need further assistance in the future. In contrast with the Lulama Programme this programme intends not only to teach the patient (addict), but also the family how to cope with stress situations. The family is mobilized to give essential support and to allow space for the young adult to grow and become independent without the risk of destroying the family or parents that are left behind.

CHAPTER III

METHOD OF INVESTIGATION

The aim of this study is to compare two models of treatment for drug addicts, one with intergenerational family therapy included in the standard programme at Lulama and one where only the standard programme is used, to determine whether there is a significant difference in the treatment results. In order to do such research a certain methodology is necessary to obtain reliable results. The aim of this chapter is to give a short description of the methodology that was used. It will give an indication of the sample and test material used and a brief description of the experimental and statistical procedures that were used to determine results.

3.1 THE SAMPLE

The sample was drawn from a population of drug addicts that reported voluntarily for treatment at Lulama in Durban (SANCA). A sample of twelve individuals had to be chosen. Due to the small population, the first available twelve were chosen. The sample was drawn during the period of December 1988 to September 1989.

The sample of twelve was randomly divided into two groups, a control group and an experimental group, the control group consisting of 8 addicts and the experimental group of 4. This was done for practical reasons. The sample consisted of males only between the ages of 16 and 25.

In the experimental group the mean age of the addicts was 20.25 and all were English speaking. The families in this group consisted of the parents, the addict and one sibling. Both parents were alive and not separated or divorced.

The families were all placed within the middle social strata. No other pathology had been diagnosed in these families. In the control group the mean age of the addicts was 21.25 and all were also English-speaking. These families consisted of the parents, the addict and two siblings. These families came from the middle social strata. Both parents were alive and still together. No other pathology had been diagnosed previously.

The experimental group and the control groups thus compare well. The only significant difference was that the families of the control group were bigger and the mean age of the addicts higher

3.2 THE MEASURING INSTRUMENTS

The measuring instruments used in this study are the following:

- The Personal Orientation Inventory (POI),
- Personal, Home, Social and Formal Relations Questionnaire (PHSF),
- Parent-Adolescent Communication (PAC),
  - Parent Form,
  - Adolescent and Mother Form,
  - Adolescent and Father Form.
- Family Satisfaction Scale,
- Madanes Hierarchy Scale (MHS),
- Family of Origin Scale (FOS),

- Family Strengths,
- Personal Assessment of Intimacy in Relationships (PAIR).

Each of the tests will be discussed.

The above tests were mainly used to gather information on three levels. Firstly, information on the functioning of the addict himself was gathered by using the Personal Orientation Inventory and the Personal, Home, Social and Formal Relations Questionnaire. Secondly, information on the functioning of the family was gathered by using the Family Satisfaction Scale, Parent-Adolescent Communication, Family Strengths, Madanes Hierarchy Scale, Family of Origin Scale and Family Strengths. Thirdly, information was gathered about the functioning of parents in terms of their intimacy by using the Personal Assessment of Intimacy in Relationships. Only one of the instruments is South African (PHSF); all the others are instruments developed in America or Europe. These instruments were used as no South African equivalents could be found. In these foreign scales the raw scores of the sample had to be used.

3.2.1 THE PERSONAL ORIENTATION INVENTORY (POI)

The Personal Orientation Inventory was designed by Shostrom (Knapp, 1976). All the information given in the text following has been taken from the manual by Shostrom (1974) and a book by Knapp (1976).

3.2.1.1 Rationale for the use of this Inventory

The test has been designed to measure values and behaviour seen to be of importance in the development of the self-actualizing person. The test

measures on two levels, Time Competence and Inner-Directed. Self-actualization is measured on 10 subscales, namely Self-actualizing Value, Existentiality, Feeling Reactivity, Spontaneity, Self-regard, Self-acceptance, Nature of Man, Synergy, Acceptance of Aggression and the Capacity for Intimate Contact (see 3.2.1.3).

3.2.1.2 Motivation for the use of this Inventory

This test has been designed to measure a person's level of self-actualization and can thus indicate the level of the person's functioning and what changes have taken place with time and treatment. This test could thus indicate the difference in test results obtained by the two different programmes.

3.2.1.3 Description of the Inventory

The POI consists of 150 two-choice comparative value and behaviour judgements. The items are scored twice, once for two basic scales of personal orientation, Inner Directed support (127 items) and Time Competence (23 items). The inner directed support orientation is designed to measure whether an individual's mode of reaction is characteristically "self"-orientated or "other"-orientated. The time-orientation reflects the degree to which the individual lives in the present rather than in the past of future.

The test is then scored a second time to obtain a score for each of the 10 (ten) subscales each of which measures a conceptually important element of self-actualization. The scales may be defined as follows:

Self-Actualizing Value (SAV) measures the affirmation of primary values of self-actualizing people.

Existentiality (Ex) measures the ability to situationally or existentially react without rigid adherence to principles.

Feeling Reactivity (Fr) measures sensitivity of responsiveness to one's own needs and feelings.

Spontaneity (S) measures the freedom to react spontaneously, or to be oneself.

Self-Regard (Sr) measures affirmation of self because of worth or strength.

Self-Acceptance (Sa) measures the affirmation or acceptance of oneself in spite of one's weaknesses of deficiencies.

Nature of Man-Constructive (Nc) measures the degree of one's constructive view of the nature of man.

Synergy (Sy) measures the ability to transcend dichotomies.

Acceptance of Aggression (A) measures the ability to accept one's natural aggressiveness as opposed to defensiveness, denial and repression of aggression.

Lastly the Capacity for Intimate Contact (C) measures the ability to develop contactful intimate relationships with other human beings unencumbered by expectations and obligations.

3.2.1.4 Reliability

The development of the POI was based on concepts of dynamic traits of personality, thus making traditional concepts of reliability inappropriate in

many instances, especially in the case of estimates of stability based on repeated administration over a given period of time. Several studies quoted by Shostrom (1974) and Knapp (1976) indicated that the reliability coefficients ranged from .55 to .85. Only three scales were found to be substandard (below .70), namely Acceptance of Aggression (.55), Nature of Man (.66), Feeling Reactivity (.69). Klavetter and Morgan (1967) administered the POI twice and found that all correlations ranged from .52 to .82. The major POI scales of Time Competence and Inner-Directed displayed generally high reliable coefficient of .71 and .77 respectively. Wise and Davis (1975) reported a test-retest coefficient of .75 and .80 for Time Competence and Inner-Directed scales respectively and Kaats (1973) reported internal consistency coefficients based on Cronbach's alpha of .80 for the Inner Directed scale and .65 for Time Competence scale.

3.2.1.5 Validity

A number of studies based on diverse populations from widely disparate regions have demonstrated the validity of the POI. An important test of validity is that this test should discriminate between self-actualizing individuals and on-self-actualizing individuals. Both authors have done research in the aspect that has indicated that the POI does discriminate between these groups.

It is important to note that the POI is extremely sensitive in measuring changes in self-actualization following encounter groups, enrichment programmes and drug education and counselling. Venter (1988) indicates that several studies done in the South African context have supported the above findings (Du Plessis, 1982; Cilliers, 1984; Henning, 1986; Scholtz, 1987).

3.2.2 THE PERSONAL, HOME, SOCIAL AND FORMAL RELATIONSHIP QUESTIONNAIRE (PHSF)

The Personal, Home, Social and Formal Relationship Questionnaire is a questionnaire which was developed in South Africa by the HSRC with South African norms. All of the information used here comes from the manual compiled by Fouché and Grobbelaar (1972).

3.2.2.1 Rationale

The level of adjustment of a person, for each of the various components of adjustment, is determined by the frequency with which he responds, in relation to himself or with the environment, and in which way these responses are mature or immature, efficient of inefficient.

This does not measure personality traits as such but rather the expression of these traits in the person's striving for harmony within the self and the environment.

This questionnaire measures four components which reflect the level of adjustment of a pupil, student or adult. The four components are the personal, home, social and formal relationships (see 3.2.2.3).

3.2.2.2 Motivation for the use of this questionnaire

The aim of this study is to determine the therapy results of two different programmes. In order to do so one has to determine whether the individual has changed. This questionnaire determines the level of adjustment which is defined as the dynamic process by which a person strives to satisfy his inner

needs through mature, efficient and healthy responses, while at the same time striving to cope successfully with the demands of the environment in order to attain a harmonious relationship between the self and the environment.

The literature (compare 2.3) indicates that an addict's adjustment is not very good and this could be a sensitive tool to determine the change in the addict through the different modes of treatment. There might be some doubt, however, because personality traits don't change that easily.

3.2.2.3 Description of the questionnaire

The questionnaire is bilingual and consists of 180 items. The person indicates on a four-point scale how often he experiences certain relations or situations. In 1969 the norms for Standard 10 pupils were calculated by applying this questionnaire to 1 788 Standard 10's and in 1971 for Standard 8's (N = 1 274) and 9's (N = 1 382). The test material consists of a self-answering sheet with four response alternatives that can be marked by hand.

The scores of the test reflect a person's functioning in four different fields. The first of these fields is the personal relations field. This refers to the intra-personal relations which are of primary importance in adjustment. The important aspects include that of self-confidence or the degree to which a person has confidence in his/her ability, real or fancied, to be successful. It also includes self-esteem, which is the person's inner appraisal based on his/her evaluation and acceptance of real or fancied personality characteristics, abilities and defects. Self-control is also seen as an important aspect and is explained as he degree to which a person succeeds in controlling and channelling his/her emotions and needs in accordance with

his/her principles and judgement. Another aspect included is nervousness where a high score indicates an absence of symptoms of nervousness as expressed by anxious, purposeless, repetitive behaviour. The last aspect that is included is health, where a high score indicates an absence of preoccupation with the psychical condition.

The second field is the home relations field which refers to the relations experienced by the person as a dependent within the family and home environment. There are two main aspects which are looked at, one being family influences which refers to the degree to which a person is a dependent in a home and is influenced by factors such as his/her position in the family, family togetherness, relationship between parents and socio-economic conditions. The second aspect which is investigated is personal freedom, which is the degree to which a person does not feel restricted by parents.

Social relations makes up the third field of functioning and refers to the manner in which a person engages in harmonious and informal relation within the social environment. This field comprises three aspects. One aspect is sociability (g) which refers to the degree to which a person has a need for and spontaneously participates in social group interaction, in comparison with the degree to which a person is averse to social group interaction. The second aspect of sociability (s) refers to the degree to which a person has a need for sociable interactions with a specific person of the opposite sex. The third aspect is the moral sense which refers to the degree to which a person feels that his behaviour corresponds to the accepted norms of society.

