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CHAPTER 1

INTRODUCTORY ORIENTATION AND STATEMENT OF THE PROBLEM

Suffering has been stronger than all other teachings and has taught me to understand what your heart used to be. I have been bent and broken, but – I hope – into a better shape.

- Charles Dickens -

1.1 INTRODUCTION

The use and abuse of, and the addiction to legal and illegal substances is world-wide on the increase, and the situation is no different in South Africa. Narconon, a drug abuse prevention program based in Johannesburg, states that 80% of the children in South Africa will experiment with drugs before matriculating, and 15% of these first-time users will become addicted (Narconon 2008:1). A survey conducted in 2003 in Cape Town revealed that 45% of high-school learners had already experienced the use of drugs, and 32% continued to use them (Gouws, Kruger & Burger 2008:223). According to the World Drug Report 2011 (UNODC 2011:4), the number of drug users appears to have increased over the last decade to some 210 million people. Globally, the United Nations Office on Drugs and Crime (UNODC 2011:4), estimates that over the last decade the number of persons between the ages of 15 and 64 who have used illicit

substances at least once has risen from 149 to 272 million, that is, from 3,3% to 6,1% of the population.

According to Searll (2002:xiii & xv), drugs are seeping into and affecting every area of our existence – our children, our health, our well-being, the crime situation, our economy, and even life itself. There is no absolute in the addiction field, and no one is immune to its devastation. Practically daily new and disturbing trends in the patterns of drug use and abuse are emerging, and there exists grave concern that the scourge of drug abuse will continue to undermine and ultimately destroy the future of our country. If history of drug use and abuse is a predictor of the future, it is likely that the search for altered states of consciousness will always be with us. People have both enjoyed these substances, and have suffered in their pursuit, and doubtlessly always will (Lessa & Scanlon 2006:31).

1.1.1 What is *addiction*?

Hersh (2008:15) describes *addiction* as a way of life that is fueled by a deep, deep need to worship something. The addict bows at the altar of a central activity that takes away stress, pain and loneliness for a while, and which gives him or her a sense of control. Like a magic carpet, addiction allows the addict to dissociate from reality and to connect to a god that seems to work much better than any other god. The truth is, however, that addiction has left countless individuals and families broken into a million little pieces.

Should drug addiction be seen as a disease? Experts in the addiction field accept this premise, largely due to advances in the field of neuroscience (Coombs 2004:29). Current research shows that the brains of addicts look different to the brains of people without addiction. According to Nace and Tinsley (2007:20), the disease of addiction, medically called *substance dependence*, prevents the addict from behaving predictably. If we accept that a disease is present when a part of the body fails to function as it should, then addiction is a disease. It is a disease entity that is characterized by compulsion, the loss of control, and continued use, in spite of adverse consequences. Like diabetes, it is a chronic disease that at best is controlled rather than cured (Coombs 2004:29).

The following definition will suffice for the purposes of this study,

> *...addicts are people who have neither the ability to consistently control their drinking or using, nor do they have the capacity to predict their behaviour once they start to drink or use. Their drinking/using causes problems in major areas of their lives and yet they continue to do so. An addict is a person who has developed a psychological dependency on a substance coupled with a physiological addiction. An addict is someone who has experienced a change in tolerance to alcohol/drugs and needs to drink/use more to acquire the desired effect. Their need to drink or use becomes a greater and greater preoccupation in their lives. At one time in their lives they had the ability to choose to drink or use. In time, it became not a matter of choice, but a compulsion (Black 2001:1).*

1.1.2 The treatment of addiction

According to Lessa and Scanlon (2006:15), the treatment of addiction is no longer a field of recovering addicts looking to share their experiences, strength and hope. The field of drug addiction is evolving into a science requiring special skills for standarized assessment procedures, skills of diagnosis and the treatment of psychiatric disorders, skills for level-of-care decisions, and an understanding of pharmacology and psychotherapeutic approaches.

There are two types of treatment centres avaliable in South Africa, namely in-patient and out-patient centres. In an in-patient treatment centre the patient resides at the facility for a prescribed period. The staff at the centre usually consists of social workers, a nurse, and administrative staff members. In some of the centres a psychologist may also be a member of the staff. In an out-patient treatment centre, the patient attends individual therapy sessions on a weekly basis, but does not reside within the facility. In most out-patient treatment centres social workers, a nurse, the administrative staff, and in some cases also a psychologist, make up the staff members.

Out-patient treatment programmes have, for a number of reasons, gained in popularity since the 1990s. Many of the stimulant abusers who were treated in protected in-patient environments relapsed within weeks of being released from residential treatment. Out-patient treatment provided an opportunity to experience a learn-as-you-go approach to

recovery, with the treatment programme providing structure and support as they resume their daily lives (Coombs 2004:102).

In-patient treatment is necessary when a patient is unable to maintain sobriety without a protective environment. It is also important in order to stabilize a medical or psychiatric condition. According to Lessa and Scanlon (2006:21), an in-patient treatment setting is not a panacea for developing successful sobriety in the ambivalent patient. Ambivalence is resolved through experience, not through education in a protective environment. The educational experience provides a foundation, but the application of possitive change in an out-patient setting reinforces recovery.

1.2 THE RATIONALE AND MOTIVATION FOR THE STUDY

1.2.1 The awareness of the problem

As part of her training to register as a psychologist, the researcher did her internship at a rehabilitation centre in Nelspruit. During this time she became aware of certain aspects that led to her undertaking this study.

In the first place, the researcher became aware of the increasing use of legal and illegal substances in the community. This aspect was decribed in broad terms in section 1.1 of this chapter.

The researcher also realised that there are not sufficient treatment facilities avaliable in South Africa to address addiction. In one case a fourteen year-old girl who was injecting herself with heroin was brought to the centre by her father. The social worker contacted several rehabilitation centres in Mpumalanga, Gauteng and Kwazulu-Natal to have the girl admitted for treatment. A rehabilitation centre that was prepared to accept the girl could not be found, due to the fact that she was too young, they only admitted boys, or that the centre was full.

Following on discussions with various psychologists and social workers about their knowledge of and training for the treatment of drug addiction, the researcher came to the conclusion that both their knowledge and their training were very limited.

During her internship, as well as in her private practice as a psychologist, the researcher mainly focused on therapeutic techniques that are commonly used to treat addiction. Alhough many clients reached abstinence, and were able to lead relatively well-adapted lives after the treatment, the researcher questioned the level of self-actualization that was reached by these clients, as well as the changes that occurred in their different relationships in their life-worlds.

The situation as described above encouraged the researcher to undertake a research study on the causes of addiction. Based on this preliminary study, the researcher became

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aware of the possible correlation between addiction and the family of origin.

The researcher consequently decided to investigate this aspect.

1.2.2 Pre-liminary literature review

The first part of the pre-liminary literature review was done regarding the family of origin as a possible cause of addiction.

1.2.2.1 The family of origin

Yeterday's smoldering coals – the unresolved feelings and unexamined messages – create today's fires.

- Melody Beattie -

Ideally, a family has a function – that is, a job to do. A 'healthy family' should create and sustain an environment which promotes the emotional and physical health, as well as the psychological well-being of its members (Tessina 2003:3).

In ideal circumstances, certain human needs have to be fulfilled so that children can grow and develop. For children to reach their full potential, they inevitably require most of these needs to be satisfied. If children grow up in an environment without these needs being fulfilled, they grow

up automatically without realizing that their needs have not been met. They may often feel confused and chronically unhappy (Whitfield 2006:17). Individuals who grew up in dysfunctional family systems never learned the confidence, self-motivation and emotional management tools they need to live healthy, happy lives, because their family members were not good role-models, and did not provide the necessary structure and information (Tessina 2003:1). According to Ferguson (2010:1), most persons belonging to an alcoholic household, struggle to try to figure out what is 'normal', and the concept of a 'healthy family' is unknown to them. Black (2001:4,5) states that it has long been recognized that persons who have been raised with physical and sexual abuse, strongly identify with people raised with addiction. Individuals raised in homes with mental illnesses, chronic health issues or physical challenges, may also identify with the same. The connecting thread between these different types of families is experiencing chronic loss that fuels emotional isolation, rigidity or shame.

According to Dayton (2007:xv, xvi), people are wired to experience love, warmth and a sense of well-being through closeness, and to fear abandonment. When children do not experience love, are not loved correctly, lose the attention and reliability upon which they depend, or if their orderly and familiar world is ruptured, it will lead to trauma. Whether the trauma is from abuse, neglect or addiction, their bodies and minds react to being frightened, hurt or overwhelmed by more intense emotion that they can process or integrate. According to Forward (1989:6), adults who

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were beaten as children, were left on their own too much, were sexually abused, treated like fools, overprotected or overburdened by guilt, almost all suffer surprisingly similar symptoms, namely a damaged self-esteem, leading to self-destructive behaviour. In one way or another, they almost feel worthless, unloved and inadequate. According to Meyer (2003:3), many persons outwardly appear to have their lives together, but on the inside they are emotional wrecks, because they have been traumatized by abuse. She further states (2003:3) that surviving the trauma of abuse can cast people into a state of psychological damage that prohibits them from functioning properly in relationships with others. Forward (1989:5) is of the opinion that parents plant mental and emotional seeds in their children, and these seeds grow as the children grow into adulthood. In some families, these seeds are love, respect and independence. But in many others, they are seeds of fear, obligation or guilt. These seeds could grow into invisible weeds that invade the individual's life in ways he or she could never have dreamed of. Their tendrils may harm her or his relationships, career, family, and even aspects like his/her self-confidence and self-esteem.

Black (2001:15) states that if family members feel trapped in a highly confusing system, they do what is needed to feel safe; they do what they need to do to preserve the family system. This typically means that they hide their feelings behind an artificial behaviour pattern. Sekouri (2010:2) agrees with this statement by saying that hanging on to destructive behaviour patterns is designed to keep the ailing

family system functioning as smoothly as it can under the circumstances. These destructive behaviour patterns become second nature, become parts of the basic survival mechanisms which are caried over into subsequent situations.

According to Tessina (2003:1), to grow up and out of a painful, dysfunctional past may seem like a miracle, too wonderful to be possible. But it can be done, if the individual possesses the correct tools and support. Leman (2007:x) states that people cannot change their past, but they can change the way they understand it, and move forward in the light of that understanding. Sekouri (2010:3) is of the opinion that individuals can leave their dysfunction behind, in favour of creativity, love, flexibility and happiness.

Based on the above, it appears as if an individual who grew up in a dysfunctional family often feels confused, chronically unhappy, lacks confidence and self-motivation, feels worthless and unloved, and inadequate to live a healthy, happy life. This results in a damaged self-esteem, which in return, leads to self-destructive behaviour (addiction). The researcher, therefore, came to the conclusion that a client's family of origin may possibly be the cause of his or her addiction. Consequently, in order to be able to assist clients suffering from addiction to deal with specific aspects emanating from their families of origin, an investigation was done into existing treatment programmes in South Africa.

1.2.2.2 Existing treatment programmes in South Africa

In order to enable the researcher to investigate the existing treatment programmes in South Africa, a study that was previously done was used as a guideline for the literature review. This study, which was done in 2004 at the Rand Afrikaans University, investigated different treatment programmes for teenagers at rehabilitation centres throughout South Africa. The results of the above study and the literature review on the existing treatment programmes will be discussed in Chapter 2.

From this discussion the researcher came to the conclusion that, although some of the programmes do include aspects of the family of origin in their treatment, it seems that there does not exist a treatment programme that specifically focuses on the family of origin as a possible cause of addiction.

1.3 THE PROBLEM STATEMENT

Although addiction is treated by means of different treatment programmes in South Africa, the the researcher discovered that the level of self-actualization of the addicts, as well as the changes in their relationships, are questionable. A preliminary literature review indicated that the family of origin could be the cause of addiction.

This study will attempt to answer the following questions:

If the family of origin is treated as a cause of addiction by means of a treatment programme,

- will changes occur in the addict's level of self-actualization and in his or her relationships with others and with the 'self', after treatment;
- will therapists and clients consider the treatment programme as satisfactory;

- will the treatment programme be effective in assisting the addict to reach an improved level of self-actualization;
- will the treatment programme be effective in assisting the addict with changes in his or her relationships with other persons and with him/herself?

1.4 AIMS OF THE RESEARCH

The main aim of the study will be to develop a treatment programme that address the family of origin as a cause of addiction. The study will be divided into the following two parts, namely

- a literature review; and
- an empirical investigation.

1.4.1 The literature review

To enable the researcher to gain knowledge to compile the treatment programme a literature review will be be undertaken.

The following research aims will direct the literature review:

- an investigation into the systems and relations theories will be undertaken to enable the researcher to gain a better understanding of these two theories, which will serve as the theoretical framework of the study;

- an investigation of the existing treatment programmes will be included in the literature review, in order to provide information on the existing programmes, as well as to indicate the non-existence of a treatment programme that addresses the family of origin as a possible cause of addiction;

- in discussions with psychologists and social workers it was ascertained that both their knowledge of addiction and their training for the treatment thereof were very limited. An investigation into important aspects relevant to the use and abuse of substances as well as to the treatment of addiction will therefore be undertaken. The knowledge gained from the literature review will be included in the training of the therapists who will take part in the study. This will be done in order to ensure that all the therapists who will form part of the study will be provided with the relevant knowledge on how to assist a client to attain abstinence, and on how to function effectively in his or her life-world. During their training guidelines will be provided on how to assist their clients to reach abstinence. This part of the study will be referred to as

phase one. Guidelines on how to assist their clients to function effectively in their life worlds form part of *phase two*.

- The purpose of this study is to develop a treatment programme that addresses the family of origin as a possible cause of addiction. To enable the researcher to develop such a programme, an investigation into the role of the family of origin will be undertaken as the last part of the literature review. This investigation, together with the knowledge obtained from the theoretical framework, will enable the researcher to compile the treatment programme. To this treatment programme that addresses the family of origin as a possible cause of addiction, will be referred to as *phase three*.

The literature review of the study will therefore include the following:

- the theoretical framework of the study;
- a discussion of existing treatment programmes;
- phase one: guidelines to therapists on how to assist their clients to attain abstinence;
- phase two: guidelines on how therapists could assist their clients to function effectively in their life worlds;
- phase three: addressing the family of origin as a possible cause of addiction.

1.4.2 The empirical investigation

During the empirical investigation data will be obtained regarding the implementation of the treatment programme. The treatment programme will address aspects of the family of origin that could be the cause of addiction. The main aim of the empirical investigation will be to determine the effectiveness of the treatment programme. To enable the researcher to determine the effectiveness of the treatment programme, the following secondary research aims will direct the empirical investigation:

- the satisfaction of therapists and clients regarding the treatment programme;
- therapists' and clients views regarding the level of self-actualization reached by clients after treatment;
- therapists' and clients' views regarding changes in the clients relationships with others after treatment;
- therapists' and clients' views regarding changes in the clients relationships with 'self' after treatment.

1.5 AN EXPLANATION OF THE RELEVANT CONCEPTS

Concepts are the terms designating the things about which a science tries to make sense (De Vos, Strydom, Fouché & Delport 2005:28).

The following concepts will be made use of throughout the study. It is therefore important for the researcher and the readers to have a clear understanding of these terms.

1.5.1 What is a *drug*?

A drug is any substance that affects or changes one's feelings, thoughts or behaviour. It not only constitutes illegal 'street' drugs, but also legimate medication, and 'socially acceptable' drugs that are in daily use, such as caffeine, nicotine and alcohol (Searll 2002:59).

1.5.2 Substance abuse

The *Diagnostic and Statistical Manual of Mental Disorders (DSM IV-R)* describes *substance abuse* as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following, occuring within a 12-month period:

1. Recurrent substance use, namely in not being able to fulfill the major role obligations at work, the school or home (*e.g.*, repeated absence or poor work performance related to substance use; substance-related absences, the suspension or expulsion from school; neglecting children or the household).
2. Recurrent substance use in situations in which it is physically hazardous (*e.g.*, driving a vehicle, or operating a machine when impaired by the use of a substance).
3. Recurrent substance-related legal problems (*e.g.*, being arrested for substance-related disorderly conduct).
4. The continued use of a substance, despite experiencing persistent or recurrent social or interpersonal problems

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caused or exacerbated by the effects of the substance (*e.g.,* arguments with the spouse about the consequences of intoxication, physical fights, etc.).

Substance abuse can be diagnosed if the symptoms of the client have never met the criteria for Substance Dependence in respect of the spesific class of substance (Lessa & Scanlon 2006:8).

1.5.3 Substance dependence

This denotes a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three or more of the following, occuring at any time in the same 12-month period (Lessa & Scanlon 2006:10):

1. Tolerance, as defined by either of the following:
   (a) a need for markedly increased amounts of the substance to achieve intoxication or the desired effect;
   (b) a markedly diminished effect with continued use of the same amount of the substance.

2. Withdrawal
   (a) the characteristic withdrawal syndrome of the substance;
   (b) the same, or closely-related, substance is taken to relieve or avoid withdrawal symptoms.

3. The substance is often taken in larger amounts or over a longer period than was intended.

4. There is a persistent desire or unsuccessful efforts to cut down on, or to control the use of the substance.

5. A great deal of time is spent on activities intended to obtain the substance (*e.g.,* visiting many different doctors, or driving long distances), or on the use of the substance (*e.g.*, chain smoking), or to recover from its effects.

6. Important social, occupational, or recreational activities are given up or reduced because of substance use.

7. The substance use is continued despite the kowledge of a persisting or recurring physical or psychological problem that has likely been caused or exacerbated by the substance (*e.g.,* the use of cocaine, despite the recognition of cocaine-induced depression, or continued drinking, despite of recognising that an ulcer was aggravated by alcohol consumption).

1.5.4 Physical dependence

Physical dependence results from actual physical changes that cause tolerance and withdrawal symptoms (Coombs 2004:69). It is therefore hallmarked by tolerance and withdrawal (Wilcocks 2002:6). The user will experience an intense craving for the drug he/she is addicted to, and will

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show physical signs of discomfort when he or she stops its use. These sensations are involuntary, and are known as withdrawal symptoms. The symptoms of the withdrawal vary in respect of the specific drug, and in some cases the drug abuse may be dangerous, or even fatal. Drugs that are known to cause physical dependence include opium and its derivatives – heroin, morphine, wellconal, codeine – and depressants of the central nervous system, such as barbiturates and alcohol (Searll 2002:65)

1.5.4.1 Drug tolerance

Tolerance develops when the effect of a certain dose gradually diminishes as the drug is taken continuously. Users find that they need to take more and more of the same drug in order to experience the same sensation (Searll 2002:65).

1.5.4.2 Withdrawal

Withdrawal occurs when the body is deprived of its usual 'drug' content, and the user is compelled to again use the drug, in order to prevent the unpleasant symptoms caused by the withdrawal of the substance in the body (Wilcocks 2002:6).

1.5.5 Psychological dependence

Psychological dependence occurs when a person believes that he/she needs the substance to be able to cope (Coombs

2004:69). In severe cases users become obsessed with the drug, and virtually all their interests and activities become focused on obtaining and using it (Searll 2002:65).

1.5.6 Co-occurring disorders

For practical reasons the term *co-occurring disorders* replaced the terms *dual disorders* or *dual diagnosis*. These latter terms, though generally used to refer to the combination of substance abuse and mental disorders, can be confusing, because they may also refer to other combinations of disorders, such as mental disorders or learning problems. Also, these last two terms may imply that only two disorders occur at the same time, when in fact, there may be more than two. For example, an individual may have both a major depressive and panic disorder, combined with alcohol dependence, and also cannabis abuse (Capuzzi & Stauffer 2007:175).

In this study, the concept *co-occurring disorders* refers to the co-occurring substance use (abuse or dependence) and mental disorders that are not simply a cluster of symptoms resulting from one disorder (Capuzzi & Stauffer 2007:175).

1.5.7 Family of origin

The primary social group comprising of the parents, their off-spring, and in some societies, other relatives sharing the same household (the extended family), is known as the *family of origin* (Colman 2001:268).

1.6 THE RESEARCH METHODOLOGY

The researcher will make use of both qualitative and quantitative research methods in this study.

Quantitative methods in research refers to the techniques or the generation and analysis of data that rely primarily on mathematical or statistical rather than on verbal procedures (Cohen & Swerdlik 2002:660).

In this study, after the implementation of the therapeutical programme, the data will be collected by means of questionnaires.

According to The Dictionary of Psychology (Colman 2001:610), a *questionnare* in psychometrics refers to a set of questions specially designed to provide objective information about some characteristics of a respondent, such as attitudes, preferences, interests, values, or the personality.

In this research study the questionaires will be completed by the therapists and the clients. Techniques of data analysis that rely primarily on mathematical or statistical methods will then be used to determine the outcomes of the implementation of phase three of the treatment programme.

According to Cohen and Swerdlik (2002:660), a *qualitative research method* is a general term for various non-statistcal procedures designed to explore how individual test items

work, both compared to other items in the test, and in the context of the entire test. In contrast to statistically-based procedures, qualitative methods involve the exploration of the issues by verbal means, such as interviews and group discussions conducted with the persons taking the tests and also with other relevant parties. Based on the results obtained from the completed questionnaires, interviews will be conducted with some of the therapists who were involved in the implemention of the treatment programme. According to Bell (2005:159), the advantage of using a structured or semi-structured format for interviews is situated in the fact that the researcher can leave the interview site with a set of responses that can fairly easily be recorded, summarized and analysed. The researcher will, therefore, make use of a structured format during the interviews.

1.7 THE DIVISION OF THE CHAPTERS

The eight chapters comprising this study are briefly outlined below.

Chapter one: Introductory orientation and statement of the problem.

This chapter gives an overview of the study, its rationale, the problem formulation, problem statement, the aims set for the research, the definitions of the concepts, and a description of the chosen research methodology. Its purpose is to place the study in perspective and familiarise the reader with the subject matter.

Chapter two: Theoretical framework and existing treatment programmes.

Chapter two will include a dicussion of the systems and the relations theory, because both these theories will be used as the theoretical framework against which phase three of the treatment programme will be developed. A discussion of existing treatment programmes in South Africa will also be included in chapter two.

Chapter three: Phase one of the treatment programme.

Chapter three will focus on phase one of the treatment programme. It will provide knowledge and guidelines to the therapists on how they can assist their clients to reach abstinence from the substances that they are taking.

Chapter four: Phase two of the treatment programme.

Chapter four will focus on phase two of the treatment programme. Phase two will provide knowledge and guidelines to therapists on how they can assist their clients to function effectively in their life-worlds.

Chapter five: Phase three of the treatment programme.

In phase three the clients will be asked to discuss incidents that happened in their families of origin. The information from the literature research, as well as from the research on the systems and the relations theory, will be used to

compile a treatment programme that therapists may implement during the empirical investigation of the study. The treatment programme will address the family of origin as a cause of addiction.

Chapter six: The research design.

In chapter six the research design will be described and the research methods will be explained.

Chapter seven: The results of the empirical investigation.

Chapter seven will consist of a summary of the research results that were obtained during the empirical investigation of the study.

Chapter eight: Summary, recommendations and limitations.

The concluding chapter will include a synthesis of the literature study and the empirical investigation. The researcher will be able to determine whether the aims mentioned in chapter one have been achieved. The limitations of the research and recommendations for further research will be indicated.

Finally, the conclusions in respect of the research study will be indicated.

1.8 CONCLUSION

The aim of chapter one was to place the study in perspective and to familiarise the reader with the subject matter.

A discussion of the theoretical framework and existing treatment programmes will follow in chapter two.

CHAPTER 2

THEORETICAL FRAMEWORK AND EXISTING TREATMENT PROGRAMMES

Only in relationships can you know yourself, not in abstraction and certainly not in isolation. The movement of behaviour is the sure guide to yourself, it's the mirror of your consciousness, this mirror will reveal its content, the images, the attachments, the fears, the loneliness, the joy, the sorrow. Poverty lies in running away from this.

- J Krishnamurti -

2.1 INTRODUCTION

The aim of this study is to investigate the family of origin as a possible cause of addiction. The family systems and relations theories will serve as the theoretical framework for the development of a treatment programme that addresses the family of origin as a possible cause of addiction. A discussion of the family systems and relations theories are therefore necessary, and will be the focus of the first part of chapter two.

To investigate existing treatment programmes for addiction in South Africa, a discussion of existing treatment programmes will be included in the second part of chapter two.

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2.2. THEORETICAL FRAMEWORK

2.2.1 Family systems theory

Family therapy first started in the 1950s when therapists in various parts of the United States of America began to study the interaction between family members. Instead of focussing on the individual as the 'problem', the focus now shifted to the family unit (Papero 1990:v).

The systems theory within psychology originated from three major areas (Nicholss & Schwartz, in Smith-Acuna 2011:7). Gregory Bateson first began to study psycho-pathology from a systems perspective. In 1954 he joined psychiatrist Don Johnson in studying families with members who suffer from schizophrenia. By 1959 they had created the Mental Research Institute. They were later joined by psychologists Paul Watzlawick, John Weakland, Jay Haley and Virginia Satir. Secondly, in 1946 Murray Bowen began working with mothers and their schizophrenic children at the Menninger clinic. By the mid-1950s he had expanded this work to include large family groups. Bowen expanded his work by applying systems concepts to understand how the extended family influences individual psychopathology, first at the National Institutes of Health, and then at Georgetown University. A third area of systems work originated in the 1950s, when Nathan Ackerman expanded the traditional psychodynamic definitions of relationship problems at the

Family Mental Health Clinic in New York (Smith-Acuna 2011:7).
Bowen indicates that individuals cannot be understood in isolation from one another, but rather as a part of their family system (Genopro: 2011:1). Each family may be viewed as a unique social system (Joseph 2010:138), and the different members of a family are emotionally connected, whereby affecting one another's thoughts, feelings and actions. Family members also seek one another's attention, approval and support, and react to each one's needs and expectations, but also distress. This emotional interdependence promotes the cohesiveness of the family unit (The Bowen Theory undated:1).

Changes in one element of the system affect all the other elements of the system (Joseph 2010:138). A change in one member's functioning is therefore followed by reciprocal changes in the functioning of the other members. Heightened tension intensifies the processes that promote the unity and teamwork of the family, and this could lead to problems. When family members, for example, become anxious, the anxiety can escalate among them, and the emotional connectedness that exists between the different members becomes more stressful than comforting. Eventually it could lead to one of the members feeling overwhelmed or out of control (The Bowen Theory undated:1).

Karson (2006:51) states that the systems theory is best known to many clinicians by means of the concept

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identified patient. The term implies that the person brought to therapy or seeking therapy has been identified as having a problem. However, the problem is often in the system, and the system's problem manifests itself in one of its members. Joseph (2010:138) states that the psychological problems of any one member can be understood by stepping back and observing the family system and the dynamics of interaction.

The family systems therapist, therefore, endeavours to understand the relationships between members of the family, and will treat the family as an organism. He or she will also attempt to change the family system (Joseph 2010:139). During assessment and therapy, symptoms are located in their systematic context for the purpose of understanding them, and for directing interventions at the system rather than at the symptom (Karson 2006:51,52). The family systems model has lent itself to various forms of therapy. Family therapists work in a variety of different ways, and make use of techniques from psychodynamic-, cognitive-behavioural- and humanistic approaches (Joseph 2010:139).

Summary

The first part of the discussion on the theoretical framework was devoted to a discussion of the family systems theory. First the history of family systems theory was discussed, and it was followed by an explanation of the theory.

2.2.2 THE RELATIONS THEORY

The relations theory was developed by Vrey (1979), Oosthuizen and Jacobs (1982) of the University of South Africa (Jacobs & Lessing 2000:77, Roets, Kruger, Lessing & Venter 2002:14). Jacobs and Lessing (2000:76) indicate that the point of departure of the relations theory is that the individual, as the central person in his/her life-world, stands in relationships with different other components in his/her life-world. These components refer to objects, ideas, people and the 'self'. Due to these different relationships, individuals develop different identities, through the interactive process of involvement, experience and the attribution of meaning, and by means of inner speech. Individuals constantly evaluate their acquired identities with regard to the related relations. By means of the evaluation of these identities individuals acquire self-images. The personal identities also contribute to the personality of the individual, which will then have an influence on behaviour. If the individual's behaviour is socially acceptable, it will contribute to sufficient self-actualization and healthy relationships in the person's life-world. If the composition of the personality results in unacceptable behaviour, it will lead to insufficient self-actualization and unsatisfying relations.

For the purposes of this study, the relations theory is divided into the following different components, namely:

- life-world;

- structure;
- process; and
- end-result.

A discussion of the different components of the theory will follow.

2.2.2.1 The life-world of the individual

Individuals as social beings can never stand alone and isolated in the world. Each individual is the centre of his own life-world, as mentioned above. This fact implies an interaction between the 'self' and the different components of his or her life-world. It was previously mentioned that the different components of the individual's life-world consist of God, objects, ideas, other people, and the person him/herself. The interactive working within the life-world leads to the founding of relations with the different components in his or her life-world (Jacobs & Lessing 2000:77).