The last field is the formal relationship field that refers to the relations occurring in formal situations in the school, college or university, or

occupation. The specific aspect that is investigated is the degree to which a person is successful in his/her formal relations.

This questionnaire also includes a desirability scale which is a validity scale indicating the honesty with which the person answered the questionnaire. The questions are of such a nature that only exceptional people can justly give favourable answers.

3.2.2.4 Reliability

The reliability of the PHSF was calculated according to the spit-half method. The highest reliability for the boys over the twelve components was .94 and the lowest was .63. The reliability for girls differed slightly.

3.2.2.5 Validity

The PSHF has been applied to pupils in two schools for behavioural deviates. The results were compared with those of the Standard 10 norm group. These results, measured on a 1% level of significance, indicated that the PHSF could discriminate relatively consistently between the norm group and the group of deviate boys. Further validity studies will have to be carried out in the future.

3.2.3 PARENT-ADOLESCENT COMMUNICATION (PAC)

The questionnaire was developed by Barnes and Olson (1985). All the information given below has been taken from an article by Barnes and Olson (1985).

3.2.3.1 Rationale

This questionnaire was developed to measure the aspects of family communication as experienced by each spouse and one adolescent. It measures both negative and positive aspects of communication as well as aspects of the content and process of the parent-adolescent interactions. In order to measure all these aspects of communication, the questionnaire was divided into two subscales, namely open family communication, and problems in the family's communication (see 3.2.3.3).

This questionnaire thus gives an overall view of communication within the family and the information gathered can be easily interpreted to the family.

3.2.3.2 Motivation for the use of this questionnaire

Adolescence is often viewed as a particularly turbulent period of challenge and change in the relationship between these emerging adults and their parents. As adolescents grow towards adulthood, parallel changes are needed in their relationships with their parents to facilitate and enable these changes, or at least remove obstacles to the demands of the developmental tasks faced by adolescents. Communication is an essential ingredient in the establishment of the type of negotiation process families adopt to meet the developmental changes dictated by the growth of individual members. The questionnaire is aimed at measuring positive as well as negative aspects of communication, in order to indicate whether the communication in a family satisfies the needs of this family.

As the literature (see 2.3.1.2) has indicated, communication is not adequate in families with addicts and the PAC is an effective instrument to indicate

changes in communication as a result of treatment. The instrument will then also be able to indicate the difference made by the different modes of treatment on the communication within these families.

3.2.3.3 Description of the questionnaire

The questionnaire is divided into three questionnaires for each member of the family, the adolescent, mother and father. Each questionnaire consists of 20 items. The adolescent receives two questionnaires. On one the items relate to his relationship with his mother and the other to his father. The parents receive a questionnaire where the items relate to his/her relationship with their son. The responses are recorded on a 5 point Likert-type scale.

In order to measure all the aspect of communication the questionnaire was divided into two subscales. The first subscale, Open Family Communication, measures the more positive aspects such as the freedom or free-flowing exchange of information, factual as well as emotional. It also looks at the lack of constraint and the degree of understanding and satisfaction experienced in their interactions. The second subscale, Problems in Family Communication, focuses on the negative aspects of communication such as the hesitancy to share, negative styles of interaction, and selectivity and caution in what is being shared.

Items from the two subscales are intermingled, to reduce response bias. The total score is a sum score. The second subscale consists of items 2; 4; 5; 10; 11; 12; 15; 18; 19; 20 and needs to be identified as the value of these items need to be added to the sum of values of the first subscale consisting of items 1; 3; 6; 7; 8; 9; 13; 14; 16 and 17.

3.2.3.4 Reliability and validity

Cronbach's Alpha was used to compute the internal consistency reliability of the questionnaire. In the total sample (n = 1.841) the alpha reliability was .87 for Open Family Communication, .78 for Problems in Family Communication and .88 for the Total Scale. These results indicate that the two subscales and the total scale are very reliable.

The validity of this test has not yet been established.

3.2.4 FAMILY SATISFACTION SCALE

This scale was developed by Olson and Wilson (1985). All the information given about this scale was obtained from an article by Olson and Wilson (1985).

3.2.4.1 Rationale

This test was devalued to assess the level of satisfaction within the family. Family satisfaction was divided into two subscales, Family Cohesion and Family Adaptability (see 3.2.4.3).

3.2.4.2 Motivation for the use of this scale

It has already been indicated (see 2.3.1) that adaptability and cohesion are problematic in families with a drug addict. This scale can determine the perceived level of adaptability and cohesion within the family. The changes in satisfaction through treatment can be determined by this scale and will give an indication of the difference in the results of the two treatment programmes.

3.2.4.3 Description of the scale

The scale consists of 14 items divided into two subscales. Items 1; 3; 5; 7; 9; 11; 13; 14 determine the satisfaction with family cohesion. Cohesion is measured in terms of emotional bonding, family boundaries, coalitions, time, space, friends, decisionmaking, interests and recreation. Items 2; 4; 6; 8 10 and 12 determine the satisfaction with family adaptability, which is measured by assertiveness, control, discipline, negotiation, roles, and rules. The responses to each item are recorded on a 5-point Likert scale. A total score is obtained by adding the 14 items.

3.2.4.4 Reliability and validity

The Cronbach alpha for the scale formed by adding these 14 variables is .92. Alpha coefficients for the 8-item cohesion scale and for the 6-item adaptability scale are .85 and .84 respectively. Test-retest Pearson correlation coefficients for the cohesion subscales were .76 and for the adaptability subscales .67. The five week, test-retest correlation for the total score was .75. No information is available on the reliability of this test.

3.2.5 MADANES HIERARCHY SCALE (MHS)

This scale was developed by Madanes, Dukes and Harbin (1980). The information given below was obtained from an article by Madanes *et al.* (1980).

3.2.5.1 Rationale

This scale was developed to support clinical observations that a hierarchical reversal takes place in families with drug addicts. This scale measures two

aspects of the hierarchy within the family namely cross-generational attachments and hierarchical reversals (see 3.2.5.3).

3.2.5.2 Motivation for the use of this scale

As indicated (see 2.3.6) hierarchical reversals are frequent in families with drug addicts. In treatment changes have to occur to rectify these reversals in order for treatment to be successful. The scale is able to give an indication of change, if any, and will thus be able to indicate the difference in results of the two different treatment programmes, if any.

3.2.5.3 Description of the scale

The scale consists of diagrams of eight different family organizations which are shown in turn to each member of the family. The person must then choose one diagram which he thinks reflects the organization in the family. The person is then asked to write the name of the family member represented by each stick figure and to indicate the distance between the family members. The person then chooses the one diagram that presents preferred relationships. The parents and then the family as a whole are brought together and asked to agree on one diagram and the distance.

A point-scoring system was developed for measuring hierarchical reversals and cross-generational attachments (1 = one parental person reverses the other parental person; 1 - one parental person reverses his own position; 1 = the index person reverses a parental person; 1 = the family as a whole reverses a parental person; 1 = each cross=generational attachment in the representations of the parental persons, the index person and the family as a whole).

Hierarchical reversals refer to a representation in which one person is placed below the other parental person: or the parental person is placed below or on the same level as the index person; or the index person is placed above one parental person, at the same level as a parental person, or both; or the index person is placed above an older sibling; or the sibling is placed above a parental person, at the same level as a parental person, or both; or the index person is placed above an older sibling; or the sibling is placed above a parental person, at the same level as parental person, or both; or a younger sibling is placed above the index person; or any combinations of these. Cross-generational attachment is seen as the touching of two stick figures across generational lines such as a stick figure representing a parental person that overlaps or touches the index person. The points are added so that for each family a low score represents a small number of hierarchical reversals and cross-generational attachment and a high score represents a high number of hierarchical reversals and cross-generational attachments.

3.2.5.4 Reliability and validity

In a study done with 36 persons and their families, two independent judges who scored the diagrams for hierarchical reversals were in agreement, 90% in the first scoring and 100% in the second. The reliability between the three independent judges who scored the diagrams for overlapping or touching between stick figures was 95% in the first scoring.

No information is available on the validity of this scale.

3.2.6 FAMILY OF ORIGIN SCALE (FOS)

The family of Origin Scale (FOS) was developed by Hovestadt, Anderson, Piercy, Cochran and Fine (1985). Information given here is based on an article by Hovestadt *et al*. (1985).

3.2.6.1 Rationale

Family of origin interventions are widely used, and theoretical assumptions upon which these techniques are based are largely without empirical validation. The FOS was developed for this purpose - to measure the perceived levels of health in the family of origin.

The FOS has two subscales, Intimacy and Autonomy. Each of these subscales was constructed by the selection of key constructs from each concept to ensure comprehensive coverage. The instrument, however, renders a total score that indicates a degree of perceived health in the family of origin (see 3.2.5.3).

3.2.6.2 Motivation for the use of this scale

The FOS can be used in two ways. One is as an instrument to quantify the perceived health of the family of origin. This instrument could thus indicate a change in the perceived health of the family of origin that a treatment programme would bring about and by so doing reflect a difference in treatment results.

The FOS was also developed to assist persons in becoming more conscious of their own perception of the level of health of the family in which they spent

most of their childhood. The therapist may be alerted to basic unresolved issues that exist between a client and his parent. The FOS is then a very good scale to use with therapy.

3.2.6.3 Description of the scale

The scale consists of 40 items on a 5-point Likert-type scale. Each item receives a score of five for the healthiest response and a score of one for the unhealthiest response. The highest possible score is 200 and the lowest possible score is 40.

The norms are based on a sample of 278 undergraduate graduate students at East Texas State University. The FOS was completed by 39 black and 239 white students who were all American citizens. The top third of the respondents scored between 160 and 198 on the scale, the middle third scored between 63 and 134.

The FOS focuses on autonomy and intimacy as two essential and interwoven concepts in the life of a healthy family which stimulate autonomy by emphasizing clarity of expression, personal responsibility and respect for other family members and openness to others in the family, and by dealing openly with separation and loss. The healthy family develops intimacy by encouraging the expression of a wide range of feelings, creating a warm atmosphere in the home, dealing with conflicts without undue stress, promoting sensitivity in family members and trusting in the goodness of human nature.

3.2.6.4 Reliability

A test-retest reliability coefficient of .97 ($p < .001$) was obtained over an interval of two weeks on 41 graduate psychology students. Test-retest coefficients for 20 items of the autonomy concept ranged from .39 to .88 with a medium of .77. Test-retest coefficients for the 20 items of the intimacy concept ranged from .46 tot .87 with a medium of .73. In an independent study of 116 undergraduate students a Cronbach's alpha (1951) of .75 and a standardized item alpha of .97 was obtained. In a South African study done by Venter (1988) a Cronbach's alpha of .97 for Autonomy and .92 for Intimacy was obtained.