Each relation that the individual forms with the components in his or her life-world can be viewed as an interactive connection between two poles, with the individual as the one pole, and the object, idea, person, and himself as the other pole (Vrey 1979:22). At each pole there is a polarization effect that consists of two components, namely a cognitive component and an affective component. The *cognitive* component refers to knowledge, and the *affective* component refers to the quality of the experience. The

result of the polarization is an attraction or a rejection, which either draws the two poles together or drives them apart. For example, the relationship between a mother and her child implies that the mother knows the child and the child knows the mother (knowledge component). In the relationship the one will love, hate, be neutral towards, or experience other emotions somewhere on this continuum (affective component). The result will either be acceptance or rejection (Jacobs 1981:14). The relationship is therefore, either pleasant or unpleasant, and is either encouraged or avoided by the individual.

2.2.2.2 The intra-psychic structure

According to research, the intra-psychic structure of each individual comprises of the ego, the self, the identities and the self-concept.

According to Raath and Jacobs (1993:7), in the subject literature there exists many different views on the meaning of 'I' (ego) and 'me' (self). A number of views on each of these two aspects will be investigated to enable the researcher to come to a conclusion in respect of this study.

(a) The ego

Vrey (1975:9) indicates the importance of clarifying the existence of the 'I', as well as its functions and task. Janse de Jonge (in: Vrey 1975:10) states that the 'I' cannot be seen as an object. Vrey explains that the 'I' is

unobservable, it is a spiritual dimension, and is the drive behind and the guide of the individual's thoughts and actions (Vrey 1975:11). According to Jacobs (1981:109), no action of an individual is imaginable without the 'I', which is therefore present in every action or thought of the individual (Jacobs 1981:109). Kuypers (in: Vrey 1975:10) indicates that it is the 'I' that observes, thinks, reminds, feels, wants, lives, and dies. It can also never be seen as an independent entity, but always exists in relation to the self (Raath & Jacobs 1993:8). Vrey (in: Raath and Jacobs 1993:8) defines the *I* as follows, "It can be concluded that the 'I' can be seen as a moral dimension that can only function in integration with the other dimensions of the personality". Therefore, it can only be seen as a derived structure that forms relations with the 'self' and the world. Jacobs (1982:110) came to the conclusion that the 'I' can be observed as a subject, as sub-conscious, as non-perceivable, and as belonging to the moral dimension of a human being.

For the purposes of this study, the *ego* will be viewed as:

- unobservable, a spiritual and moral dimension;
- the drive and guide behind the individual's thoughts and actions;
- observing, thinking, reminding, feeling, wanting, living, and dying; and
- not independent, but always existing in relation to the 'self'.

(b) The 'self'

The individual first recognizes himself through his relations with other people. In his communion with others he/she learns to know himself. Through these conceptions of his 'self', as well as through his conceptions of others, he forms an image of himself (Jacobs 1982:8,124). Every person, therefore, has a perception of himself. He sees himself as a thinking-feeling-doing-willing unity (Vrey, in: Raath & Jacobs 1993:9). According to Raath & Jacobs (1993:9), the self is the means by which the organism is aware of, and understands itself as a being, with a past history, and a probable or possible future.

Although there exist many views about the concept 'self', there are still many unanswered questions about the concept. One of the most fundamental questions asked is if the 'self' can be seen as a fact that can be objectively indicated in time and space, or if the 'self' is a construct that defines the attributes of the individual (Roets, *et al.* 2002:18). Vrey (1975:12) believes that the 'self' can be seen as an object, due to the fact that the individual is consciously aware of his body, together with its functions (Vrey 1975:12). The individual is not only consciously aware of himself, but in his consciousness he/she also places him/herself in different categories, for example 'man', 'husband', 'friend', and so forth. While referring to him/herself in respect of different categories, the individual also, at the same time, evaluates him/herself, for example 'strong man', 'faithful husband', 'loyal friend', *etc.* (Vrey

1975:12). When doing this, the ‘self’ is ascribing certain attributes to him/herself. One can consequently come to the conclusion that the ‘self’ is a fact, because it can be indicated in time and space. The ‘self’ can, however, also be seen as a construct, due to the fact that it ascribes attributes to itself.

Can the ‘self’ be seen as an object only, or can it be seen as both object and subject? The ‘self’ is an object, something that can be perceived by the senses (Roets, *et al.* 2002:18). According to Hugenholtz (in: Jacobs 1981:110), the ‘self’ can be placed at a distance, and be seen as the ‘autonomous me’. According to Jacobs (1981:122), the ‘self’ contains everything that can be the object of a person’s consciousness; therefore, everything that the individual has and everything that he owns. The fact that the ‘self’ also consists of external objects like clothing, a house, a car, *etc.*, also indicates the ‘self’ as an object (Jacobs 1981:123). There are sometimes referred to these objects as extensions of the ‘self’. On the other hand, the ‘self’ is an observer, and it can reason; this very aspect makes the ‘self’ a subject (Roets, *et al.* 2002:18). According to Vrey (1975:12), the fact that the self as object is the ‘self’ that the consciousness is directed towards, indicates self-consciousness. Meaning is therefore attributed to the ‘self’. This attribution of meaning is much more than the mere attribution of meaning for the sake of use only. Personal involvement is also present. The ‘self’ is built up of experiences that are both positive and negative. These experiences are subjective in nature. Jacobs (1981:122)

describes the 'self' as the centre of experience and meaning-attribution, as the total objective environment and the total subjective environment of the individual. Van Zyl (1983:32) came to the conclusion that mankind has always observed the 'self' in the past, has thought about the 'self', has experienced the 'self' emotionally, and has identified the 'self' with certain values, choices and behaviour. This view of the 'self' can be seen in artforms, as well as in written works of the past. According to Van Zyl (1983:32), mankind has viewed himself objectively and experienced the 'self' subjectively, and by means of this process, a self-image is formed. Vrey (1975:13) came to the conclusion that the 'self' as 'self' (not the 'I') is a subject, due to the fact that it is the core of the individual. It is also the initiator of various constellations of actions and functions of the consciousness. Thus, the 'self' is object, but also subject.

The 'self' can also be described as a singular entity. This is obvious when an individual speaks of the 'self' as 'my', 'mine', 'myself', *etc*. In this regard the 'self' refers to idiosyncratic concepts, for example, "I am an introvert", "I am clever", *etc*. However, when the social interaction of the 'self' with different people is taken into consideration, the inference can be made that the 'self' is also multiple in nature. This multiplicity can be seen in the different relations that the individual forms with different people (Jacobs 1982:18). Vrey (1975:14) prefers to refer to the 'self' as multi-faceted, rather than 'multiple', due to the complex spectrum of the relations of the 'self' with other individuals, God, and objects.

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According to Vrey (1975:78), a person's 'self' can be described as the *gestalt* of who and what he is, and that he can call his own. Vrey further states (1975:78), that the 'self' includes the ideas, attitudes, thoughts, values, and commitments of that person. According to Jacobs (1981:122), the 'self' contains the individual's passionate actions, his living habits, his genetic attributes, as well as all his learned habits. Raath and Jacobs (1993:8) define an individual's own *self* as "…the core of man's life, the world in which he lives and as he perceives it – as he sees it and experiences it". The *self* can be described as follows (Dayton 2007:7):

Drawn from the cloth of our parents' personalities and the fabric of our early experiences, the self is a tapestry into which we have daily woven all of our varied perceptions and experiences. It holds, in its evanescent grip, our thoughts, concerns, dreams, fears and aspirations.

The 'self' is a fluid, adaptable system; it is porous, always interacting with the environment (Dayton 2007:7). The 'self' is therefore built up of experiences that are both positive and negative. The 'self' is also not developed, once and for all. It is a constantly evolving container that is developed in relationship to others (Moreno, in: Dayton 2007:7). The 'self' is therefore not static but dynamic (Roets, *et al.* 2002:18).

The conclusion can therefore be made that the 'self' refers to the following, namely what I think of myself, how I feel about myself, and what I know about myself. We are

consciously aware of the ‘self’. It is the sum-total of all that we can call our own. It includes our attitudes, ideas, thoughts, values, and commitments.

For the purposes of this study, the ‘self’ will be seen as

- a fact, because it can be indicated in time and space;
- a construct, due to the fact that it ascribes attributes to the ‘self’;
- an object; it can be perceived by the senses. It also contains everything the individual has, and everything that he owns. It is the *gestalt* of who and what he is, and what he can call his own;
- a subject, because of the fact that the ‘self’ is an observer, and it can reason;
- positive or negative, due to different experiences;
- singular and multiple;
- dynamic; and
- an individual’s ideas, attitudes, thoughts, values and commitments.

(c) Identity or status identities

Raath and Jacobs (1993:9) state that to understand the development of a personal identity one needs to distinguish between the terms *identity* and *identification*. *Identity* can be defined as the meaning attached by someone to him/herself as a person. This means that it is the answer to the question, “Who am I?” (Gouws, *et al.* 2008:109).

Identification, on the other hand, refers to the concept *to become identical to* (Raath & Jacobs 1993:9).

Within a few months after birth the child will not only become aware of himself, but also of his surroundings, and the significant people in his life. The attitudes of these significant people are of the utmost importance in the formation of the child's identity: does he feel that they accept him and love him? The influence of the significant people is brought about by the continuous interaction between the child and other people in his life-world (Raath & Jacobs 1993:10). Therefore, as the child grows up, he learns to distinguish between himself and his life-world. Through this process he becomes more and more aware of the 'self', and forms his own self-identity (Roets, *et al.* 2002:26).

The fact that the individual is in relationships, results in a need to identify himself with certain groups. It is essential for identification to take place, due to the fact that identification results in a healthy self-identity (Roets, *et al.* 2002:26,27). Gouws, *et al.* (2008:24) state that the question, "Who am I?" is critical for the self-concept of the adolescent. As the individual develops and changes, the answer to the question, "Who am I" will change, and consequently the self-identity of the individual will also change. Identity formation is thus a lifelong, and according to Gouws, *et al.* (2008:109), largely an unconscious process.

Before a certain identity is formed, an individual needs to identify with a specific attribute (Jacobs 1981:19). The development of a self-identity requires involvement, as well as the attribution of meaning to the physical and psychological 'self' (Jacobs 1981:124). If a child, for example, begins to perform the role of a boy, identification has taken place, and a certain identity ('a boy') has been formed (Jacobs 1982:19).

The self-identity includes various categories of the 'self', for example, boy or girl, learner, friend, sibling, *etc*. Later in life categories of the 'self' could include aspects such as employer, life partner, parent, *etc*. It is important to take note of the fact that self-identity also includes attributing terms like 'pretty' or 'ugly', 'good' or 'bad', and later in life, terms like 'successful', 'reliable' and 'hardworking' (Roets, *et al.* 2002:27). If a girl, for example, asks herself, "Who am I?" and she answers, "I am a pretty girl", she is attaching meaning to herself as a person, and her self-identity is formed. Jacobs (1981:125) emphasizes that extensions of the 'self' like objects, organizations, ideas, *etc*. are just as important in the establishment of identities. An individual's identity can therefore be described as a sense of the 'self'. It is concerned with those elements of character or personality that are distinguishing (Gouws, *et al*. 2008:109). Le Roux (in: Jacobs 1981:125) states that an individual can have many self-concepts in accordance with his various identities. It is important to take note of the fact that these self-concepts could be either positive or negative (Roets, *et al.* 2002:27).

It appears that apart from the self-image, there is also an ideal image. The self-image refers to the adolescent's perception of him/herself at a particular time, while the ideal image refers to what the adolescent would like to be. Identification during adolescence can be seen as an activity to reconcile the self-image and the ideal image (Gouws, *et al.* 2008:110).

Adolescents sometimes tend to over-identify themselves with members of their peer group, or with figures they admire, and they temporarily lose their own identity. In time they shift their attention to new identification models that represent values that they intend making their own in the future (Gouws, *et al.* 2008:110). However, during the process of identification and the formation of an identity there needs to be a balance between self-identity and social integration. If not, it could lead to the destruction of the individual's own identity (Roets, *et al.* 2002:27). Identity diffusion, also referred to as identity confusion, could arise if an adolescent is incapable of making any decisions about himself and his roles. Identity diffusion could also be the result of too little opportunity for experimentation with social roles, with the result that different roles cannot be integrated. When adolescents are confronted with conflicting value systems, they lack the ability or self-confidence to make decisions (Gouws, *et al.* 2008:112). Identity diffusion is dangerous; it leads to an alienation of the 'self', and results in an individual being too self-conscious to say, "This is me". The extreme forms of self-

alienation are found in psychopaths and schizophrenics (Roets, *et al.* 2002:27).

A pre-requisite for identification is self-knowledge. The individual needs to be true to his own inner 'self', and not suppress the true 'self', due to weakness or temporary advantages like for example popularity. This happens, for example, if a talented painter sells motor cars for a living, or if someone who knows the truth keeps quiet. Individuals who suppress their own 'self' are aware of their own behaviour, are not satisfied with it, and despise themselves. This could lead to a neurosis, but if the individual gains insight into his own identity, it could lead to the unfolding of the 'self' (Roets, *et al.* 2002:26).

A person with an established identity is able to take a realistic point of view, is able to say, "I can", or "I cannot", "I will", or "I will not", "I am", or "I am not", "I ought to", or "I ought not to", and then acts accordingly. In other words, it is the individual who has come to a realistic self-definition who is able to achieve self-actualization. The above can take place, due to the fact that there are clear boundaries between the discovered and the defined 'self'. Between these boundaries the individual can adapt, negotiate, and even compromise. He cannot move or even negotiate outside these borders, due to the fact that it is in conflict with his established identity (Roets, *et al.* 2002:26).

For the purposes of this study, *identity* will be viewed as

- the meaning attached by a person to him/herself as a person;
- the answer to the question, "Who am I?"
- the result of self-knowledge. As a child grows up he/she distinguishes between him/herself and his life-world. He/she becomes more and more aware of him/herself and gets to know him/herself. Through this process different identities are formed;
- important during adolescence;
- dynamic. Significant changes in an individual or in his/her rolls lead to a re-assessment of the 'self'. Identity-formation is therefore a lifelong and largely unconscious process;
- the result of involvement and the attribution of meaning by the 'self';
- consisting of various categories. An individual also has many self-concepts in accordance with his various identities;
- inclusive of attributes.

(d) The self-concept

According to Jacobs (1981:171), it is through the self-concept that an individual takes note of himself as well his life-world. Jacobs compares the self-concept with a pair of glasses, and the individual observes his life-world through the glasses. Purkey (1988:1) defines the term *self-concept* as, "…the totality of a complex, organized and dynamic system of learned beliefs, attitudes and opinions that each person holds to be true about his personal existence".

Purkey (1988:1), further states that self-concept is different to self-esteem (feelings of personal worth and a level of satisfaction regarding one's self), or self-report (what a person is willing and able to disclose). This is the image of himself that he protects whenever he is attacked or insulted (Roets, *et al.* 2002:20).