3.2.6.5 Validity

The validity of the FOS has been confirmed by many studies. Hovestadt *et al.* (1985) quotes Holder (1978) who measured the perceived health in the family of origin, as measured by the FOS in 25 male members of alcohol-distressed marriages and 25 male members of non-alcohol distressed marriages. An alcohol distressed marriage is one in which the alcohol use of the husband is seen as a major factor in marital distress. A non-alcohol distressed marriage is one in which the alcohol use of the husband is not a factor in the marital distress. A significant difference [$t(48) = 3.20$, $p < .01$] in perceived health of the family of origin was revealed.

3.2.7 FAMILY STRENGTHS

This test was designed by Olson, Larsen and McCubbin (1985). All the information given in this section was obtained from an article by Olsen, Larsen and McCubbin (1985).

3.2.7.1 Rationale

Problem families are easily identified and diagnosed but little is known about how a "strong" family might be identified. Sound research into the dynamics of the socalled healthy or normal family is minimal. This scale attempts to identify the healthy family. Two concepts are seen as important when looking at family strength. Family strengths was constructed in such a way that both concepts of pride and accord are covered comprehensively (see 3.2.7.3). The instrument, however, renders a total score that gives an indication of the strength of a family.

3.2.7.2 Motivation for the use of this scale

Family strengths gives a quantitative reflection of the strengths of the family, therefore the difference in results each programme has would be clearly indicated and would then give an indication of the effect the intergenerational family therapy programme has on the strength of the drug addict and his/her family of or origin.

3.2.7.2 Description of the scale

Family strengths focuses on pride and accord as two major parts of the strength of a family. Pride is seen as loyalty, trust and respect attributes, and accord is the family's sense of competency.

The instrument contains twelve items that have been broken down into the two dimensions, Pride and Accord, on a 5-point Likert-type scale. The scoring on Family Strengths is done by acquiring a sum score for the twelve-item scale.

Items 2; 4; 6; 7 and 11 are added then subtracted from the constant of 30 and then added to the remaining items.

3.2.7.4 Reliability and validity

Cronbach's alpha was computed for each factor separately and the total scale on sample /1 (n = 1 330) and sample /2 (n = 1410). The alpha reliability for Pride for the combined samples was .88 and for Accord .72. The overall alpha reliability was .83 for both samples.

Test-retest reliability coefficients were also computed. The time lapse between the first and second administration was four weeks. There were 116 subjects in the sample. The Pearson correlations between time 1 and time 2 were .73 for pride, .70 for accord and .58 for the total.

No information was given on the validity of this test.

3.2.8 PERSONAL ASSESSMENT OF INTIMACY IN RELATIONSHIPS (PAIR)

This test was designed and developed by Schaefer and Olson (1981). All the information given below is based on an article by Schaefer and Olson (1981).

3.2.8.1 Rationale

The PAIR was developed as a tool for educators, researchers and therapists. The inventory determines the degree of intimacy that an individual experiences according to his own perception towards his marital partner. The PAIR provides systematic information on five types of intimacy, i.e. emotional,

social, sexual, intellectual and recreational (see 3.2.8.3) in terms of expected and perceived intimacy. The PAIR attempts to

- identify the degree to which each partner presently feels intimate in the various areas of the relations; and
- identify the degree to which each partner would like to be intimate.

3.2.8.2 Motivation for the use of this inventory

It has been previously indicated (see 2.3.1) that the lack of intimacy between parents has been strongly linked to drug addiction within the family system. The intergenerational family therapy programme aims to improve these aspects of the family system. The scores on the PAIR would thus be a good indicator of the effect of the programme on the intimacy between the parents of the drug addicts compared to the effect of the normal Lulama Programme.

3.2.8.3 Description of the inventory

The inventory consists of 36 items on a 5-point Likert-type scale. Each item receives a score of 5 for the healthiest response and a score of 1 for the unhealthiest response. The raw scores are then translated into a score similar to a percentile (actual range 0 to 96). All PAIR scores are given in profile format with separate scores for each specific type of intimacy. There is no total score.

Several psychometric test construction criteria were used to select items for the final inventory, amongst which factor analysis and frequency distribution

were the most important. The initial inventory consisted of 75 items: ten items for each of the six types of intimacy and 5 items for a conventionality scale.

The six types of intimacy originally described by Olson (1975) were firstly emotional intimacy, which is seen as the experience of a closeness of feeling. The second is social intimacy, seen as the experience of having common friends and similarities in social networks. The third is intellectual intimacy, seen as the experience of sharing ideas. The fourth kind of intimacy described is sexual intimacy which is seen as the experience of sharing general affection and/or sexual activity. The fifth type is recreational intimacy which is seen as the shared experiences of interests in hobbies, mutual participation in sporting events. The sixth and last type described is spiritual intimacy which is the experience of showing ultimate concerns, a similar sense of sharing in life and/or religious faith. The conventionality scale included is Edmond's Conventionality Scale which is used in order to see how much the individual is attempting to create a good impression. Only the items with the best factor-loading on the a priori scale and those that complied best with the criteria for intimacy were used in the final inventory. The sixth type of intimacy, i.e. spiritual intimacy, were excluded from the final inventory.

3.2.8.4 Reliability and validity

To determine the reliability and the validity of the PAIR it was administered to 192 non-clinical couples before they began an enrichment weekend. Data were gathered from 12 separate enrichment weekends, each having 12 to 20 couples participating. The PAIR was one instrument among several used in an overall evaluation of the effects and outcome of the programme. A battery of instruments was administered before the weekend, one month after the week-

end and then a follow-up six months later. Only the pre-test data were used for the validity and reliability analysis.

The sample consisted of 192 couples who had been married between one and 37 year s (x length of marriage = 11.8; SD = 8.3), ranging in age from 21 to 60 - years old (x Age = 35,3,SD = 8.6) with 9% having been formerly married and 55% having more than a high school education (x years of education = 14 1,51 = 2.2). Reliability testing consisted of a split-half method. No test-retest analysis had been conducted at the time. Cronbach's Alpha Reliability Coefficients achieved with the six item scale was at least .70.

This inventory has also achieved a high level of reliability in South Africa. In the study done by Venter (1988) the Cronbach Alphas obtained were .66; .62; .71; .51; .65; .85. Grobler (1988) in her study obtained the following scores: .87; .40; .80; .79; .64; .87.

The instrument does not assume any ideal or absolute degree of intimacy per se, although validity tests indicate that couples, in general, distribute themselves in a normal fashion around the mean. The scores have meaning in terms of the difference within each of the partner's perceived and expected degrees of intimacy and also in terms of the difference between the two partners.

3.4 STATISTICAL PROCEDURES

3.4.1 THE EXPERIMENTAL DESIGN

The experimental research design used in this research is the intergroup design which is the before-after two-group design (Smit, 1983).

The procedure of this design is that two randomly selected groups (group A and group B) are subjected to pre-testing before group A is subjected to the Lulama Programme including intergenerational family therapy, and group B is subjected to the programme at Lulama. The two groups are again tested two weeks after completion of both programmes and the scores obtained by the pre- and post-testing are compared (Smith, 1983).

3.4.3 COURSE OF THE RESEARCH

The persons admitted at Lulama and who were interested in the programme were randomly divided into two groups - group A and group B.

Group A was in addition exposed to the intergenerational family therapy programme during the duration of their stay at Lulama (see 2.5.2). Group B was only exposed to the Lulama Pprogramme and not to the intergenerational family therapy programme. All the participants were tested before any treatment was started and again tested after completion of treatment. During the pre- and post-testing all the measuring instruments were used.

3.5 STATISTICAL PROCESSING

The research question is whether there is a significant statistical difference between the two groups.

3.5.1 STATISTICAL PROCESSING

To direct the research the following research hypotheses have been formulated:

Null hypothesis: There is no significant statistical difference between group A and group B with respect to the measuring of the dependent variable by all the measuring instruments.

Alternative hypothesis: Group A, not group B, will after completion of the Lulama Programme including the intergenerational family therapy, compared with the Lulama Programme, show a statistically significant difference of the dependent variable, which indicates a positive change in the functioning of the addict, family of origin and parental couple as measured by the measuring instruments.

3.5.2 STATISTICAL TECHNIQUES

Two different statistical techniques were used to determine the effect of the intergenerational family therapy programme.

The groups involved in this research were for practical reasons very small (group A, n = 4 and group b, n = 8) so that non-parametrical statistical techniques had to be used to determine the effect of the programmes. The Wilcoxen Test for dependent groups and the Mann-Whitney U Test for independent groups were used. Throughout, the average of achievement for each group was determined and then tested for significance (0.05 level).

3.5.2.1 The Wilcoxen Test

This test was used to compare the same groups' scores before and after the groups' exposure to the different programmes in order to see whether there was any significant growth. Group A was too small to obtain a reading on the tables so only the significant growth of group B could be determined.

The Wilcoxen Test is a non-parametrical alternative to the t-test for two dependent groups. The data must be at least on ordinal level and must be distributed in a continuous way.

For the purpose of this discussion, the procedure of this technique will not be explained, as it is done in detail by Roscoe (1975).

3.5.2.2 The Mann-Whitney U Test

This test was used to compare the two scores from the pre- and post-testing of the two groups (group A and group B), in order to obtain the significant differences between the two groups, pre- and post. It was also used to obtain scores that determined the significant growth difference between the two groups between the pre- and the post-testing.

The Mann-Whitney U Test is a non-parametrical alternative to the t-test for two independent groups and is nearly as powerful as the t-test. As with the previous test, this test requires at least ordinal data and a distribution which is continuous. This test does not require any assumption with respect to population parameters such as a normal distribution curve of homogeneity of variance.

For the purpose of this discussion the procedure of the technique will not be explained as this is done in detail by Roscoe (1975) and Du Toit (1981).

A one-or two-sided test can be used and in this instance a one-sided test was used.

CHAPTER IV

RESULTS

The aim of this chapter is to report on and discuss the results obtained during the pre- and the post-testing. The discussion of the results will be done on the three levels of functioning previously identified (see 4.2), namely the addict's functioning, the families' functioning and the parents' functioning. The results of each test used on the different levels will be discussed individually. At the end a summary of the results will be given combining the results of each level. On each level the discussion will focus on two points, firstly whether there was any difference between the pre-testing of the two groups and the post-testing of the two groups, and secondly whether there was any difference between the pre- and post-testing of each group.

Group A, as stated previously (see 3.5.2.1 and 3.5.2.2), was too small to obtain a significant reading on the tables, therefore no information can be given on the growth within this group. Because of this problem a test was done to determine whether there was a significant statistical difference in the growth level between programmes A and B. This was obtained by using the difference between group A's pre- and post-testing and group B's pre- and post-testing. These data are presented in the Mann-Whitney U Test under "Between".

4.1 THE ADDICT'S FUNCTIONING

The addict's functioning was assessed by using two tests, namely the POI and the PHSF. The results of these tests will be discussed below.

4.1.1 THE PERSONAL ORIENTATION INVENTORY

4.1.1.1 The results

The results indicating the possible difference between and within the two groups are given in Tables 4.1 and 4.2 respectively.

TABLE 4.1 THE MANN-WHITNEY U TEST FOR THE PERSONAL ORIENTATION INVENTORY

	X(A)		X(B)		P Value		
Subtest*	Pre	Post	Pre	Post	Pre	Pos	Between**
TC	12.25	13.25	13.25	12.38	0.3657	0.2707	0.1476
I	70	75.25	74.38	74.63	0.46585	0.5000	0.3049
SAV	14.25	15.50	15	15.38	0.33365	0.43185	0.5000
Ex	19.50	20.75	18.13	17.50	0.18885	0.15195	0.0548
Fr	14.75	14.75	15.88	17.63	0.3986	0.1297	0.1327
S	9.75	10.75	9.50	10	0.5000	0.5000	0.1915
Sr	6	9.50	6.88	7.63	0.5000	0.13225	0.06865
Sa	13.25	12.75	14	12.88	0.30295	0.39875	0.3986
Nc	8.75	10.75	7.88	9.13	0.3973	0.0493*	0.5000
Sy	6.50	5.50	3.50	4.75	0.07085	0.11055	0.3345*
A	16.25	13.50	13.25	14.88	0.0986	0.17215	0.00925*
C	16.75	16.25	15.38	16.38	0.26845	0.46535	0.21

Key:

TC = Time Competence
I = Inner-directed
SAV = Self-actualizing Value
Ex = Existentiality
Fr = Felling Reactivity
S = Spontaneity
Sr = Self-regard
SA = Self-acceptance
Nc = Nature of Man
Sy = Synergy
A = Acceptance of Aggression
C = Capacity for Intimate Contact

The * indicates a significance on the 0.05 level.
The ** indicates the difference obtained between the scores that are obtained between group A's pre- and post-testing, and groups B's pre- and post-testing.

TABLE 4.2 THE WILCOXON SIGNED-RANK STATISTICS FOR THE DIFFERENCE IN PRE- AND POST-TESTING FOR THE PERSONAL ORIENTATION INVENTORY

Subtest	A	B
Time Competence	2.0	-3.5
Inner-direction	3.0	-0.5
Self-actualizing Value	2.0	0.5
Existentiality	5.0	-1.5
Feeling Reactivity	0	13*
Spontaneity	2.5	-1.5
Self-regard	5	7
Self-acceptance	5	18*
Nature of Man	2.5	9.0
Synergy	-1.5	8.0
Acceptance of Aggression	-5.0	7.5
Capacity for Intimate Contact	-1.5	7.5

Key:
The * indicates a significance on the 0.5 level.

4.1.1.2 Discussion of the results

The results in Table 4.1 indicate that both groups were the same at the commencement of the treatment programmes in all the subtests of the POI. The random selection of groups was successful and an interpretation of the results can be made.

The results in Table 4.1 indicate that a statistically significant difference in the post-testing was noted between the two groups for the subtest Nature of Man (NC). The addicts in group A appear to have changed for the better. This would mean that the addicts in group A have a more constructive view of the nature of man. This would indicate that the Lulama Programme, including the intergenerational family therapy, was more effective than the Lulama Programme on this dimension.

The subtest Synergy (SY) (see Table 4.1) shows a statistically significant difference in growth between the two groups. The results indicate that group B has changed more positively while group A changed in a negative direction. This indicates that the addicts of group B grew significantly more than the addicts of group A in the ability to transcend dichotomies.

The subject concerned with measuring the ability to accept one's natural aggressiveness (A) indicates that there was a statistically significant difference in the growth between the two groups. In this case the average scores indicate that group B has grown more in the positive direction and group A in a negative direction. Group B has indicated a more significant growth than group A on this dimension, that is, the degree to which they accept their natural aggressiveness. The Lulama Programme was therefore more successful in obtaining growth in the two mentioned dimensions than the Lulama Programme including intergenerational family therapy. The results in Table 4.2, indicating the growth within the two groups, reflect a statistically significant growth for group B in the subtest Feeling Reactivity (FR) and Self-acceptance (SA). This indicates that the addicts in group B have grown to be more sensitive to their own needs and feelings and are more able to accept themselves in spite of their weaknesses or deficiencies. No information can be given on the growth within group A as the sample was too small to obtain any statistically significant results.

4.1.2 THE PERSONAL, HOME, SOCIAL AND FORMAL RELATIONSHIP QUESTIONNAIRE

4.1.2.1 The results

The results of the possible difference between and within the two groups are given in Tables 4.3 and 4.4 respectively.

TABLE 4.3 THE MANN-WHITNEY U TEST FOR THE PERSONAL, HOME, SOCIAL AND FORMAL RELATIONSHIP QUESTIONNAIRE

	X(A)		X(B)		P Value		
Subtest*	Pre	Post	Pre	Post	Pre	Pos	Between**
Self-c	1.75	2.5	3.5	3.13	0.1673	0.3996	0.10445
Self-e	2.25	2.75	3.25	2.75	0.33105	0.2136	0.1004
self-ctr	2.25	3.25	2.13	2.63	0.29135	0.12795	0.21575
Nerv.	3.75	3.5	3.63	3.5	0.36545	0.331235	0.039545
Hlth.	2.25	3.25	3.13	3	0.3000	0.3975	0.04405*
Fam.inf.	1.75	3.25	2.25	1.88	0.3595	0.05275	0.0029*
Pers.fr.	4	4.25	3.25	3.13	0.2446	0.2426	0.23055
Soc.(G)	4.5	4.25	3.38	3.75	0.3621	0.42985	0.2969
Soc.(S)	5.5	5.25	4.25	4.5	0.22695	0.21315	0.1253
Mor.s.	2.5	2.25	3.5	3.63	0.16905	0.12925	0.09585
Form.r.	3	4	3	3.375	0.16175	0.3020	0.2983
Des.sc	7.5	7.25	6.88	6.63	0.1641	0.1627	0.42875

Key:

Self-c	Self-confidence	Self-e	Self-esteem
self-ctr	Self-control	Nerv.	Nervousness
Hlth.	Health	Fam.inf.	Family influence
Pers.fr.	Personal freedom	Soc.(G)	Sociability-(G)
Soc.(S)	Sociability-(S)	Mor.s.	Moral sense
Form.r.	Formal relationships	Des.sc	Desirability scale

The * indicates a significance on the 0.05 level.
The ** indicates the difference obtained between the scores that are obtained between group A's pre- and post-testing, and groups B's pre- and post-testing.

TABLE 4.4 THE WILCOXON SIGNED-RANK STATISTICS FOR THE DIFFERENCE IN PRE- AND POST-TESTING FOR THE PERSONAL, HOME, SOCIAL AND FORMAL RELATIONSHIP QUESTIONNAIRE

Subtest	A	B
Self-confidence	3.0	-3.5
Self-esteem	1.5	-3.0
Self-control	3.0	3.5
Nervousness	-1.00	-1.5
Health	3	-1
Family influence	5	-3
Personal freedom	1	-1
Sociability - (G)	-1	3
Sociability - (S)	-0.5	2.5
Moral sense	-0.5	0.5
Formal relationships	1.5	4.5
Desirability scale	-0.5	-2.5

Key:
The * indicates a significance on the 0.5 level.

4.1.2.2 Discussion of the results

The results in Table 4.3 indicate that there was no significant difference in the pre-testing between the two groups at the commencement of the two programmes. The random selection of the two groups was successful and thus the data can be interpreted.

Table 4.3 indicates that there was no significant difference between the two groups after the completion of the two programmes. The results in Table 4.3 further indicate that group A has grown more in the two subscales of Health and Family influence than group B. Group A has grown more in the dimension which indicates an absence of preoccupation with the physical condition and their awareness of influences of their families such as their position within the family, the family togetherness, the relationship between the parents and the socio-economic condition.

- The results thus indicate that the Lulama Programme including the intergenerational family therapy precipitated more growth than the Lulama Programme alone on the mentioned dimensions.

The results in Table 4.4 indicated no significant growth in the post-testing for group B. No data are available for group A as a result of the small numbers.

4.2 THE FAMILIES' FUNCTIONING

The families' functioning was assessed with several measuring instruments (see Chapter iii). The results of each measuring instrument used will be discussed and a concluding discussion of all the measuring instruments will be given.

4.2.1 PARENT-ADOLESCENT COMMUNICATION

4.2.1.1 The results

The results obtained in order to indicate the possible difference between and within the groups are given in Tables 4.5 and 4.6 respectively.

TABLE 4.5 THE MANN-WHITNEY U TEST FOR THE PARENT ADOLESCENT COMMUNICATION

	X(A)		X(B)		P Value		
Subtest***	Pre	Post	Pre	Post	Pre	Pos	Between**
Father	62.25	69	67.63	67.13	0.2477	0.5000	0.3991
Mother	56	69	76.13	76.88	0.0204	0.1327	0.0161*
A-Father	52	60.25	59.13	57.13	0.0735	0.22155	0.07405
A-Mother	58.7	60.25	66.75	58.63	0.1002	0.43235	0.0585

Key:
The * indicates a significance on the 0.05 level.
The ** indicates the difference obtained between the scores that are obtained from the difference between group A's pre- and post-testing, and group B's pre- and post-testing.
The *** indicates the subtest of this test. Father indicates the father's perception of his communication with his son, Mother indicates the mother's perception of her communication with her son. The following two subtests indicate the adolescent's (addict's) communication with his father and mother respectively.

TABLE 4.6 THE WILCOXON SIGNED-RANK STATISTICS FOR THE PRE- AND POST-TESTING FOR THE PARENT ADOLESCENT COMMUNICATION

Subtest***	A	B
Father	2.0	- 1.5
Mother	5.0	- 2.5
A-Father	5	- 1
A-Mother	2.5	-12.0*

Key
The * indicates a significance on a 0.05 level.
*** See Table 4.5

4.2.1.2 Discussion of the results

In Table 4.5 the results indicate that there was no significant difference between the two groups at the commencement of the treatment programme. The results in this table also indicate that there was no difference between the two groups in the post-testing in any of the fields. This would indicate that neither of the two treatment programmes was more effective than the other.