According to Purkey (1988:2), it is clear that a self-concept has at least three major qualities, namely (1) it is learned; (2) it is organized; (3) and it is dynamic.

For the purposes of this study the researcher will discuss the above three qualities with regard to the term 'self-concept'.

It is learned

Purkey (1988:2) indicates that the self-concept gradually emerges in the early months of life, and is shaped and reshaped through repeated perceived experiences, particularly with significant others. According to Gouws, *et al*. (2008:100), a person's self-concept is not inborn, but is acquired through interaction with the 'self' and with other people of importance. Raath and Jacobs (1993:24), likewise, declare, "… a child is not born with a specific self-concept, but he learns to know himself through his life-experiences and in the process he forms a negative or positive self-concept".

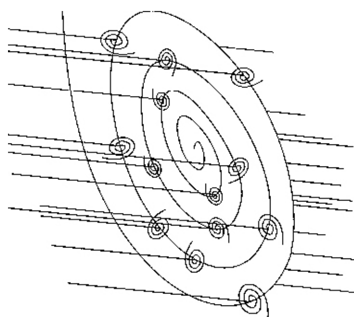
Purkey (1988:2) states that the fact that the self-concept is learned has certain important implications for counsellors, namely

- because the self-concept does not appear to be instinctive but a social product developed through experience, it possesses relatively boundless potential for development and actualization;
- because of previous experiences and present perceptions, individuals may perceive themselves in ways different from the ways others see them;
- individuals perceive different aspects of themselves at different times with varying degrees of clarity - therefore inner focus is a valuable tool for counselling;
- any experience which is inconsistent with one's self-concept may be perceived as a threat, and the more of these experiences there are, the more rigidly the self-concept is organized to maintain and protect itself. When a person is unable to get rid of perceived inconsistencies, emotional problems arise.

It is organized

Purkey (1988:3) states that each person maintains countless perceptions regarding his/her personal existence, and each perception is orchestrated with all the others. It is this generally stable and organized quality of the self-concept that gives consistency to the personality.

Purkey (in: Raath & Jacobs 1993:21) explains the organization of the self-concept by means of the following sketch:



(Source: Gouws, *et al.* 2008:98)

Each of the small spirals represents a specific concept that a person has of himself or herself. All the concepts are not equally important, because the nearer the concept is to the centre of his being, the more important it will be for the person, and the more difficult it will be to change that specific concept. Those concepts that are further away from the centre will be less stable and therefore easier to change. The small spirals of the self-concept cannot function independently, because they are all integrated concepts of a person's total life. Therefore, if a problem should arise within one of the concepts of the 'self', it will influence the entire 'self'. Another characteristic of the self-concept is that each small spiral (concept) has its own positive and negative values. This characteristic is illustrated by the horizontal lines of the sketch. Each of the smaller concepts has a value (Raath & Jacobs 1993:22). For example, if a person's appearance is important to him/her,

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it would be placed close to the core of the self-concept. If the person experiences his/her appearance as negative, it could have a negative value (Gouws, *et al.* 2008:99). It should also be noted that success and failure also influence the organization of the self-concept. According to Gouws, *et al.* (2008:99), if the ability to perform a particular action is given an exceptionaly high ranking, failure in that area may have a detrimental effect on the self-evaluation of other, apparently unrelated abilities, while success in the same area may enhance the self-evaluation of abilities in other areas.

It is dynamic

The self-concept is also dynamic, in the sense that it may change from time to time, and from situation to situation (Gouws, *et al.* 2008:98). The self-concept moves between two poles, positive and negative, and is not always the same. For example, if a child obtains good marks in a test, the pendulum moves to the positive side, but if the child achieves bad marks in another test, the pendulum moves to the negative side (Roets, *et al.* 2002:21).

The characteristics of the movement of the pendulum that determine an individual's entire self-concept at different times can be described as follows (Roets, *et al.* 2002:22-23):

A realistic self-concept

:The individual accepts his/her positive and negative attributes.

:The individual does not have to be successful in everything he or she does.

A realistic positive self-concept

:The individual accepts his/her positive and negative attributes.

:The strength of the individual's positive attributes is strong enough to ensure that the negative attributes do not influence the self-concept or the individual's becoming in a negative way.

:The healthiest self-concept of all five.

A realistic negative self-concept

:A serious setback occurs, *e.g.* failing a grade. The individual feels a total failure. It affects all of his/her positive attributes.

:The individual's entire self-concept moves to the negative pole. The individual's negative self-concept is realistic in the situation. However, the negative perception of the 'self' is usually temporary.

:It is important to take note of the fact that if the self-concept remains negative, it is unrealistic and not realistic negative.

An unrealistic negative self-concept

:The individual continues to believe that he/she is a total failure. This results in unrealistic beliefs.

:This one negative aspect dominates all the positive attributes.
:The pendulum is stuck at the negative pole. In serious cases the self-concept loses its dynamic character.
:Such a total negative self-concept is unrealistic.

<u>An unrealistic positive self-concept</u>
:Signs of a negative self-concept appear in behaviour, but the pretence of a positive self-concept is present.
:The individual moves away from the true 'self' and provides answers that are not true.
:The individual creates an ideal 'self', and gives answers according to that image, but it is a false image of the true 'self'.
:The individual closes him/herself off from his true 'self' and his/her weak attributes.
:The individual strives towards an image of what he/she thinks he/she should be and others want him/her to be.
:The individual escapes reality and does not accept his/her negative attributes in a realistic manner.

It is also important to note that the self-concept is not only dynamic due to the fact that it can change, but also because it has considerable dynamic qualities in its influence on a person's behaviour (Andrews, in: Raath & Jacobs 1993:18). Every single experience in a person's life, whether it is pleasant or unpleasant, has an influence on the development of his self-concept. On the other hand, the self-concept also plays an active role in the way the person experiences a situation (Raath & Jacobs 1993:18).

The degree of the stability of the self-concept plays an important role in the composition of the personality. The instability of the self-concept could be the result of various factors. Conflicting self-concepts could be the result of the way an individual is treated by people important to him/her in his/her life-world. It could also be the result of a difference between the individual's true self-concept and the ideal self-concept (Roets, *et al.* 2002:20).

For the purposes of this study the self-concept will be viewed as

- the individual's inner image of himself: "This is me";
- the image he protects whenever he is attacked;
- having three major qualities: it is learned, organized, dynamic;
- acquired through interaction with the 'self' and other people important to the 'self' (learned);
- existing of countless perceptions - each perception is orchestrated in an organized manner with the others (organized);
- changing from time to time, and from situation to situation (dynamic);
- moving between a realistic self-concept, realistic positive self-concept, realistic negative self-concept, unrealistic negative self-concept, and an unrealistic positive self-concept;
- an influencing factor in behaviour;

- playing an active role in the way a person experiences a situation.

(e) Conclusion

According to the relations theory, the intra-psychic structure of each individual comprises of four components, namely an ego, a 'self', identities, and a self-concept. The four components of the intra-psychic structure were discussed in the above section. It is, however, important to take note of the fact that although the four components of the intra-psychic structure can be distinguished from one another, they are so closely interwoven that they can never truly be separated (Raath & Jacobs 1993:22).

2.2.2.3 The inter-active process

According to the relations theory, the inter-active process includes involvement, experience and the attribution of meaning by means of inner speech.

A discussion of each of these concepts will follow.

(a) Involvement

According to Jacobs and Lessing (2000:78), the concept *involvement* refers to the actual action of getting involved. The involvement could be physical or psychological in nature, and implies perseverance, diligence and dedication. The individual gets involved in certain events in his life-

world through the 'self' and through others, and by getting involved certain identities are formed (Jacobs & Lessing 2000:78). Involvement therefore leads to identification with people, places or things. It is impossible to gain knowledge regarding any aspect if an individual does not get involved with that aspect (Roets, *et al.* 2002:42). An individual can also not become involved in something in what or with someone in whom he does not have any interest (Vrey 1979:37). The conclusion can be made that an individual becomes involved with a view of greater and deeper knowledge and understanding. The fact that an individual gets involved also indicates that he wants to be involved (Vrey 1979:37). Involvement, therefore, refers to the act of giving attention to a person or matter because a person wants to do so. Involvement could be seen as the psychic vitality or life force whereby significant goals are aspired to and realized (Roets, *et al.* 2002:42). Involvement thus leads to the achievement of goals and to fulfilment within a person's life-world. It is not passive, but action is implied.

Inadequate involvement affects an individual's cognitive structure, emotional life and value system (Jacobs 1982:12). Inadequate involvement could promote under-actualization which, in turn, gives rise to anxiety, frustration, failure, *etc*.

For the purposes of this study, involvement will be viewed as

- the actual action of getting involved; it is not passive but entails action;
- physical or psychological in nature;
- the reason why certain identities are formed;
- the motivation for gaining a greater and deeper knowledge and understanding;
- a purposeful action; and
- a pre-requisite for the realization of goals and fulfilment in life.

(b) Experience (affective)

When an individual gets involved, he attributes meaning to his involvement, and experiences things like success, failure, frustration, *etc*. (Jacobs 1982:12). His experience could therefore be positive or negative. The experience will also determine if the individual will be attracted to the specific aspect, situation or relation, or not. One can come to the conclusion that an individual's experience of a relation will determine the quality of that relation, due to the fact that it is affective in nature. The above emphasizes the unique and individual nature of one's relations. Experience, therefore, determines the quality of involvement and meaning-attribution. Jacobs (1982:12) states that experience is always limited to the affective consciousness of the individual, and will always accompany an activity or condition of involvement and meaning-attribution. The intensity of the experience determines the clearness and the stability of the meaning that is being formed.

Experience also gives an indication of how an individual is experiencing his identity in a specific situation (Jacobs & Lessing 2000:78). In other words, experience refers to, for example, how a father is experiencing his fatherhood, or how the employee is experiencing his new job. The conclusion can be made that experience does not happen in a vacuum, but is related to a person's situation. An individual's experience, therefore, indicates how he evaluates a specific situation.

For the purposes of this study *experience* will be viewed as

- the act whereby meaning is attributed by an individual when he becomes involved;
- positive or negative in nature;
- the determining factor in an individual's decision of being attracted to an aspect, situation or relation, or not; determining the quality of different relations;
- emphasizing the unique and individual nature of relations;
- always limited to the affective consciousness;
- the indicator of how an individual is experiencing an identity in a specific situation;
- related to a specific situation;
- an indicator of how the individual evaluates a specific situation.

(c) The attribution of meaning (cognitive)

According to Jacobs and Lessing (2000:79), the attribution of meaning implies that the individual recognizes, knows, and understands. These cognitive abilities give the individual the ability to discover the meanings of his different identities. By means of the attribution of meaning, the individual is able to orientate himself in his life-world. It can be regarded as an individual's personal understanding of his life-world (Roets, *et al.* 2002:42). Through this orientation the individual is able to stand in certain relationships to objects and people that are important to him, as well as to himself (Jacobs 1982:71). According to the *Victor Frankl Institute: Official Website on Logotherapy and Existential Analysis* (undated:2), human beings are called upon to bring forth the best in themselves and in the world by perceiving and realizing the meaning of the moment in each and every situation. Meaning can be both denotative and connotative. *Denotative* meanings have a logical dimension, and make common understanding possible. *Connotative* meanings are uniquely personal in nature. An experience can be so intense that the denotative meaning is concealed by the attribution of connotative (illogical) meaning, and this then clouds the person's understanding (Roets, *et al.* 2002:42).

For the purposes of this study the *attribution of meaning* will be viewed as

- the cognitive ability, whereby the individual discovers the meaning of his different identities;
- the reason why an individual is able to recognize, to know and to understand;
- the reason why an individual can orientate himself in his life-world;
- the reason why an individual can understand his life-world;
- denotative or connotative in nature;
- when denotative, it has a logical dimension; it makes common understanding possible;
- when connotative, the meanings are uniquely personal to that individual.

(d) Intra-psychic dialogue/Inner speech

Intra-psychic dialogue refers to the way a person talks to himself about himself. It need not be a discussion or talk in the usual sense of the word; it need not be spoken, and the person may not even be aware that he is talking to himself. It can also happen in the subconscious mind (Raath & Jacobs 1993:29).

According to Jacobs and Lessing (2000:84), the individual is constantly busy evaluating his relations with objects and happenings in his life-word. This evaluation takes place through inner speech. Self-talk occurs in all dimensions of a person's life, and can range from how he experiences his physical ability, to how he feels about his relationship with his family (Raath & Jacobs 1993:30). Raath and Jacobs

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(1993:30) also state that the individual's self-talk depends on the norms and values of his society. An individual's self-talk is therefore influenced by his own subjective value system (Jacobs & Lessing 2000:84).

By means of self-talk the individual reasons with himself (Raath & Jacobs 1993:31). The intra-psychic dialogue usually vacillates between positive and negative extremes. Negative intra-psychic dialogue often initiates an unrealistic negative self-concept due to the fact that the individual puts himself down. He tells himself he is "stupid", even though he is of average intelligence (Roets, *et al.* 2002:23,24). The fact that he is unrealistic in his reasoning with himself does not upset him at all. The way that he experiences the things in his life-world, the way how he gives meaning to them and becomes involved in them, will be influenced more and more by this unrealistic self-talk (Raath & Jacobs 1993:31). An individual is continuously busy with self-talk that will sometimes be positive and at other times negative, depending on how he feels about himself (Raath & Jacobs 1993:29). If the self-talk is continuously negative, the individual will become less and less accepting of himself (Raath & Jacobs 1993: 31).

The conclusion can thus be made that the intra-psychic dialogue is the catalyst that moves the pendulum of the self-concept between positive and negative poles. The power of self-talk sets the self-concept into movement. This movement of the self-concept is dynamic, and it happens subconsciously (Raath & Jacobs 1993:31).

For the purposes of this study, *intra-psychic dialogue* will be viewed as

- the way a person talks to himself about himself;
- taking place in the conscious, as well as in the subconscious mind;
- the means by which an individual continuously evaluates his relations;
- occurring in all dimensions of the individual's life-world;
- influenced by an individual's own subjective value system;
- the catalyst that moves the pendulum of the self-concept between positive and negative.

(e) Conclusion

According to the relations theory, the intra-psychic process consists of three aspects, namely involvement, experience and the attribution of meaning. During the intra-psychic process there is continuous interaction between involvement, experience and meaning-attribution. Through this interaction by means of their inner-speech, the individuals evaluate their status identities with regard to specific relations. This evaluation leads to an own idea of the 'self' in certain events and situations, and influences the nature of the individual's relations. He thus forms a self-image with regard to a certain identity (Jacobs & Lessing 2000:80).