Table 4.5 indicates that a statistically significant difference of growth between the groups had taken place in one of the fields. This field is the field that

measures the mother-perception of the communication between mother and son. This indicates that the mothers of group A felt that the communication between themselves and their sons had improved and the mothers of group B felt that it had hardly changed. It is important to note in this test that the subtest measuring the addicts' perception of the communication supports the feeling that the communication between themselves and their mothers had improved although the change is not statistically significantly different from group B. The Lulama Programme including the intergenerational family therapy was more successful in obtaining growth in this instance than the Lulama Programme alone.

The results in Table 4.6 indicate a statistically significant growth in only one of the subtests in group B. This test measures the addict's perception of his communication with his mother. The growth in this instance is negative, meaning that the addicts feel that the communication between themselves and their mothers has deteriorated. As mentioned previously, no data were available for Group A.

4.2.2 FAMILY SATISFACTION SCALE

4.2.2.1 The results

The results indicating the possible difference between and within the groups are given in Tables 4.7 and 4.8.

TABLE 4.7 THE MANN-WHITNEY U TEST FOR THE FAMILY SATISFACTION SCALE

	X(A)		X(B)		P Value		
Subtest	Pre	Post	Pre	Post	Pre	Post	Between**
Father							
Cohesion	22	22.25	26.63	28.38	0.1002	0.13355	0.46545
Adaptability	16.75	16.75	18.63	20.13	0.1297	0.3339	0.4322
Total	38.75	39	45.25	48.5	0.10095	0.1344	0.4659
Mother							
Cohesion	23	22.75	26.36	28.88	0.39895	0.30425	0.3984
Adaptability	15.25	15	19.13	18.13	0.11435	0.3339	0.33365
Total	38.25	37.75	45.5	44	0.2754	0.3666	0.5000
Addict							
Cohesion	20.5	23	28.13	23.75	0.04305*	0.5000	0.01045*
Adaptability	16.25	17.25	17.13	16.63	0.2707	0.3598	0.14835
Total	36.75	40.2	45.25	40.38	0.0615	0.3657	0.0047*

The * indicates a significance on the 0.05 level.
The ** indicates the difference obtained between the scores that are obtained from the difference between group A's pre- and post-testing, and group B's pre- and post-testing.

TABLE 4.8 THE WILCOXON SIGNED - RANK STATISTICS FOR THE DIFFERENCE BETWEEN THE PRE- AND POST-TESTING FOR THE FAMILY SATISFACTION SCALE

Subtest	A	B
Father		
Cohesion	1.0	12.5*
Adaptability	0.0	7.5
Total	0.0	-2.5
Mother		
Cohesion	-0.5	-8.5
Adaptability	5	-4
Total	2.0	-2.5
Addict		
Cohesion	0	12*
Adaptability	0.0	-7.5
Total	5.0	-3.5

Key
The * indicates a significance on the 0.05 level.

4.2.2.2 Discussion of the results

The results in Table 4.7 indicate that there was a statistically significant difference between the two groups at the commencement of the programmes in the subtest measuring the addict's perception of the cohesion in the family. The subsequent significance in the results for this subtest cannot be interpreted as other factors could be responsible for the changes that have occurred. The remaining subtests have been found not to differ significantly for the two groups (see Table 4.7) on the pre-testing.

Table 4.7 indicates that there was no significant difference between the two groups after the completion of the two programmes. Table 4.7 shows that group A has experienced a more significant growth than group B on the subscale that measures the addict's perception of the satisfaction he obtains from the family as a whole. In the interpretation of these results caution has to be taken as the data in this subtest include the data from the previous subtest discussed above. Considering then that one part of the result for this test was already different at the commencement of the two programmes it is possible that the results of this test are also not valid.

The results in Table 4.8 indicate in the subtests' testing of the fathers' and the addicts' perception of the satisfaction gained from the family, a statistically significant growth within group B. The subtests indicating the fathers' and the addicts' perception of the cohesion indicated that they feel that the cohesion has improved. No data are available on the growth within group A as a result of the size of this group.

4.2.3 THE FAMILY OF ORIGIN SCALE

4.2.3.1 The results

The results indicating the possible change between and within the two groups are given in Tables 4.9 and 4.10 respectively.

TABLE 4.9 THE MANN-WHITNEY U TEST FOR THE FAMILY OF ORIGIN SCALE

	X(A)		X(B)		P Value		
Subtest	Pre	Post	Pre	Post	Pre	Post	Between**
Intimacy							
A	10.75	10.5	11.12	11.74	0.31645	0.06535	0.2054
B	12.75	13.25	11.5	11.37	0.5000	0.01445*	0.1297
C	12.25	13.25	12.63	12.25	0.1804	0.1239	0.1489
D	11.5	11.75	10.38	10.5	0.09495	0.10665	0.139485
E	13	13.25	11.88	12	0.2162	0.14845	0.46505
Total	60.25	62	57.48	57.86			
Autonomy							
A	10.25	12.75	12	12.55	0.06975	0.1407	0.0848
B	12.5	13	13.25	12.25	0.2729	0.19365	0.07305
C	12.5	12.75	12.13	12.12	0.3966	0.2669	0.5000
D	10.5	11	11.38	11.74	0.1062	0.1870	0.3831
E	11.5	11	11.88	11.61	0.30625	0.09295	0.46195
Total	57.25	60.5	60.63	60.27			
Total	117.5	122.5	118	118.13	0.43295	0.17425	0.10055

Key:
The * indicates a significance on the 0.05 level.
The ** indicates the difference obtained between the scores that are obtained from the difference between group A's pre- and post-testing, and group B's pre- and post-testing.
The *** indicates the subtests, firstly for intimacy. A measures the range of feelings, B measures the mood and tone, C measures conflict or resolution, D measures the empathy and E measures the trust in the family. Secondly the autonomy in the family is measured. A measures clarity of expression, B measures responsibility, C measures the respect for others, D measures the openness to others and E measures the acceptance of separation and loss in the family.

TABLE 4.10 THE WILCOXON SIGNED - RANK STATISTICS FOR THE DIFFERENCE BETWEEN THE PRE- AND POST-TESTING FOR THE FAMILY OF ORIGIN SCALE

Subtest	A	B
Intimacy		
A	-1	7
B	1.0	-1.5
C	2.0	-2.5
D	0.5	0.5
E	0.5	1.5
Total		
Autonomy		
A	3	5
B	0.5	-5.5
C	0.5	1.0
D	1.5	3.0
E	-0.5	-2.5
Total	3	-1

Key *** See table 4.9

4.2.3.2 Discussion of the results

The results in Table 4.9 indicate that there are no statistically significant differences in the pre-testing between the two groups and thus the results can be compared and interpreted.

The results of this test (see Table 4.9) indicate, in the post-testing, that there was a difference noted in the subtest (B) that measures the addicts' perception of the mood and tone within the family. The results indicate that (during post-testing) the addicts in group A see the mood and tone of the family more positively than the addicts in group B. The Lulama Programme including the intergenerational family therapy was more successful in obtaining growth in this dimension than the Lulama Programme alone.

The results in Table 4.10 indicate no significant growth within any of the subtests for group B. As previously mentioned no information is available for group A.

4.2.4 FAMILY STRENGTHS

4.2.4.1 The results

The results indicating the possible changes between and within the groups are given in Tables 4.11 and 4.12 respectively.

4.2.4.2 Discussion of the results

The results in Table 4.11 indicate a statistically significant difference in three subtests prior to the commencement of the research. These subtests are the subtests measuring the adolescents' (addicts') perception of the pride and the accord in the family and the subtest measuring the perception of the mothers of the family strengths as a whole. No further interpretation can be made of the results on these subtests as other factors might be responsible for any changes that have been noted. In the remainder of the subtests no statistically significant change was noted prior to the commencement of the two programmes.

In Table 4.11 the results indicate that a statistically significant difference was noted between the groups in the post-testing on several subtests. The subtest measuring the fathers' perception of accord in the family indicated that the fathers of group B see the accord in the family as significantly higher than that of the fathers in group A. The results further indicate that the perception of the

mothers of group B of the pride and the accord in the family is significantly higher than that of the mothers in group A.

TABLE 4.11 THE MANN-WHITNEY U TEST FOR FAMILY STRENGTHS

	X(A)		X(B)		P Value		
Subtest	Pre	Post	Pre	Post	Pre	Post	Between**
Father							
Pride	29.5	24.5	10.13	32	0.39895	0.09655	0.0039*
Accord	10.5	11.25	15	15.63	0.0524	0.0345*	0.43175
Mother							
Pride	40	35.75	45.13	47.63	0.15195	0.0204*	0.0248*
Accord	24.5	19.75	30.13	30.38	0.1717	0.01215*	0.0155*
Adolescent							
Pride	8.25	10.75	13.13	14.51	0.0158*	0.0723	0.4321
Accord	32.75	30.5	43.25	44.88	0.0065*	0.0254*	0.2477
Total							
Father	21.75	21.75	24	24.13	0.43235	0.5000	0.5000
Mother	10.5	10.25	15.25	12.88	0.01565*	0.0422*	0.13785
Adolescent	32.25	32	39.25	36.88	0.07230	0.2473	0.13225
Family total	34.82	32.7	42.61	43.11	0.01070	0.0085*	0.0370*

Key:
The * indicates a significance on the 0.05 level.
The ** indicates the difference obtained between the scores that are obtained from the difference between group A's pre- and post-testing, and group B's pre- and post-testing

TABLE 4.12 THE WILCOXON SIGNED - RANK STATISTICS FOR THE DIFFERENCE BETWEEN THE PRE- AND POST-TESTING FOR FAMILY STRENGTHS

Subtest	A	B
Father		
Pride	.-5.0	10.5
Accord	0.5	6.0
Mother		
Pride	-3.0	4.5
Accord	2	3.
Adolescent		
Pride	1.0	0.5
Accord	-1	-12*
Total		
Father	-3.0	10.5
Mother	-2.0	4.5
Adolescent	-0.5	- 5.5
Family total -4 6		

Key
The * indicates a significance on the 0.05 level.

The total score of all the members of the families also indicates a significant difference between the two groups. The results indicate that the members of group B feel that the family is stronger after the Lulama Programme than the members of the families that went through the Lulama Programme that included the intergenerational family therapy. It is important to note here that the total score includes the scores of the subtests that were different prior to the commencement of the two programmes and that these could have an influence on the latter result. It is the belief of the researcher that the evidence that change in the other subtests has occurred is sufficient to allow importance to be ascribed to the latter results. These results would indicate that the Lulama Programme was more effective than the Lulama Programme including the intergenerational family therapy on these dimensions.