2.2.2.4 The ultimate goal: self-actualization

According to Colman (2001:660), the concept *self-actualization* was first introduced by the German psychiatrist Kurt Goldstein. Colman (2001:660), further states that Goldstein defined the concept as the motive to realize one's latent potential, to understand oneself and to establish oneself as a whole person.

Carl Rogers believed that self-actualization is closely related to each individual's perceived reality and self-concept. Rogers further believed (The Encyclopaedia of Psychology 2001:1) that an individual's self-concept can become distorted by the need of the approval of others, which can lead to the alienation from one's true beliefs and desires, and to the suppression of one's tendency to self-actualization (The Encyclopaedia of Psychology 2010:1).

According to Gouws, *et al.* (2008:104), *self-actualization* can be described as the ultimate goal of personality development.

Vrey (1979:46,47) states that self-actualization involves an individual's physical abilities, his/her intellectual abilities, emotional experiences, and moral consciousness. Due to the fact that all these aspects are involved, the individual is able to acquire his human selfhood, and to reach self-actualization. Vrey further states (1979:46) that self-actualization does not have anything to do with perfectionism. However, the self-actualizer is completely

involved in his life-world. He experiences intense pleasure, as well as the deepest sorrow. He is, though, not only involved in his own life, but also in the lives of the people who make up part of his life-world. The self-actualizer has a realistic view of himself; he, therefore, accepts himself as he is, and his inabilities and limited abilities do not influence his self-concept in a negative way (Vrey 1979:46). Due to this self-acceptance there is no time for guilt, anxiety, shame or aggressive feelings (Brennicke & Amick, in: Vrey 1979:46). The fact that no energy is wasted on anxiety and other defence mechanisms, allows the individual to focus his energy on problems and circumstances outside himself (Vrey 1979:46).

Maslow conducted a study (Papalia & Olds 1985:498) on thirty-eight persons whom he thought had fully realized their potential, and had, therefore, reached self-actualization. This selected group of people included such historical giants as Albert Einstein, Ludwig von Beethoven, Abraham Lincoln, and Eleanor Roosevelt, along with lesser-known people whom Maslow knew personally. After making a study of these people's lives, Maslow identified sixteen characteristics that distinguished these self-actualizers from the average person (Papalia & Olds 1985:498). According to Maslow (in: Boyum 2010:1-4, and in: Papalia & Olds 1985:498), these characteristics are the following:

(a) *A realistic view of life*

Self-actualized individuals exhibit more realistic perceptions of reality, and are more comfortable with them. They accept the good and the bad, the highs and the lows, and are able of telling the difference.

(b) *An acceptance of themselves, of other people, and the world around them*

These individuals see reality as it is, and accepts responsibility for it. They are as objective as a subjective being can be in their perceptions.

(c) *Spontaneity*

They exhibit spontaneity, simplicity and naturalness. They are capable of doing whatever feels good and natural to them. They do not try to hurt others, but respect what is good for them.

(d) *Catering for problems*

These self-actualizing individuals focus on solving problems rather than on merely thinking about them. They are also people who are generally strongly focused on problems outside themselves. They are concerned with the problems of society, and are willing to work in an effort to solve them.

(e) *A need for privacy, and a certain degree of detachment*

Self-actualizing individuals need to be alone, and need solitude. They enjoy times of quiet reflection, and do not always need people around them.

(f) *Independence and the ability to function on their own*

These individuals are capable of doing things, and can make decisions on their own. They believe in themselves, and in who and what they are.

(g) *An un-stereotypical appreciation of people, things and ideas*

These individuals experience joy in the simple and the natural. To them the sunsets are always beautiful; they can still enjoy the games they played as children.

(h) *The mystic experiences, the peak experiences*

These persons have a history of peak experiences which are profoundly spiritual, and which may be mystical or religious.

(i) *An identification with everybody human*

These individuals identify with all of mankind. They are aware of and sensitive to the people around them.

(j) *Interpersonal relationships*

They have a deeply loving and intimate relationship with a few people. They are capable of fusion, of greater love, and of more perfect identification than other people.

(k) *Democratic values*

These individuals believe in the equality of all human beings, that every person has a right to his/her opinion, and that each person has his strengths, but also his weaknesses.

(l) *The ability to separate means from ends*

These individuals know the difference between means and ends, and between good and evil. They also do not twist these in a way that may hurt themselves or others.

(m) *A sense of humour that is lively, not cruel*

These people enjoy humour. They like to laugh and joke, but not at the expense of others. They are generally seen as good-natured, but are also capable of being very serious.

(n) *Creativity*

These individuals are often highly creative, and their creativeness can be expressed in many dimensions.

(o) *A lack of conformity*

These people are aware of the fact that they are not perfect, and that there are continuously new things to learn, and new ways to grow. They never stop striving.

(p) *A demonstrated ability to rise above the environment, rather than merely adjusting to it*

These persons maintain a strong individuality. They are not so absorbed that they cannot evaluate, for example, their culture objectively, so that they can make decisions about what is best for them and for those whom they care about.

What happens if an individual does not reach self-actualization? Frankl states that when a person cannot realize his "will to meaning" in his life, he will experience an abysmal sensation of meaninglessness and emptiness. The frustration of existential need for meaningful goals will give rise to aggression, addiction, depression, and suicide, and it could engender or increase psycho-somatic maladies and neurotic disorders (Victor Frankl Institute, undated:2).

For the purposes of this study, the sixteen characteristics of successful self-actualizers that Maslow identified, as well as the views of Vrey and Frankl, will be used as a guideline to determine the level of self-actualization that someone has reached.

2.2.2.5 Summary

The last part of the discussion of the theoretical framework was taken up by a discussion of the relations theory and included a discussion of the life-world of an individual. As a social being, a person can never function in a vacuum. He stands in a relationship to God, objects, ideas, other people and the 'self'. Interaction takes place between the individual and the different components in his life-world. The discussion also focused on the intra-psychic structure of the individual. According to research, the intra-psychic structure of each individual consists of four components, namely an ego, a 'self', identities and a self-concept. The chapter also included a discussion of the intra-psychic process that takes place in the individual's life-world. The literature indicates that the intra-psychic process occurs by means of involvement, experience and meaning-attribution through inner speech. A discussion of self-actualiation, as well as the characteristics of successful self-actualizers, completed the discussion.

2.3 Existing treatment programmes in South Africa

To enable the researcher to investigate existing treatment programmes in South Africa, a study that was undertaken for a doctoral dissertation was used as a guideline. The study investigated different treatment programmes for teenagers at rehabilitation centres in South Africa and was completed in 2004 at the University of Johannesburg (previously the Randse Afrikaanse Universiteit). The

following data regarding the location, theories, models and treatment programmes were collected during the investigation (Louw 2004:119-125):

Table 2.1: Theories, models and treatment programmes in South-Africa

Rehabilitation centre	Location	Theories/ Model/ Programmes
Centre 1	Northern Cape	Morel Model Teen Challenge Programme
Centre 2	Western Cape	Morel Model Teen Challenge Programme Twelve Steps Programme
Centre 3	Gauteng Mozambique	Morel Model Teen Challenge Programme
Centre 4	Western Cape	Morel Model Teen Challenge Programme
Centre 5	Western Cape	Behavioural Model
Centre 6	Mpumalanga	Moral Model
Centre 7	Eastern Cape	Narrative Model Biopsychosocial Model
Centre 8	Gauteng	Cognitive Behaviour Therapy Medical Model
Centre 9	Gauteng	Socio-Educational Program
Centre 10	Mpumalanga	Neurolinguïstic Programming
Centre 11	Gauteng	Biopsychosocial Model
Centre 12	Gauteng	Twelve Step Programme Medical Model
Centre 13	Western Cape	Twelve Step Programme Medical Model
Centre 14	Western Cape	Minnesota Model Medical Model
Centre 15	Western Cape	Twelve Step Programme Medical Model

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The above theories, models and treatment programmes will subsequently be discussed.

Moral Model

Addiction is viewed as a set of behaviours that violate religious, moral, or legal codes of conducts (Miller 1999:22) and the client's personal choices regarding these aspects are viewed as the main reason for their addiction (Sunshine Coast Medical Centre:1). Clients therefore choose behaviour that is immoral, sinful and sometimes illegal (Miller 1999:2) and these behaviours result in addiction.

Medical Model

The medical or disease model has been the dominant model of addiction treatment since 1960 (Sunshine Coast Health Centre: 2011:1). The model assumes that mental problems are ultimately physical problems and in the same way that physical conditions can be classified and treated, so too can mental conditions also be classified and treated. During the classification and treatment of mental problems the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* are used (Joseph 2010:25,94). During treatment clients need to 'accept' their diagnosis and are persuaded by therapists to follow a life of abstinence from substances (Sunshine Health Centre 2011:1).

Minnesota Model

The first requirement of the Minnesota model is abstinence, while the second part of treatment deals with underlying emotional trauma. During this part of treatment, counsellors make use of their own skills and approaches to assist their clients. During the third part of treatment time is spend with "recovering addicts" and the focus is on reaching out to help others who are still suffering from addiction (Lefever 2008:31,32).

Behaviour Model

During treatment, therapists focus on the environmental conditions that shape behaviour. In behaviour therapy there is no need to uncover unconcious forces and the task of the therapist is to eliminate the unwanted behaviours of the client which are seen as the result of learning. The therapist is therefore concerned with the removing of spesific symptoms, developing new adaptive behaviour and the changing of environmental reinforcement contingencies (Joseph 2010: 72,78).

Narrative Model

According to Feedman and Combs (in: Joseph 2010:157), clients are engaged in story telling and the use of metaphors to make sense of their lives and to understand their experiences. During therapy, therapists assist clients

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to see stories from different point of views, search for new solutions and develop new meanings.

With regard to substance abuse treatment the problem could be seperated from the personal identity of the client during story telling. An 'alcoholic' becomes a 'person oppressed by the Alcohol Bully'. The name of the problem is decided in collaboration with the client and has the effect of liberating the client from the label of the addiction (van Wormer & Davis 2008:108).

Biopsychosocial model

According to Colman (2001:92) the biopsychosocial model deals with the interaction of mind and body and the effects of this interaction. With regard to substance abuse the *biology* of chemical use relates to the hereditary components in the etiology of the illness and the physical symptoms that may arise with extended use. The *psychological* component refers to the thinking that leads to the addiction, while the *social* component in addiction relates to where does the addictive activity takes place and where is the impact of the addiction felt (van Wormer & Davis 2008:11,12).

Cognitive Behavioural Therapy

Joseph (2010:90.91) states that many theorists have been interested in finding ways in which different models could be integrated. Therapists therefore began to integrate

cognitive ideas with behavioural ideas, resulting in what is now known as *cognitive-behavioural therapy* (CBT). The cognitive-behavioural therapist views substance dependence as learned behaviour that is acquired through experience.

During treatment clients need to (1) identify spesific needs that are met when they use or abuse substances and (2) develop skills that provide alternatives to meet these needs (Kadden 2002:1).

Teen Challenge Programme

The programme provides addicts with effective and comprehensive Christian faith-based solutions to alcohol- and drug problems (Teen Challenge International 2011:1). The programme was founded in 1958 in New York and brought to South Africa in 1997. Therapy involves treatment over a period of twelve months for addicts between the ages of thirteen to forthy years of age. Treatment includes rehabilitation, developing a structured life style, teaching discipline, building relationships, teaching respect for authority and teaching self-respect and self-esteem (Teen Challenge Westen Cape: undated 4-6).

Twelve Steps Programme

The Twelve Steps programme was originally designed by Alcoholics Anonymous and addresses the client's spiritual foundation as the recovery from the effects of alcholism

(Buddy 2009a:1). Addicts need to apply the following steps during treatment (Buddy 2009b:1; Lefever R 2008:237-238):

Step 1 – Honesty: After years of denial, recovery can begin. Clients admit that they are powerless over their addiction and that their lives have become unmanageable.

Step 2 - Faith: Client's need to believe that a power greater than themselves could restore their sanity.

Step 3 - Surrender: Clients need to turn everything to a higher power.

Step 4 - Soul searching: Client's make a fearless moral inventory of themselves.

Step 5 - Integrity: Client's need to admit to a higher power, themselves and others the exact nature of their wrong doings.

Step 6 - Acceptance: Client's need to accept character defects exactly as they are, become entirely willing to let them go and have a higher power remove all these defects of character.

Step 7 - Humility: Client's need to humbly ask a higher power to remove their shortcommings.

Step 8 - Willingness: Client's need to make a list of all persons they have harmed, and become willing to make amends to them.

Step 9 - Forgiveness: Clients need to make direct amends to such people, except when to do so would injure them or others.

Step 10 - Maintenance: Clients need to continue to take personal inventory and when they are wrong, they need to promptly admit it.

Step 11 - Making contact: Through prayer and meditation, client's need to make contact with a higher power.

Step 12 - Service: Clients need to carry this message to other addicts who still suffer, as well as practice these principles in their own lives.

Social Educational programme

The programme addresses both physical and cognitive aspects of addiction. Clients first goes through physical detoxification (Louw 2004:164). During the next phase of treatment attention is paid to the development of personal skills, personal values, integrity and individual responsibility. Attention is also paid to the restoration of relationships with family and friends, as well as to future career opportunities (Narcanon 2009:1). Therapeutical assistance does not form part of the programme. During

therapy clients work through prescribed textbooks (Louw 2004:164).

Neuro-linguistic programming (NLP)

Neuro-linguistic programming consists of a set of techniques that results in effective behavioural modification (Smith 2008:1). The programme combines three concepts: neurology, language and programming. The body functions are regulated through the neurological system, language determines how the individual communicates, while programming refers to the kind of models of the world that are created by the individual (Dilts 2011:1).

The last part of chapter two was taken up by a discussion of the different treatment programmes in South Africa.

2.4 CONCLUSION

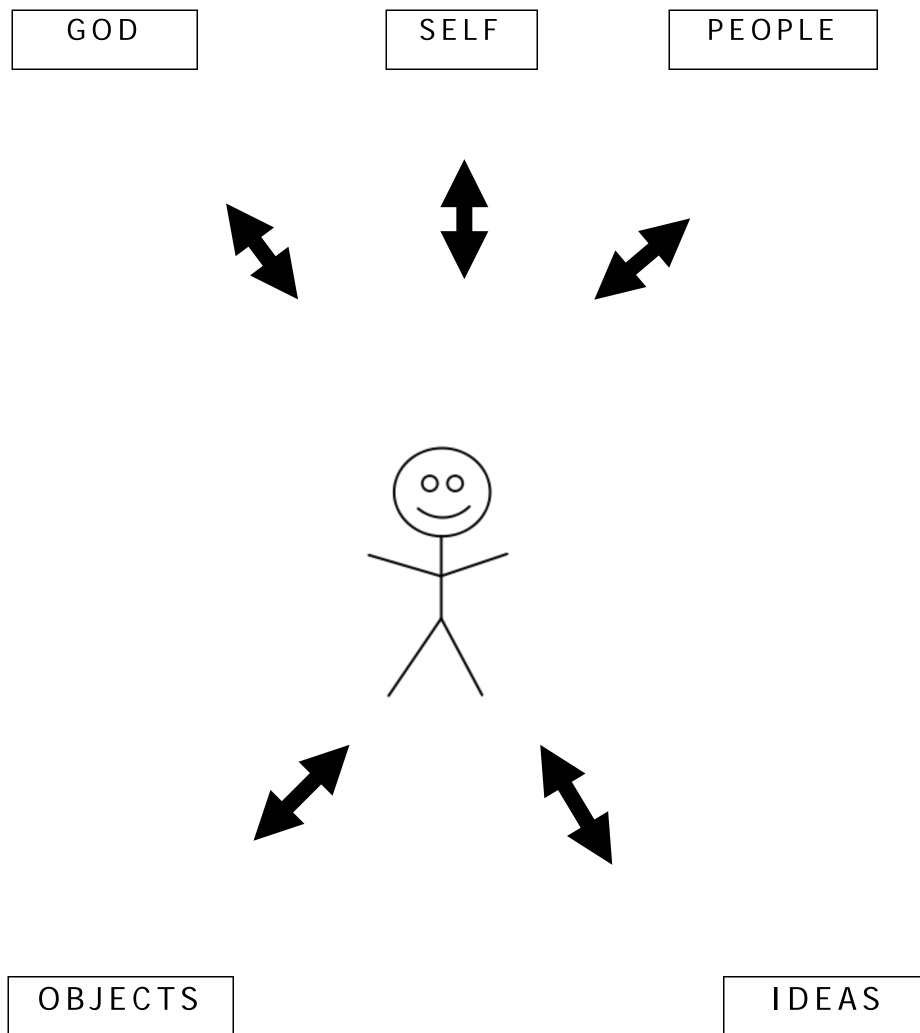
The first part of chapter two focused on the family systems and relations theories. The reason for including a discussion of the family systems and the relations theories in the study is because it will serve as the theoretical framework for the developement of *phase three* (see Chapter five) of the treatment programme.

(a) The family systems theory

The family systems therapist views the client that is brought to therapy as the *identified patient.* However, the problem is often in the family system. During therapy the therapist attempt to change aspects regarding the family system. For the client to be able to heal, problems that occured within the family of origin needs to be addressed. With regard to this study the addict is viewed as the *identified patient* and for the addict to heal from his or her addiction, aspects in the addicts family of origin needs to be addressed during therapy.

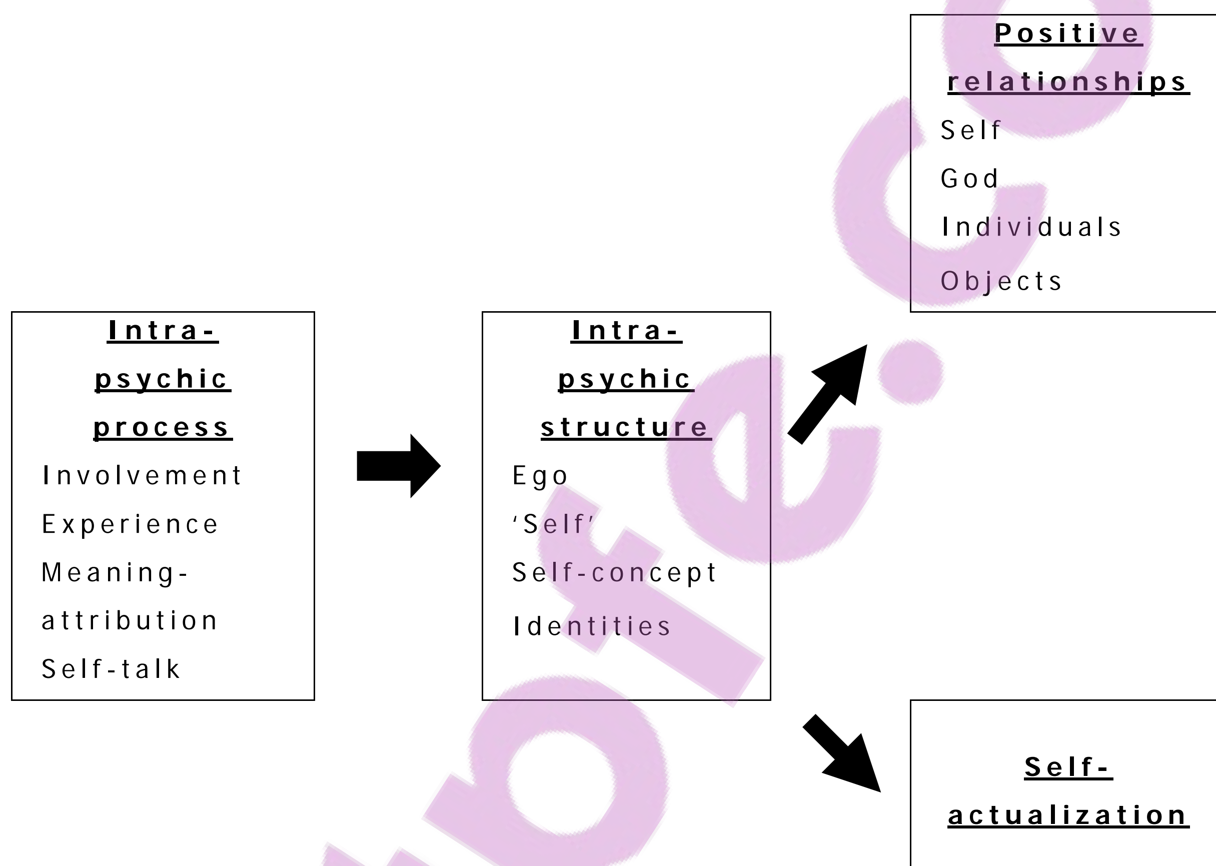
(b) Relations theory

The point of departure of the relations theory is that an individual, as centre of his life-world, stands in a relation to different components of his/her life-world. The different components of the individual's life-world consist of God, other people, objects, ideas and the 'self'.



Through the interactive process of *involvement, experience*, and the *attribution of meaning,* and by means of *self-talk,* the individual develops different identities. He/she constantly evaluates these acquired identities with regard to the related relations, and in this evaluation acquires self-concepts for each identity. If his behaviour is socially acceptable, it will contribute to sufficient self-actualization and healthy relations in his/her life-world. If the personality

composition results in unacceptable behaviour, it will lead to insufficient self-actualization and unsatisfying relations.



Problematic behaviour, like addiction, is a symptom of something that went wrong in the individual's intra-psychic structure. A low self-concept is, for example, a symptom of something that is wrong in the individual's intra-psychic structure, and little will be gained by assisting the individual to improve his self-concept. The basic cause of the problem needs to be addressed, and not the mere symptom. The individual's intra-psychic structure is formed

by means of the intra-psychic process, and it is therefore not the intra-psychic structure that needs to be addressed and changed in the treatment program, but the intra-psychic process.

For this reason the treatment program of this study will focus on the intra-psychic process in the individual namely *involvement, the attribution of meaning, experience* and *self-talk*.

A change in the intra-psychic process will lead to change in the intra-psychic structure, and this will result in changes in the individual's relationships, as well as the level of self-actualization reached by the individual. The researcher therefore reasoned that if the treatment programme is effective, changes will occur in the individual's relationships with the 'self', God, others, objects and ideas, as well as the level of self-actualization reached. The researcher will thus be able to determine the effectiveness of the treatment programme by investigating these two aspects after the implementation of the treatment programme.

(c) Existing treatment programmes in South Africa

The second part of chapter two focused on existing treatment programmes in South Africa. After the investigation the researcher concluded that, although some of the existing treatment programmes in South Africa involve certain aspects regarding the family of origin in their treatment programmes, it appears that there is not a

treatment programme in South Africa that addresses the family of origin as a cause of addiction.

(d) Summary

Based on the results of the literature review the researcher concluded that there is not an existing treatment programme in South Africa that addressed the family of origin as a cause of addiction.

The researcher also concluded that the treatment programme (Chapter five) that is going to be compiled for the study will focus on:

Firstly, the intra-psychic processes in the individual, namely *involvement, experience, meaning-attribution* and *self-talk*. Due to the fact that the aim of the study is to investigate the family of origin as a cause of addiction, the treatment programme will focus on the client's *involvement, experience* and *meaning-attribution* with regard to his/her family of origin.

Secondly, to be able to determine the effectiveness of the treatment programme, changes in the individual's relationships with the 'self', others, God, objects and ideas, as well as the level of self-actualization reached after the implementation of the treatment programme, will be investigated. Due to the fact that the study focuses on the family of origin as a possible cause of addiction,

relationships with ‘others’ will refer to the client’s relationships with his/her parents and siblings.

Chapter three will focus on phase one of the treatment programme. This phase will provide therapists with guidelines to be able to assist clients to abstain from the substances that they are using.

CHAPTER 3

PHASE ONE OF THE TREATMENT PROGRAMME

3.1 INTRODUCTION

The aim of chapter three is to discuss phase one of the treatment programme for addiction. Phase one of the treatment programme provides guidelines for therapists on how to assist clients to reach abstinence from the substances that they are addicted to. To be able to assist the clients to reach abstinence, therapists first need to determine the severity of the drug use or abuse. To determine the severity of the client's addiction the therapist needs to establish

- *what* the substance or substances are that the client is using;
- how *often* and *how much* the client is using.

After the therapist has established the severity of the addiction, the level of care that the client needs has to be established.

The second part of chapter three will provide information on the different levels of care available for clients suffering from addiction.

3.2. THE SEVERITY OF THE ADDICTION

To be able to determine the severity of the client's addiction, the therapist needs to determine which substances, how often, and how much the client is using.

3.2.1 What substance or substances is the client using?

All psycho-active substances (drugs) alter the feelings, thoughts and behaviour of a person. The substances directly affect the brain and the central nervous system (CNS). The specific effects of the substances are highly complex. Feelings are altered when the substances affect the neurotransmitters and the intercellular communications that seek a balance between the excitatory and inhibitory functions. Specific drug actions depend on the route of administration, the dose, the presence or absence of other drugs, and the clinical state of the individual (Perkinson 2008:19).

Substances are divided into certain categories, and the therapist needs to be aware of the category in which the substance or substances that the client is using, falls.

A brief discussion of the classification of substances will follow.

3.2.1.1 Drug classification

Psycho-active substances are often categorized by their prevalent mood-altering qualities. Due to the fact that these substances have similarities with other substances, they are universally categorized in the same way (Lessa & Scanlon 2006:31). According to Schuckit (2000:9), it is possible to learn the characteristics of a drug class and then apply the general rules to a specific case. Although there are many possible classifications, Schuckit provided (2000:9-10) a breakdown of drugs into classes that are of particular use in clinical settings, and in which the drug classes are determined by the most prominent CNS effects at the usual doses.

(a) *Depressants of the central nervous system (CNS)*

Substances that are classified under this group dull the central nervous system and generally slow down all functioning, causing the user to feel relaxed and drowsy (The Cape Town Drug Counselling Centre 2007:24). The use of these drugs is therefore characterized by the depression of the excitable tissues at all levels of the brain, along with relatively few analgesic properties at the usual doses (Schuckit 2000:9). These substances are also known as *downers*. The CNS depressants include most sleeping medication, anti-anxiety drugs (also called *anxiolytics* or *minor tranquilizers*), and alcohol. It is important to note that anti-psychotic drugs (also called *major tranquilizers* or *neuroleptics*) are not CNS depressants, due to the fact that

they do not resemble the anti-anxiety drugs in their structure or predominant effects, do not cause physical dependence, and are rarely used to induce a 'high' (Schuckit 2000:9).

(b) *Central nervous system sympathomimetics or stimulants (CNS)*

Substances that are classified in this group stimulate the central nervous system and generally speed up all functioning, making the user feel pumped-up, energetic and euphoric (The Cape Town Drug Counselling Centre 2007:23). Substances in this category stimulate the central nervous system, increasing alertness, and relieving fatigue (Van Wormer & Davis 2008:137). Most of these drugs block the actions of the inhibitory nerve cells via the inhibition or removal of some neurotransmitters from the space between the nerve cells (the synapses). Some also enhance the actions of the stimulatory systems by the release of transmitter substances from the cells, or by direct action on the cells themselves. These substances include the amphetamines, methylphenidate (Ritalin), all forms of cocaine, and weight-reducing products (Schuckit 2000:9). These drugs are also known as 'uppers' (The Cape Town Drug Counselling Centre 2007:23).

(c) Opioid analgesics

The concept *opioid* refers to drugs that are derived from the opium poppy (*Papaver somniferum)*. This family of drugs

includes not only the natural and direct derivatives of the plant, such as opium, morphine and codeine, but also semi-synthetic and synthetic opioids, such as heroin, pethidine and Wellconal (Searll 2002:239,240). These drugs are also known as *narcotic analgesics,* and are used to decrease pain, coughing and diarrhea (Schuckit 2000:9).

(d) *Cannabinols (principally marijuana)*

In these substances the active ingredient is tetrahydro-cannabinol (THC), which has the predominant effect of producing euphoria, an altered time sense, and at doses higher than those usually found in clinical situations, hallucinations (Schuckit 2000:9).

(e) *Hallucinogens*

Hallucinogenic plants have been used for centuries as medicines to cause an altered sense of reality, and for spiritual and religious purposes (Van Wormer & Davis 2008:144), although Schuckit (2009:9) states that hallucinogens have no accepted medical use. Schuckit further states (2009:9) that these drugs are predominantly used for enhanced sensory perceptions. Hallucinations may also occur, but usually only visually.

(f) *Inhalants*

Used almost exclusively by children and teenagers, inhalants are a group of volatile chemicals that easily evaporate, and

are inhaled, often directly from the container (Van Wormer & Davis 2008:136). Various fuels, aerosol sprays, glues, paints, and industrial solutions are all classified as inhalants. They are used to alter the state of consciousness, producing primarily light-headedness and confusion (Schuckit 2000:10

(g) *Over-the-counter drugs and other prescription drugs*

A variety of medication is sold without a prescription, for instance, for the treatment of constipation, pain, cold symptoms, nervousness, insomnia, and other common complaints. There is also a number of other prescription drugs that are less likely to be misused, including diuretics, anti-parkinsonian drugs, laxatives, and some anti-psychotic medicines (Schuckit 2000:10).