The results in Table 4.11 also indicate that there was a statistically significant difference in the growth between group A and group B in the fathers' perception of the pride. There was also a significant statistical difference in the growth level between the mothers of group A and B in their perception of the pride and accord dimensions within the family. The results on all three these subscales were in favour of group B.

In summary one can say here that the Lulama Programme and not the Lulama Programme including the intergenerational family therapy initiated more growth on the above-mentioned dimensions.

The results in Table 4.12 indicate that in only one of the subtests has a statistically significant growth within group B occurred. The subtest that measures the addicts' perception of the accord within the family indicates that a negative growth has taken place. This could mean that the addicts see that the accord in the family has deteriorated. No interpretation can be made of the scores obtained for group A as the group is too small to indicate any statistical differences.

4.2.5 THE MADANES HIERARCHY SCALE

4.2.5.1 The results

The results indicating the difference between and within the different groups are given in Tables 4.13 and 4.14 respectively.

TABLE 4.13 THE MANN-WHITNEY U TEST FOR THE MADANES HIERARCHY SCALE

	X(A)		X(B)		P Value		
Subtest	Pre	Post	Pre	Post	Pre	Post	Between**
Total	3.75	4.5	7.38	8.88	0.00755	0.0052*	0.1695

Key
The * indicates a significance on the 0.05 level.
The ** indicates the difference obtained between the scores that are obtained from the difference between group A's pre- and post-testing, and group B's pre- and post-testing

TABLE 4.14 THE WILCOXON SIGNED - RANK STATISTICS FOR THE DIFFERENCE BETWEEN THE PRE AND POST TESTING FOR THE MADANES HIERARCHY SCALE

Subtest	A	B
Total	5	18*

Key
The * indicates a significance on the 0.05 level.

4.2.5.2 Discussion of the results

The results in Table 4.13 indicated that the two groups differed prior to the commencement of the two treatment programmes. No interpretation can be made of the results indicating significance as other factors could be responsible for these differences. The results in Table 4.14 indicate that there was a statistically significant growth within group B. This indicates that there was a positive change in the hierarchy of the family as perceived by the family. As previously mentioned no information is available for group A.

4.3 THE PARENTS' FUNCTIONING

The parental functioning was assessed by using the Parental Assessment of the Intimacy in the Relationship (see 2.2.8).

4.3.1 PERSONAL ASSESSMENT OF INTIMACY IN RELATIONSHIPS

4.3.1.1 The results

The results that possibly indicate the difference between and within the two groups are given in Tables 4.15 and 4.16 respectively.

4.3.1.2 Discussion of the results

The results indicated that the two groups differed in two subtests at the commencement of the two programmes (see Table 4.15). These two subtests are the fathers' perception of the perceived sexual intimacy and the expected intellectual intimacy. In these two subtests no further interpretation can be made as other factors are possibly responsible for any of the significant changes that have occurred.

In Table 4.15 the subtest measuring the conventionality for both mothers and fathers shows a statistically significant difference. Important to note is that the Conventionality subtest gives an indication of the extent to which an individual is responding to the PAIR in a socially desirable fashion. The higher the Conventionality subtest score, the more the individual is responding in a socially desirable way. Looking at the results there is a statistically significant difference between the two groups in the post-testing for both the mothers and the fathers. It becomes apparent when looking at the scores that both mothers' and fathers' scores are very high for group B, which suggests the interpretation that both mothers and fathers in group B are trying to appear to feel better than what they really do. They are in other words faking good (Olson and Scheafer, 1981). The mothers and fathers of group A thus appear to be

TABLE 4.15 THE MANN-WHITNEY U TEST FOR THE PERSONAL ASSESSMENT OF INTIMACY IN RELATIONSHIPS

	X(A)		X(B)		P Value		
Subtest	Pre	Post	Pre	Post	Pre	Post	Between**
Father perceived							
A	52.5	58.25	74	77.38	0.10095	0.07335	0.5000
B	45	58.5	49.75	51.38	0.27505	0.27575	0.22035
C	33	43.5	69.75	69.75	0.0164*	0.01655	0.15325
D	51	62.75	57.75	59	0.43175	0.0327	0.22115
E	44	55	56.88	66.63	0.0737	0.08675	0.46605
F	51.5	52.5	79.75	80	0.03575	0.0132*	0.5000
Father expected							
A	78.5	86	73.75	87.5	0.30425	0.29175	0.698825
B	76	82	65	67	0.1301	0.19325	0.3643
C	86	84	77.25	81.63	0.0994	0.43125	0.19535
D	85	76	65.75	77.5	0.0137*	0.33445	0.21995
E	84	86	67	76.5	0.0518	0.2430	0.17385
Mother perceived							
A	35.5	26	59.5	65.5	0.07265	0.0108*	0.1327
B	54	49.5	58.25	62	0.3342	0.30426	0.27435
C	55	49.5	66.75	68.75	0.1152	0.1160	0.073
D	39	33	56.5	59.5	0.22155	0.0521	0.43245
E	44	40	60.5	58.25	0.1002	0.10095	0.3984
F	39	29.5	64.75	70.5	0.07265	0.01095*	0.13225
Mother expected							
A	82	87	85.75	86.25	0.1641	0.5000	0.30265
B	72	88	69.5	74.75	0.43185	0.16995	0.024*
C	76	83	84	87.75	0.0998	0.2183	0.4656
D	80	90	79	89.5	0.43185	0.4612	0.5000
E	63	65	74.5	89.5	0.1730	0.0137*	0.049*

Key:
The * indicates a significance on the 0.05 level.
e ** indicates the difference obtained between the scores that are obtained from the difference between group A's pre- and post-testing, and group B's pre- and post-testing.
A = Emotional intimacy
B = Social intimacy
C = Sexual intimacy
D = Intellectual intimacy
E = Recreational intimacy
F = Conventionality scale

TABLE 4.16 THE WILCOXON SIGNED - RANK STATISTICS FOR THE DIFFERENCE BETWEEN THE PRE- AND POST-TESTING FOR THE PERSONAL ASSESSMENT OF INTIMACY IN RELATIONSHIPS

Subtest	A	B
Father perceived		
Emotional intimacy	2	8
Social intimacy	4	-1
Sexual intimacy	3	1
Intellectual intimacy	3	3
Recreational intimacy	1.5	13.0*
Conventionality scale	0	1
Father expected		
Emotional intimacy	2	18*
Social intimacy	1.5	3.5
Sexual intimacy	-0.5	8.5
Intellectual intimacy	0	14.5*
Recreational intimacy	0.5	10.0
Mother perceived		
Emotional intimacy	-2	4
Social intimacy	-1.5	6.5
Sexual intimacy	-1.5	5.5
Intellectual intimacy	-1.0	-0.5
Recreational intimacy	-1.5	-5.0
Conventionality scale	-2.0	8.5
Mother expected		
Emotional intimacy	2.0	1.5
Social intimacy	5	8
Sexual intimacy	1.5	11.0
Intellectual intimacy	1.5	10.5
Recreational intimacy	0.5	14*

Key
The * indicates a significance on the 0.05 level.

more honest with themselves and more in touch with their feelings. The above results have to be taken into consideration when interpreting the rest of the results as the mothers and fathers of group B seem to be idealizing the relationship while minimizing the problem (Olson and Scheafer, 1981).

The results further indicate that there was a statistically significant difference in the post-testing in the field measuring the mothers' perception of the perceived emotional intimacy and their perception of the expected recreational intimacy. It appears that the mothers in group B tested statistically significantly higher than the mothers in group A on these two dimensions. These results would indicate that the Lulama Programme was more effective than the Lulama Programme including the intergenerational family therapy on these dimensions.

The results further indicate a significant statistical difference between the amount of growth which was observed in the two groups as a result of the different programmes. The mothers of group A have shown a more significant growth than the mothers of group B on the subscale expected Recreational Intimacy while the mothers of group B have shown a more significant growth than the mothers of group A on the subscale expected Recreational Intimacy. These results would indicate that neither of the two programmes was significantly more effective.

The results in Table 4.16 indicate that in group B four subtests showed a statistically significant growth within the subtest. The four subtests are the subtests measuring the fathers' perception of the expected emotional intimacy and the expected intellectual intimacy and the mothers' perception of the expected recreational intimacy. The subtest results on this table support the results found in Table 4.15. No data are available on the growth within Group A as the group was too small to obtain any statistical significant readings on the tables.

4.4 THE SUMMARY OF DISCUSSIONS

The results on the level of the addicts' functioning as indicated by the results on the POI and the PHSF (see 4.1.1.2 and 4.1.2.2) indicate that some limited changes have occurred between the pre- and post-testing. The aim of the Lulama Programme, including the intergenerational family therapy programme, was to help the addict individuate from the family and to become aware of the effects that the family has on his addiction (see 2.5.2). The results indicated that there was a statistically significant difference between the two groups in the subtest Nature of Man at the post-testing, where group A felt more positive in their view of the nature of man. The Lulama Programme including the intergenerational family therapy was more effective than just the Lulama Programme to obtain this change.

The results also indicated that there was a statistically significant growth difference in the two groups. The addicts in Group B were more able to transcend dichotomies and accept their natural aggressiveness. The addicts of group A were more aware of the effects of the addiction on their health and of the family influence (see Table 4.3). The above seems to indicate that the effects of the two programmes were different. The focus on growth is such that group A seems to be more aware of the effects that the family and other outside factors have on his addiction, while the changes in group B were clearly directed more specifically at an inward or individual change. The results indicate that the expectations of group A were met in that they were more aware of the family influences (see 2.5..2.2) but the group did not move to become more individuated. Thus the Lulama Programme including intergenerational family therapy only had limited success. In contrast group B, after just the Lulama Programme, was more individuated, the effects that the

family could, however, have on their addiction were completely ignored. The aim of the programme including the intergenerational family therapy was to make the members aware of the faulty communication or broken down communication networks and help them improve or re-establish these networks of communication (see 2.5.2.2).

The results of the Parent-Adolescent Communications indicate a statistically significant difference in growth, indicating the improvement in communication between mother and son of group A, while the communication between mother and son of group B deteriorated markedly (see 4.2.1.2). This would indicate that the aim of the programme including intergenerational family therapy was partially attained. It can thus be said that the Lulama Programme including the intergenerational family therapy was more effective in obtaining growth.

The Lulama Programme including the intergenerational family therapy was designed so as to make the family aware of the problems in the family (see 2.5.2.2). The family would then become dissatisfied and the Lulama Programme including the intergenerational family therapy programme would help the family to improve the satisfaction gained from it.

It would appear from the results of the Family Satisfaction Scale that the expected results were only partly achieved (cf. 4.2.2.2). The persons in group A (Lulama Programme including intergenerational family therapy) did not perform significantly better than the persons in group B on any of the subscales after completion of the programme. It was found, however, that the addicts in Group A experienced a more significant growth than those in group B on the subscale that measures the addicts' perception of the satisfaction obtained from the family as a whole. The assumption can therefore be made

that the Lulama Programme including the intergenerational family therapy was partly successful in helping the addict to confront problems within the family of which he/she had become aware, and in so doing derive greater satisfaction from the family. Similar results were not found in the parents.

The results of group B indicated that the fathers as well as the addicts showed a statistically significant growth in the cohesion of the family. Two reasons can be given for this. One is that the Lulama Programme was effective and helped the members of the families in group B change and adjust at the end of therapy thus feeling more satisfied. A second one is that the members preferred not to involve the family, and the family agreeing, thus played into the dynamics previously discussed in the connection between drug addiction and family dynamics. The researcher is more inclined to accept the second reason, although further research will have to be done to determine this.

The FOS scale was used in this instance to obtain an indication of the addicts' perceived level of health in his family of origin and also to give an indication of the basic unresolved issues in the family of origin (see 3.2.6.3). The addicts in the families of group A indicate in the family of origin scale (see 4.2.3.2) at the post-testing that they are more aware of the mood and tone of the family. This is an indication of the effectiveness of the Lulama Programme including the intergenerational family therapy in making the addict aware of how the feelings and emotions in the family affect his addiction. This test indicated that in group A the addict became aware of many unresolved feelings. On the Family Strengths test (see 4.2.4.2) the results indicate that the fathers of group B see the accord as significantly better during post-testing than the fathers in group A. The same results are seen in the subtest measuring the mothers' perception of pride and accord in the family. The total score of the whole family

also indicates the same mode of change. Group B feels that the family is stronger and A not. These results indicate that the Lulama Programme seems to be more successful than the Lulama Programme including the intergenerational family therapy. Looking at the difference in growth between these two groups in this test one finds that the above data are supported. In group B the results indicate a growth in the fathers' perception of pride, in the mothers' perception of pride and accord, and in the total score for the family's perception of strengths. These data would indicate that the Lulama Programme was more effective than the Lulama Programme including the intergenerational family therapy. A further explanation is that the Lulama Programme including the intergenerational family therapy, focuses on the family and the family becomes aware of their lack of strength, and consequently the low scores are achieved. If this is indeed the reason, then the Lulama Programme including the intergenerational family therapy is very effective and is obtaining its goal.

On the parental relationship level, as measured by the PAIR (see 4.3.1.2), it seems that the parents of group B were trying to appear a lot more positive than they really were after the programmes. Group A indicated clearly that all was not well in the relationship as seen in the low average score in the pre- and post-testing. Only a few of the subtests indicated significant differences of growth and although the parents of group A knew something was lacking in their relationships they found it hard to indicate exactly what it was that was lacking.

Again it was the aim of the programme including the intergenerational family therapy to make the parents aware of any problems within the parental relationship and then help them to solve these problems. The results indicated

that the parents did become more aware of the problems but by the end of the programme the problems still existed and often the expectations grew even further away from reality. The programme thus failed to help in improving the problems.

The alternative hypothesis can be accepted in some of the subtests but the researcher is of the opinion that the null hypothesis should be accepted for the research. The results obtained on most of the tests indicated only small changes in some of the subtests. A closer look at the results indicates almost no statistically significant difference at post-testing or growth in a large number of the subtests and thus indicates that the null hypothesis should be accepted.

The results further indicated that the Lulama Programme successfully precipitated statistically significant growth in the participants (group B) on some of the dimensions measured on the scale. These dimensions are: Feeling Reactivity (Fr), and Self-acceptance (Sa) on the POI; negative growth on the addict's perception of his/her communication with his/her mother on the Parent-Adolescent Communication; the fathers' and the addicts' perception of the satisfaction gained from the family on the Family Satisfaction Scale; negative growth in the addicts' perception of the accord within the family as measured by Family Strengths; a positive change in the hierarchy of the family as perceived by the family on the Madanes Hierarchy Scale; the fathers' perceived recreational intimacy, their expected emotional and intellectual intimacy on the PAIR. As indicated, Group A was too small to determine whether the Lulama Programme including intergenerational family therapy made any significant impact on the growth of the subjects.

CHAPER 5

CONCLUSION

In this section the most significant conclusions following from the research, as well as certain limitations in the research are indicated, and finally suggestions for further research are made.

The research has indicated that the Lulama Programme including the intergenerational family therapy was not as successful as expected. It became apparent that the programme presentation, in comparison with the Lulama Programme, resulted in statistically significantly better results in only a few dimensions of the addict and his/her family of origin. The former programme could precipitate significantly more growth in only very few relationship dimensions, in contrast to the Lulama Programme. It would appear that the Lulama Programme achieved better results in only very few relationship dimensions during post-testing, and precipitated more growth than the Lulama Programme which included the intergenerational family therapy.

The researcher has found two significant flaws in this research, namely the size of the sample and the measuring instruments used.

The Wilcoxon Test could not be used for group A as the group was too small to obtain readings on the tables. The effect of this was that the growth of group A could not be obtained as was done with the growth in group B. The Mann-Whitney U Test had to be used to achieve this. If the group had been bigger the growth of group A could have been determined and more significant

results made possible. The researcher thus regards a bigger sample as essential for further effective research.

One of the major problems of this research is that the tests used to assess the family and the parents are American and that no standardized scores for the South African population exist. This made assessment difficult as only the raw scores could be used and not standardized scores, which would have enabled more accurate interpretations. Research should be done to construct more tests to assess the family and its function in a more objective way as the tests used in this research were all self-report questionnaires and a margin of subjectivity was inevitable

A further suggestion for future treatment programmes is that the period of therapy should be extended to obtain significant change. The period between the pre- and the post-testing should also be extended as some of the changes possibly take longer to become visible.

SUMMARY

The question posed in this research is whether intergenerational family therapy included in the Lulama Programme has a different effect on the addict and his family of origin than the Lulama Programme alone. This topic was chosen as the problem of drug abuse and its treatment poses an ever-increasing dilemma for the South African Health Care professions.

In the literature study numerous researchers indicate that the family and the structure within it lead to and aggravate drug addiction. The young child involved in the triangle, or the need to maintain the equilibrium within the family for survival, are just a few examples mentioned. Further, a look is taken at what some theorists see as intergenerational family therapy and how it is applied. The theorists that were discussed were Bowen, Boszormenyi-Nagy and Spark and Napier.

Against this background a programme including intergenerational family therapy was designed and applied to a section of the population at Lulama. This was consequently compared to a section of the populaton which only went through the Lulama Programme.

The results indicated that the null hypothesis had to be accepted for the researcher. The results indicated that there were significantly more differences between the two groups during post-testing on the measuring instruments used. Some of the differences were in favour of the Lulama Programme and others were in favour of the combined programme. There was also a significant difference in some dimensions in the level of growth that the two pro-

grammes had precipitated. Here too, there was a discrepancy in the success of the two programmes.

The results also indicated that there were several problems. One of the main problems was that the sample was too small. The reason for this was the ethical and practical problems involved in obtaining the sample. Other questions such as the tests used and the length of the programme and the period between the pre- and post-testing also became an issue.

It is the view of this researcher that research in this field is vitally important. It has become clear in this research that the programme including the intergenerational family therapy had limited success, more research has to be done before this becomes a programme that can be widely recommended.

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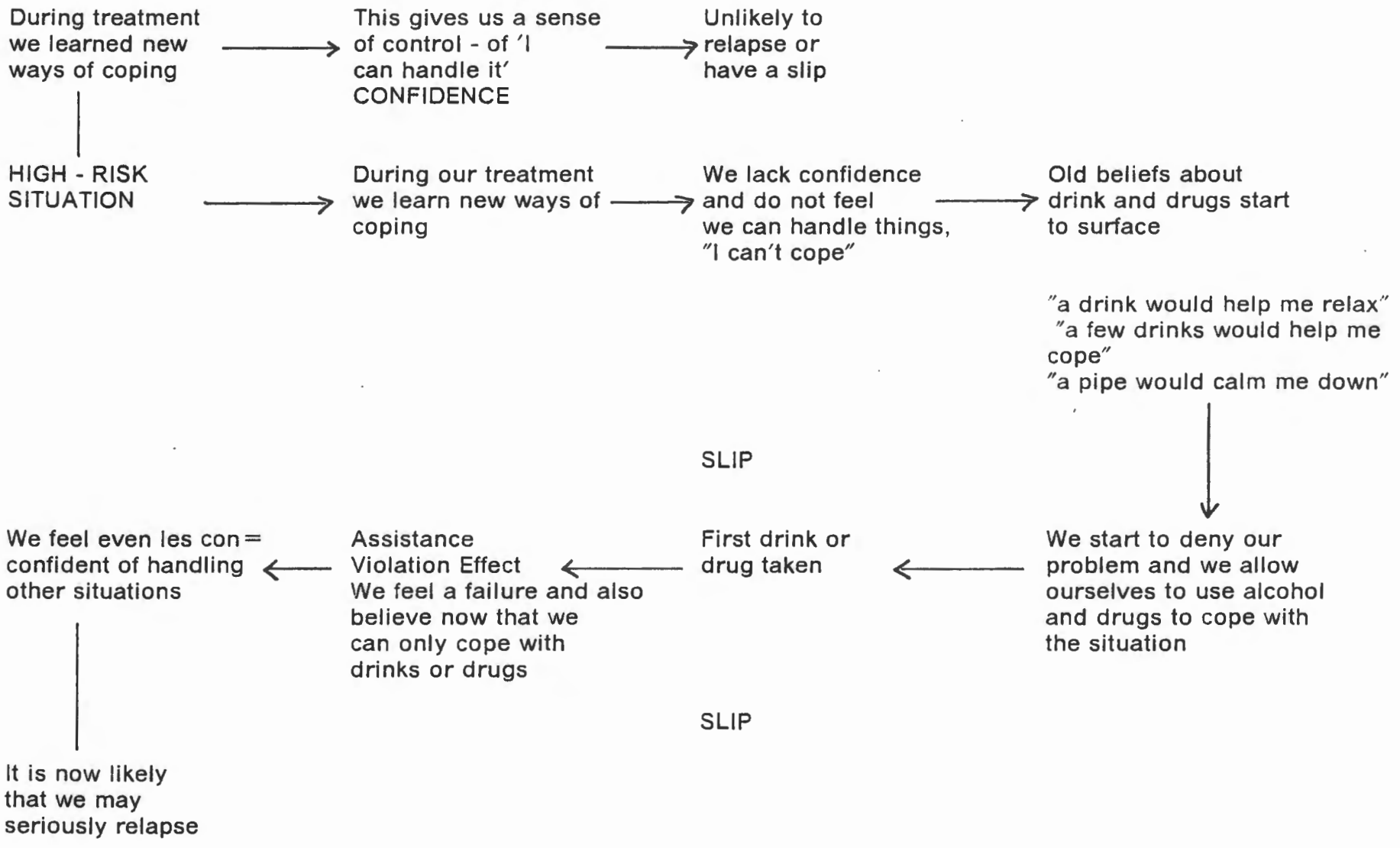
APPENDIX I