3.2.1.2 The primary substances being abused in South Africa

It is not the purpose of this study to discuss all of the drugs of abuse. The intention of the researcher is to develop a practical treatment program for therapists. To determine the major drugs of abuse in South Africa, the statistics provided by The South African Community Epidemiology Network on Drug Use (SACENDU) were used as a guideline. Appendix A provides the statistics from SACEDU for the time January 2005 to June 2009. On grounds of these results, one can come to the conclusion that the following substances are the primary substances of abuse:

- Cape Town: Methamphetamine, Alcohol, Dagga and Heroin.
- Gauteng: Alcohol, Dagga, Crack, Heroin.
- Mpumalanga: Alcohol, Dagga, Heroin, Crack/Cocaine.
- Port Elizabeth: Alcohol, Crack/Cocaine, Dagga, Dagga/ Mandrax, over-the-counter medication.
- The Northern Region: Alcohol, Dagga, Crack, Heroin.
- East London: Alcohol, Dagga, Crack/Cocaine.

For the purposes of this study, an in-depth discussion will be made of Alcohol, Dagga, Heroin, Crack, Cocaine, and Methamphetamine.

To be able to determine the severity of a client's addiction, therapists need to determine what substances their clients are using. They also need to understand the effect of the different substances on their clients. It is therefore necessary to provide them with knowledge regarding the substances mostly abused in South Africa.

3.2.1.2.1 Alcohol

Alcohol is regarded as a central nervous system depressant (Edmonds & Wilcocks 2000:21). However, when alcohol is first consumed, it acts as a stimulant, and then, as more alcohol is consumed, it acts as a depressant (Searll 2002:264). In South Africa today, as in most other countries, alcohol is the most commonly used legal drug. It is also the most abused lethal drug (Wilcocks 2002:1).

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(a) How alcohol is taken

Alcohol is sold legally at liquor stores, restaurants, bars and grocery stores, and is widely available. It is swallowed by the user. Alcohol varies in strength and type, *e.g.* spirits, ciders, beer and wine, but all of these have a similar effect on the user (The Cape Town Drug Counselling Centre 2007:35).

(b) The physical effects of alcohol

According to Wilcocks (2002:4), as tolerance increases, more alcohol is needed to reach the intended effect. This is the reason why, at a certain stage of dependence, the alcoholic will and can drink enormous quantities on a regular basis, quantities that the average person could not possibly handle. Some people have a high tolerance by nature; others develop their ability to handle large quantities of alcohol as the nervous system accommodates to its effects, and the liver gets more efficient at metabolizing alcohol. Alcoholics, therefore, because of their behavioural tolerance, may be able to drive fairly well, even though legally intoxicated. *Behavioural tolerance* refers to the process of learning to adapt one's behaviour to the presence of the drug. Chronic alcoholics may be only moderately drunk at the blood alcohol level of 0.4, a level at which a normal drinker may be comatose. It is also important to note that tolerance levels are subject to alteration, following a period of abstinence. At the later stage of alcohol dependence the tolerance for alcohol will decrease. This is because of the damaging effect of alcohol

on all the organs of the body, particularly the liver, that is responsible for detoxifying alcohol. The liver, which previously increased its oxidizing function to cope with the large and regular quantities of alcohol it had to process, now becomes damaged, and its efficiency is reduced. Tolerance reversal then occurs where the drinker loses his or her ability to handle alcohol. The liver is no longer efficient, and the experienced drinker now gets drunk on the first drink (Van Wormer & Davis 2008:128).

Withdrawal symptoms are usually indicated within 24 hours, and can last for several days (Van Wormer & Davis 2008:129). Drinkers who have developed tolerance may experience severe withdrawal symptoms when they abstain from drinking. The onset of the withdrawal symptoms is rapid. They can include insomnia, anxiety, tremors, palpitations, headaches, bowel upsets, nervousness, aggression, and physical or mental discomfort. *Delirium tremens* is an extreme manifestation of the alcohol abstinence syndrome, and develops within a day or so of withdrawal. This reaction may include frightening hallucinations and life-threatening convulsions (Searll 2002:266). The typical medical treatment for alcohol withdrawal involves the use of another drug from the same class. Black coffee and other favourite remedies are of no use in trying to speed up the brain's recovery from a night or weekend of indulgence. Caffeine plus alcohol creates a 'wide-awake drunk'; the reaction time is still impaired. Even the day after a binge the functions involving coordination

and concentration are seriously altered (Van Wormer & Davis 2008:129).

Although it only needs minutes for alcohol to reach the brain, it takes the liver one hour to break down one glass of wine or 300ml of beer (Stoppard 2000:38).

Physical symptoms of alcohol abuse include trembling hands, a hangover, vomiting and nausea, a loss of appetite, impaired co-ordination, slowed reflexes, and a decrease in concentration (The Cape Town Drug Counselling Centre 2007:36).

Malnutrition in alcoholics is common, as a high percentage of an alcoholic's calorie-intake is in the form of alcohol, and the protein- and vitamin-intake is severely reduced. Anorexia may develop, and there may be a marked weight-loss. In the early stages of abuse, however, weight-gain can occur (Searll 2002:264).

Alcohol amnesic disorder, or a blackout, is a period of amnesia during intoxication. The person may seem fully conscious and normal when observed by others, but he/she is unable to remember what happened, or what he or she did while intoxicated. This disorder may last for a few seconds, or for days (Perkinson 2008:22).

Alcohol abuse is also associated with cerebral blood flow abnormalities. Small doses of alcohol produce cerebral activation, while higher doses induce cerebral vasoconstriction and overall decreased brain activity. Chronic alcoholism is associated with a reduced cerebral

blood flow and cerebral metabolism, especially in the frontal and temporal regions of the brain (Amen 1998:230). Alcohol abuse may therefore lead to the irreversible loss of brain tissue and memory, particularly the short-term memory (Searll 2002:265).

The Wernicke-Korsakoff syndrome is a neurological emergency that should be treated by the immediate parenteral (intramuscular) administration of thiamine. The symptoms begin with a sudden change in organic functioning. The client becomes ataxic (unable to control muscle movement) with a wide-based, unsteady gait. He/she may be unable to walk without support, is mentally-confused, and unable to transfer information from the short-term to the long-term memory. He or she may be disorientated, listless, inattentive, and indifferent to the environment. Questions directed at him/her may go unanswered, or he/she may even fall asleep. The etiology of this syndrome involves a thiamine deficiency due to dietary, genetic or medical factors (Perkinson 2008:22).

Alcohol is a toxic drug which, when taken in excessive amounts over a period of time, will affect practically every system and organ in the body, either directly or indirectly (Wilcocks 2002:17).

(c) The psychological effects of alcohol

According to Edmonds and Wilcocks (2000:16), all dependence on alcohol and any psychoactive drug is first and foremost psychological. A person tries the substance

and discovers that the effect is in some way beneficial. In small doses, alcohol relieves tension and anxiety, makes people talkative, and helps them to lose their inhibitions, and become more comfortable in social situations. However, large doses and prolonged use nearly always lead to a gradual deterioration in moods and behaviour. Alcohol abuse can lead to hallucinations, delusions, blackouts, confusion, disturbed and irrational behaviour, and confabulation (constructing fictitious tales to mask the inability to remember events) (Searll 2002:264).

(d) The social effects of alcohol

The disease of alcoholism could occur with any person at any point in their development. It has been noted in children as young as 10 years, and in people in their seventies. It has also been noted that alcoholism in teenagers develops more rapidly than in older persons, due to the fact that the teenager has a developing, and as yet immature, system. Alcoholism has no regard for race, class, occupation or sex (Edmonds & Wilcocks 2000:20).

3.2.1.2.2 Cocaine

The South American coca plant (Erythroxylon coca) can be used to provide energy and stave off hunger. When chewed, it rarely creates social or medical problems (Mans 2000:44). Due to its stimulating effect the leaves of the coca plant have been chewed for more than 1 200 years by Indians living in Peru and Bolivia, as well as by the inhabitants of

the small towns in the Andes mountains (De Miranda 1987:34). In the nineteenth century cocaine was hailed as a wonder drug and recommended vicariously as a painkiller, a local aesthetic, an aphrodisiac, and a remedy for cancer, asthma, and digestive disorders. The drug became part of many powders and tonics, and until 1903, was one of the secret ingredients in Coca-Cola (Searll 2002:197). The active ingredient cocaine was first isolated in 1830. When the leaves are soaked and mashed, the more potent drug, cocaine, is extracted as a paste. Processed from the coca leaf, cocaine is then produced as a white powder (Van Wormer & Davis 2008:137), and can be obtained as cocaine hydrochloride. Various methods have been tried to free the mixture from the cocaine hydrochloride to obtain a more pure cocaine basis, the reason being to get a stronger cocaine 'high' when the product is used. To some of these methods are referred to as *fee basing*. Highly flammable dissolvents are used, which makes the process very dangerous (De Miranda 1987:34). The highly volatile gases used to freebase the drug sometimes explode and can lead to death (Arterburn & Burns 2007:88).

(a) How cocaine is taken

Cocaine has a bitter taste, and the powder in its original form can be mixed with talcum powder or teething powder to increase the quantity. The end product is then about 20% pure (The Cape Town Drug Counselling Centre 2007:28). Sniffing cocaine is known as 'snorting'. It is the process of inhaling cocaine powder through the nose, where it is

absorbed into the bloodstream through the nasal tissues (NIDA 2010:1). When snorted, the cocaine powder is ground and scraped into lines on a mirror or another smooth surface, with a razor blade or bank card (Mans 2000:44).

Although it is normally snorted, it may also be smoked (Mans 2000:44). Cocaine is, however, almost un-absorbable when it is smoked (De Miranda 1987:34). By smoking cocaine, up to 90% of the drug is destroyed. Instead, the powder is converted to freebase cocaine in a chemical treatment that frees the potent 'base' material from the salt, and produces crystalline 'rocks of great purity'. The freebase cocaine is then smoked in a pipe or glass phial. This is known as *basing* or *batting*. The latter method produces a 'high' that is much more rapid, intense and euphoric than the sensation produced by sniffing cocaine powder. Freebasing is not only highly addictive, it is also extremely dangerous (Searll 2002:200).

Cocaine can also be inhaled by placing it on tinfoil, heating the foil at the bottom with a lighter, and then breathing in the fumes, a process known as *foiling*. It may also be inhaled nasally from an eyedropper, and then smeared on the teeth, the gums and the tongue (Arterburn & Burns 2007:88).

Cocaine is sometimes, though rarely, injected into the bloodstream in the form of a liquid solution. Occasionally it is mixed with other drugs, including Ecstasy, dagga and opioids before being administered (Searll 2002:200).

(b) The physical effects of cocaine

In the normal communication process in the brain, dopamine is released by a neuron into the synapse, where it can bind with dopamine receptors on neighbouring neurons. Normally, dopamine is then recycled back into the transmitting neuron by a specialized protein called the dopamine transporter. If cocaine is present, it attaches to the dopamine transporter and blocks the normal recycling process, resulting in a build-up of dopamine in the synapse, and that contributes to the pleasurable effects of cocaine. When cocaine enters the brain, it blocks the dopamine transporter from pumping dopamine back into the transmitting neuron, flooding the synapse with dopamine. This intensifies and prolongs the stimulation of receiving neurons in the brain's pleasure circuits, causing a cocaine 'high' (NIDA 2010:1).

Cocaine is rapidly metabolized by the brain from the bloodstream, and then travels back to the blood (Van Wormer & Davis 2008:137). Cocaine hydrochloride reaches the brain within about fifteen minutes, creating a 'high' (Searll 2002:209). According to Stoppard (2000:75), the 'high' will not be experienced for longer than half an hour. The intensity experienced is determined by the strength of the cocaine, the environment in which the drug was taken, how often cocaine is used, as well as the user's tolerance levels (Stoppard 2000:75). The drug can be found in the urine up to 8 hours after ingestion (Van Wormer & Davis 2008:137).

Cocaine is also the drug most closely associated with heart problems and heart attacks. Cocaine-related deaths may occur on the first use of cocaine, although rarely, and are often a result of cardiac arrest or seizures, followed by respiratory arrest (Van Wormer & Davis 2008:173-174).

(c) The psychological effects of cocaine

Dependence on cocaine is primarily psychological. The 'high' is so pleasurable and powerful that users can become addicted after their first 'hit' (The Cape Town Drug Counselling Centre, undated:27).

Cocaine creates a false confidence and causes elation (De Miranda 1998:30). The user experiences an instant feeling of euphoria, well-being and increased energy, becomes talkative, excitable, and may believe that he or she is mentally very alert, and has increased strength and stamina. Fatigue and the appetite are temporarily suspended, and the user may feel sexually aroused. The 'high' from snorting cocaine may last 15 to 30 minutes, but the 'high' from smoking it may last only 5 to 10 minutes (NIDA 2010:1). When its extreme euphoria wears off, it leaves the user depressed, and often suicidal (Arterburn & Burns 2007:88).

Cocaine psychosis may occur with the heavy (daily) use of cocaine. The syndrome is very similar to paranoid schizophrenia, and is characterized by aggressiveness, violent behaviour, and vivid hallucinations. An itching sensation known as *cocaine bugs* may be present – the user believes that insects, snakes and worms are crawling all

over his or her body, or are burrowing under the skin. The user may also hear voices, suffer from exaggerated fears, and delusions (Searll 2002:204).

(d) The social effects of cocaine

Frequent violent behaviour is often manifested, and injecting cocaine with unsterilized needles could transmit AIDS, hepatitis, and other diseases (Arterburn & Burns 2007:88).

3.2.1.2.3 Crack

Crack is the smokeable from of cocaine (De Miranda 1998:30) and is a central nervous system stimulant (Edmonds & Wilcocks 2000:26). Developed in the mid-1980s, crack is more concentrated than other forms of cocaine because the water is boiled out of the cocaine powder through a heating process (Van Wormer & Davis 2008:136). After the heating process, an alkaline substance is added to the cocaine powder to form the 'rocks' (Searll 2002:208). It is this crystal ('rock') which then has a much higher level of purity than cocaine powder (Edmonds & Wilcocks 2000:26).

(a) How crack is taken

Indissoluble in water, crack cannot be inhaled or injected, and instead, is smoked in special pipes (called *stems*) or in glass bottles or cigarettes (Searll 2002:209). When a pipe is used, the vapour is inhaled by the user after heat has been

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applied beneath the crystal contained in the pipe (Edmonds & Wilcocks 2000:26). The name of the drug is derived from the cracking sound the crystal makes when being smoked (Mans 2000:47). Crack may also be burnt on a piece of tinfoil and inhaled as a vapour (Searll 2002:209).

(b) The addictive effect of crack

Crack is highly addictive (Edmonds & Wilcocks 2000:26) and extremely dangerous, because you never know which chemicals were used to produce it (Mans 2000:47).