During treatment we learned new ways of coping
This gives us a sense of control - of 'I can handle it' CONFIDENCE
Unlikely to relapse or have a slip
HIGH - RISK SITUATION
During our treatment we learn new ways of coping
We lack confidence and do not feel we can handle things, "I can't cope"
Old beliefs about drink and drugs start to surface
"a drink would help me relax"
"a few drinks would help me cope"
"a pipe would calm me down"
We start to deny our problem and we allow ourselves to use alcohol and drugs to cope with the situation
SLIP
First drink or drug taken
Assistance Violation Effect
We feel a failure and also believe now that we can only cope with drinks or drugs
We feel even les con= confident of handling other situations
SLIP
It is now likely that we may seriously relapse

APPENDIX II

HIGH-RISK SITUATIONS

1. **Interpersonal Conflicts**
   Arguments, fights, frustration, anger, jealousy, disagreements.

2. **Abstinence Violation Effect**
   A situation which follows an initial slip; person feels guilty, anxious, weak, disappointed, sense of failure, lack of control, tendency to want to give in and continue drugging/drinking.

3. **Social Pressure**
   An individual or a group exerts pressure on you to consume alcohol or take your drug; seeing someone else using alcohol or drugs eg. on TV, group of friends - glamorize the picture.

4. **Negative Emotional States**
   Fear, anxiety, depression, sadness, loneliness, grief, disappointment, boredom, worry - reactions to job, financial, domestic or interpersonal problems.

5. **Craving and Sensation Seeking and Testing Personal Control**
   Physical craving following exposure to substance cues eg. listening to someone explain how you make a white pipe. Sensation seeking - i.e. a person wants to enhance positive feelings of pleasure, celebration, sexual excitement. Use of the substance to test the ability to use it in a controlled way. Tests of willpower eg. pub friends who still smoke - keeping alcohol in the house.

6. **Negative Physical states**
   Situations involving illness, fatigue, injury, physical pain, headaches.

7. **Interpersonal Evaluation**
   A situation involving negative evaluation - criticism, fear of not being accepted.

APPENDIX III

RELAPSE WARNING SIGNS

1. **Apprehension about well-being**

   Fear and uncertainty. A lack of confidence in the ability to stay sober. This apprehension may be brief.

2. **Denial**

   The patient re-activates denial systems in order to cope with apprehension and resultant anxiety and stress. The denial systems re-activated in this stage of the relapse dynamic correspond with the denial system utilised to deny the alcoholism during initial phases of treatment.

3. **Adamant commitment to sobriety**

   The patient convinces himself that "he will never drink again". Once a patient convinces himself that he will never drink again, the urgency of pursuing a daily programme of recovery diminishes.

4. **Compulsive attempts to impose sobriety on others**

   The patient attempts to impose sobriety or individual standards for recovery on others. This involves judgements about the drinking of friends and spouses and the quality of the sobriety programmes of fellow recovering alcoholics. When dealing with the issues of sobriety, the patient begins to focus more on what other persons are doing, rather than on what he himself is doing.

5. **Defensiveness**

   The patient displays a noticeable increase in his defensiveness when talking about his problems or recovery programme.

6. **Compulsive behaviour**

   Behaviour patterns become rigid and repetitive. The patient tends to control conversational involvement either through monopoly or silence. A tendency toward overwork and compulsive involvement in activities begins to appear. Non-structured involvement with people is avoided.

7. **Impulsive behaviour**

   There are impulsive reactions. The impulse may be an over-reaction to acute episodes of stress. There are also reports of impulsive activities being the culmination of a chronic stress situation. These over-reactions to stress may form the basis of decisions which affect major life-areas and and commitments to ongoing treatment.

8. **Tendencies toward loneliness**

   Patterns of isolation and avoidance increase. There are generally valid reasons and excuses for this isolation. Patients report short episodes of intense loneliness at increasing intervals.

9. **Tunnel vision**

   Patients tend to view their life in isolated fragments. They might focus exclusively on one area, preoccupy themselves with it and avoid looking at other areas. Sometimes preoccupation is with positive aspects thus creating a delusion of well-being and security. Others may preoccupy themselves with the negative aspects thus assuming a victim position which confirms their belief that they are helpless and being treated unfairly.

10. **Minor depression**

    Symptoms of depression begin to appear and persist. Listlessness, flat acceptance and oversleeping may become common.

11. **Loss of constructive planning**

    The patient's life-planning deteriorates. Attention to detail subsides. Wishful thinking begins to replace realistic planning.

12. **Plans begin to fail**

    Due to lack of attention to detail, or the pursuit of unrealistic objections, plans begin to fail.

13. **Idle daydreaming and wishful thinking**

    The ability to concentrate diminishes and concentration is replaced with fantasy. The "if only" phrase becomes more common in conversation. The fantasies are generally of escape or of 'being rescued from it all" by some unlikely set of circumstances.

14. **Feelings that nothing can be solved**

    A failure pattern develops. In some cases the failure is real, in other cases it is imagined. The generalised perception of "I've tried my best and it isn't working out" begins to develop.

15. **Immature wish to be happy** Conversational content and thought patterns become vague and generalised. The desire to "be happy" or "have things work out" becomes more common without ever defining what is necessary to be happy or have things work out..

16. **Periods of confusion**

    Episodes of confusion increase in terms of frequency, duration and severity.

17. **Irritation with friends**

    Social relationships, including friends and intimate relationships, as well as treatment relationships formed with therapists and AA members, become strained and conflictual. The conflictual nature increases as confrontation of the patient's progressively denigrating behaviour increases.

18. **Easily angered**

    Hyperreacting becomes more frequent. Often the fear of extreme overreaction to the point of violence may seriously increase the level of stress and anxiety.

19. **Irregular eating habits** The patient begins overeating or undereating. The regular structure of meals is disrupted. Well-balanced meals are often replaced by less nourishing "junk foods".

20. **Listlessness**

    Extended periods of inability to initiate action develop. These are marked by inability to concentrate, anxiety and feelings of apprehension. Patients may report this as a feeling of being trapped or having no way out.

21. **Irregular sleeping habits**

    Episodes of insomnia are reported. Nights of restlessness and fitful sleeping are reported. There may be episodes of sleeping marathons of

12-20 hours reported at intervals varying between 6 and 15 days. These sleeping marathons may result from exhaustion.

22. **Progressive loss of daily structure**

Daily routines become haphazard. Regular sleeping hours are disrupted. Inability to sleep results in oversleeping. Meal structures disappear. Complaints of inability to keep appointments become more common and social planning decreases. Patients report feeling rushed and overburdened at times and then face stretches of idle time in which they don't know what to do. An inability to follow through on plans and decisions is reported. Patients may report that they know what they should do, but are unable to overcome strong feelings of tension, frustration, fear or anxiety that prevent them from following through.

23. **Periods of deep depression**

Depression becomes more severe, more frequent, more disruptive and longer in duration. These periods generally occur during non-structured time periods and are amplified by fatigue and hunger. During these times the patient tends toward isolation and reacts to human contact with irritability and anger while at the same time complaining that nobody cares.

24. **Irregular attendance at treatment meetings**

Attendance at AA and/or therapy appointments are scheduled and then missed. Rationalisation patterns may develop to justify this. The effectiveness of AA and/or treatment is discounted.

25. **Development of an "I don't care attitude"**

The patient exhibits an "I don't care" attitude, which may mask a feeling of helplessness and extremely poor self-image.

26. **Open rejection of help**

The patient may cut himself off from viable sources of help. This may be accomplished dramatically through fits of anger or open discounts. At other times it may be done through quiet withdrawal.

27. **Dissatisfaction with life**

The patient begins to think: "Things are so bad now I might as well get drunk because they can't get any worse". Life seems totally unmanageable.

28. **Feelings of powerlessness and helplessness**

This may be marked by an inability to initiate action. Thought processes are scattered, judgement is distorted, concentration and abstract thinking abilities are impaired.

29. **Self-pity**

The patient becomes indulgent in self-pity. The self-pity may often be used as an attention-getting device.

30. **Thoughts of social drinking**

The patient realises that drinking could normalise many of the feelings and emotions he is experiencing. The hope that perhaps he could again drink in a controlled fashion begins to emerge. Sometimes the thought may be challenged while at other times it is entertained. The patient feels he has few alternatives other than drinking.

31. **Conscious lying**

Denial and rationalisation become such extreme processes that even the patient may recognise the lies and deceptions. In spite of this recognition, he may feel unable to interrupt the pattern.

32. **Complete loss of self-confidence**

The patient feels that he cannot get out of this trap no matter how hard he tries. He becomes overwhelmed by his inability to think clearly or to initiate action.

33. **Unrealistic resentment**

The patient feels covert anger at the world in general and with his inability to function. This anger may be generalised or focused at particular persons, including self.

34. **Discontinues all treatment**

Attendance at treatment stops. Patients who were taking Antabuse report episodes of forgetting to take it, or manipulations to avoid taking it.

Supportive relationships become strainful. Patients may drop out of treatment despite the realisation that they are acting irrationally.

35. **Overwhelming loneliness, frustration, anger, and tension**

The patients feels totally overwhelmed and feels that there are no available options except to return to drinking or even suicide. The fear of "going mad" is intense. There are intense feelings of helplessness and desperation. Drinking may occur impulsively.

36. **Start of "controlled" drinking**

The patient may attempt to control small quantities of alcohol on a regular basis, or may engage in one short term and low consequence binge.

37. **Loss of control**

The patient loses the ability to "control" drinking and enters a phase of loss of control drinking.