(c) The physical effects of crack

Due to the fact that crack is inhaled, it is absorbed into the bloodstream more quickly than cocaine powder. The drug reaches the brain within about ten seconds, and creates an instant 'high' (Searll 2002:209). The 'high' lasts only 15 seconds, at the most. When smoked, crack produces a massive, explosive release of neurotransmitters (Stoppard 2000:79). Physical symptoms may include insomnia, paranoia, hallucinations, impotence, weight loss, memory loss, and violent mood swings. There is also evidence that crack smoking can cause seizure of the brain, and strokes. Another condition associated with the use of crack is known as *crack-lung,* which involves chest pains, breathing problems, and high temperatures (Searll 2002:210).

(d) The psychological effects of crack

The euphoric effect of crack is similar to that of cocaine, but is much more powerful. Although the 'high' is extremely intense, it is short-lived, and is rapidly followed by depression, anxiety, and irritability. If an addict cannot obtain a supply, he/she may become suicidal (Searll 2002:209-210).

(e) The social effects of crack

Crack, when smoked, causes anger and severe aggression, and is therefore a recognized contributing factor to community violence (De Miranda 1998:30).

3.2.1.2.4 Methamphetamine ('tik')

Methamphetamine is a white, odourless, bitter-tasting crystalline powder that easily dissolves in water or alcohol (NIDA, undated:1). The drug can easily be made in clandestine laboratories from relatively inexpensive over-the-counter ingredients, and can be purchased at a relatively low cost (about R15-R30 per straw) (Plüddemann, Myers & Parry 2009:1).

(a) How methamphetamine is taken

Methamphetamines are usually available in powder form ('crystal meth'), and can be snorted, injected or smoked (Van Worner & Davis 2008:138). It is commonly smoked in a light bulb or glass pipe, called a *lolly*. The crystals are

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heated in the bulb/pipe and inhaled. (The Cape Town Drug Counselling Centre 2007:26). In South Africa it is typically smoked by placing the powder/crystal in a light bulb, from which the metal threading has been removed. A lighter is used to heat the bulb, and the fumes are smoked (Plüddemann, *et al.* 2009:1).

(b) The addictive effect of methamphetamine

Methamphetamine is a very addictive stimulant drug that affects the central nervous system.

(c) The physical effects of methamphetamine

Methamphetamine increases the release of very high levels of the brain chemical dopamine, which is involved in motivation, the experience of pleasure, and motor function (NIDA, undated:1). Common effects of intoxication are euphoria, increased energy and self-confidence, insomnia, restlessness, irritability, a heightened sense of sexuality, and tremors. Respiratory effects include increased respiration, pulmonary edema, pulmonary hypertension, and a decreased lung capacity. Cardiovascular effects include an increased heartrate and blood pressure, tachycardia (an abnormal rapid heartbeat), and arrhythmias. Users run the risk of overdose, characterized by dehydration, hyperthermia, convulsions, renal failure, a stroke, and myocardial infarction. Prolonged use can result in severe weight loss/anorexia, severe dermatological problems, and a high risk of seizures (Plüddemann, *et al.* 2009:1). It can also lead to severe dental problems (NIDA, undated:1).

Longterm use also increases the risk of contracting HIV and Hepatitis C due to injecting the drug, and risky sexual behaviour ((Plüddemann, *et al.* 2009:1).

(d) The psychological effects of methamphetamine

According to Gouws, *et al.* (2008:219), the substance gives an immediate, extremely pleasurable 'rush' or *flush*. The 'rush' only lasts a few seconds, but is followed by a feeling of euphoria (a 'high') which lasts for several hours. Users feel extremely active and energetic, and can stay awake for hours; and they seldom feel hungry. Long-term methamphetamine abuse has many negative psychological consequences, including anxiety, confusion, insomnia, mood disturbances, and violent behaviour. Chronic methamphetamine abusers may also display a number of psychotic features, including paranoia, visual and auditory hallucinations, and delusions, for example, the sensation of insects creeping under the skin (NIDA, undated:1).

(e) The social effects of methamphetamine

Methamphetamine is characterized by violent outbursts, due to panic and fear (The Cape Town Drug Counselling Centre 2007:26). The drug is also being marketed for losing weight, making it popular among women (Gouws, *et al*. 2008: 219).

3.2.1.2.5 Heroin

Heroin is typically sold as a white or brownish powder, or as the black sticky substance known on the streets as *black tar heroin*. Although purer heroin is becoming more common, most street heroin is 'cut' with other drugs, or with substances such as sugar, starch, powdered milk or quinine. 'Street' heroin can also be cut with strychnine, or other poisons. Due to the fact that heroin abusers do not know the actual strength of the drug or its true contents, they are at risk of overdose, or death (Narconon 2005: 1).

(a) How heroin is taken

In the past the main mode of heroin use has been through injection, however, improvements in the purity of heroin and the fear of HIV, have resulted in more new users snorting or smoking heroin. Some heroin users prefer to smoke heroin with dagga, or to inhale the vapours (*chasing the dragon*) (South African Health Information 2008:1). Typically, a heroin abuser may inject him/herself up to four times a day. Intravenous injection provides the greatest intensity and most rapid onset of euphoria (7 to 8 seconds), while intramuscular injections produce a relatively slow onset of euphoria (5 to 8 minutes) (Narconon 2005:3-4). When the drug is sniffed or smoked, peak effects are usually felt within 10 to 15 minutes (Narconon 2005:4).

(b) The physical effects of heroin

The rush experienced by users is usually accompanied by a warm flushing of the skin, a dry mouth and a heavy feeling in the extremities, which may be accompanied by nausea, vomiting and severe itching. Other short-term effects include depressed respiration, clouded mental functioning, and the suppression of pain. After the initial effects, abusers will usually be drowsy for several hours, and their cardiac functions are slow. Breathing is also severely slowed, sometimes to the point of death (Narconon 2005:5).

Long-term physical effects include scarred and/or collapsed veins, bacterial infections of the blood vessels and heart valves, abscesses and other soft-tissue infections, and liver or kidney disease. Lung conditions, including various types of pneumonia and tuberculosis, may result from the poor health conditions of the abuser, as well as from heroin's depressing effects on the respiration. Many of the substances in 'street' heroin may include substances that do not readily dissolve, and result in clogging the blood vessels that lead to the lungs, liver, kidneys or brain. This can cause infection or even the death of small patches of cells in the vital organs. Immune reactions to these or other contaminants can cause arthritis or rheumatological problems (Narconon 2005:5-6).

Heroin is highly addictive and can lead to physical dependence. Tied in with physical dependence is the idea of tolerance. After several weeks of regular use, which usually means increasing the amounts, the pleasure of the first

heroin 'highs' is replaced by the relief of getting hold of the drug. At this stage the user is truly hooked, and there is little or no pleasure in taking the drug – only the blocking-out of the pain that develops when the body begins crying out for another dose. If someone stops taking heroin after prolonged regular use, he or she feels dramatically ill, and will experience withdrawal symptoms, also known as *cold turkey*. This reaches a peak about three days after the last heroin was taken. The symptoms are similar to those of a particularly bad case of flu – fever, aching limbs, sweating, restlessness, cramps and insomnia. The skin becomes terribly itchy, and develops bumps resembling goose bumps (hence the term 'cold turkey'). In addition, the user feels anxious and isolated, and often has unsettling waking dreams. The symptoms recede after about a week or ten days, but the feeling of weakness and loss of wellbeing can last for several months. By finally 'riding it out' through these last stages of withdrawal, the user overcomes most of the effects of physical dependence (Connolly 2000:12,14).

Regular use of heroin also introduces a range of other health side-effects. The greatest risk is contracting hepatitis or HIV. Both of these conditions are passed on in the exchange of bodily fluids, and there is a serious risk of contracting these diseases when persons injecting heroin share the same needles or syringes (Connolly 2000:12).

(c) The psychological effects of heroin

Heroin destroys the addicts' personalities; they isolate themselves, and they lose their sense of responsibility

(Gouws, *et al.* 2008:216). The drug causes psychological dependence, because the brain feels enjoyment during the rush of a heroin 'high', and the 'pleasure circuits' of the brain associate this enjoyment with heroin (Conolly 2000:10).

(d) The social effects of heroin

There is a strong link between the use of heroin and crime: addicts often resort to theft, prostitution or violence in order to raise the cash for their drugs. Their entire lives become centred around obtaining, preparing, and administering the drug. As a result, addicts are often oblivious to their physical needs, eating poor food, and living in squalid conditions (Searll 2002:243).

3.2.1.2.6 Cannabis/marijuana (dagga)

The word *marijuana* is derived from a Spanish word meaning 'a substance causing intoxication" (Benshoff & Janikowski in Van Wormer & Davis 2008:47). Dagga is the most commonly abused illegal drug in South Africa. It is often regarded as a 'soft drug', but is a potent hallucinogen that can have lasting and harmful effects (Searll 2002:181). According to the National Narcotics Control Board (Drug Wars, undated:2), there is no medicinal use for dagga recognized in any country, and there is no scientific evidence that the dagga plant as such has any medicinal purposes that have not been substituted by safer drugs. Edmonds and Wilcocks (2000:29) state that dagga has many

detrimental effects on the user, and it is psychologically also highly addictive.

The most common form of dagga consists of the dried leaves and the flowers of the Cannabis Sativa plant (Mans 2000:25). In appearance it looks similar to dried herbs, the colour can range from green-grey to green-brown, and it often contains broken woody stems and seeds known as *pips*. Rooi-baard dagga, which is dagga that has gone to seed, is reddish in colour (Searll 2002:181). The plant can grow in unfavourable conditions, and is therefore cultivated almost anywhere (Mans 2000:26). The drug contains a number of substances, called cannabinoids, and it is these cannabinoids that affect the brain, the heart and the lungs (The Cape Town Drug Counselling Centre, undated:21). There are 61 cannabinols that are synthesized by the plant (Drug Wars, undated:1). The main psycho-active ingredient is tetrahydrocannabinol, or THC. The potency of dagga depends on the amount of THC it contains. 'Good quality' dagga usually consists of the upper leaves and the flowering tops, due to the fact that these parts contain the highest concentration of THC (Searll 2002:182).

Dagga can also be obtained in the form of hashish. *Hashish* is a thick tar-like substance, and looks like sticky toffee that has melted. Hashish is basically the resin of the dagga plant, that is extracted when the plant is compressed when it is wet. The resin is then dried and marketed. A piece of this resin is broken off, and is usually smoked in what is known as a *hubbly bubbly*. Hashish is more concentrated

than dagga, and there are users who claim that it is 30% stronger than dagga (Drug Wars, undated:5).

(a) How marijuana is taken

Dagga can be smoked, swallowed or eaten (The Cape Town Drug Counselling Centre, undated:51). The drug is, however, primarily smoked, and is usually mixed with tobacco, because dagga does not easily burn on its own. The tobacco of a cigarette would be removed and would then be mixed in with the dagga (the pipes and stems are removed), and would be placed back into the cigarette, or Rizzia (handmade cigarette). The smoking of a dagga cigarette is known as a *slow boat* (Drug Wars, undated:2). Handmade cigarettes are commonly called *joints* or *spiffs*. A variety of pipes may be used, ranging from ordinary tobacco pipes to special dagga pipes (*chillums*) and water-pipes (*hubbly-bubblies*), which filter the smoke through a small reservoir of water. Broken-off bottle necks, sometimes known as *green pipes,* are frequently used for dagga smoking. When Mandrax is added to the dagga in a bottleneck, it is referred to as *white pipe*. The mouth of the pipe is blocked by a tightly coiled piece of paper (usually silver cigarette paper or tinfoil), called a *diamond* or a *gerrick* (Searll 2002:183). Dagga is also brewed and swallowed as tea, or it is mixed and eaten in a muffin/cake known as *space cakes* or *dagga cakes* (The Cape Town Drug Counselling Centre, undated:51).

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(b) The physical effects of cannabis

When dagga is smoked the effect will reach its peak after about 3 minutes, and the user will experience the effect for a period of 2 to 3 hours. The stronger the dose of dagga that is taken, the more intense the so-called *trip* will be (Drug Wars, undated:5).

Cannabis, which is fat soluble but not water soluble, is metabolized by the liver, and distributed throughout the body much more slowly than alcohol (Van Wormer & Davis 2008:152). The THC accumulates in the fatty tissues of the brain and sex glands, and is eliminated at a very slow rate. According to Searll (2002:182), traces of THC from only one 'joint' can remain in the body for up to three weeks. Drug Wars (undated:1) states that it takes approximately 30 days for the body to rid itself of the THC of one dagga cigarette, and in certain parts of the body it could take up to 6 months (Drug Wars, undated:1).

A syndrome known as reverse tolerance develops in dagga smokers. The regular dagga smoker finds that he/she needs to smoke *smaller* amounts of the drug for the same results. This is because the THC from previous doses is stored in the body's fatty tissue and needs only to be topped up in order to produce a feeling of being 'stoned' (Searll 2002:184).

The vital systems of the body are affected by the use of dagga, namely the reproductive system, the respiratory system, the immune system, and the cardiovascular system. There is evidence that prolonged dagga-use can cause at

least a temporary loss of fertility in both men and women, and can reduce the levels of male and female sex hormones. Studies have shown that men who use dagga tend to have a lower sperm count than is normal for men of their age. The drug may also cause women to have irregular menstrual cycles. Dagga is particularly dangerous for pregnant women, and may result in miscarriage, premature birth, low birth-weight, still-birth or fetal abnormalities. The THC crosses the placenta, and is also found in breast-milk. One dagga cigarette has more than twice as much tar as a strong tobacco cigarette. Due to the fact that cannabis contains high concentrations of cancer-producing toxins, regular dagga-smoking carries a big risk of lung cancer. Dagga-smoking is also associated with chronic respiratory tract conditions, such as bronchitis, asthma and emphyzema. Chronic dagga-use leads to a general deterioration in the user's health, and tends to interfere with the body's immune system. This could lead to the development of viral and bacterial infections. The effects of dagga on the cardiovascular system include tachycardia (an abnormally rapid heart-beat), and low or high blood pressure. These changes may precipitate angina, or even death (Searll 2002: 187,190).

Whether dagga causes physical addiction, has not been conclusively established. However, research has shown that dagga smokers may develop withdrawal symptoms if the drug is withheld after prolonged use. The main symptoms include depression, irritability, sleep disturbances,

sweating, shivering, nausea, tremors, and muscle convulsions (Searll 2002:184).

(c) The psychological effects of cannabis

A marijuana 'high' is euphoric for most users. Its general effects are relaxation, and feelings of calmness (Arterburn & Burns 2007:76). Excessive talkativeness, inappropriate giggling, disturbance in judgment, and distortion of perception may be present (Edmonds & Wilcocks 2000:29). Searll (2002:184-187) describes *dagga* as an accumulative drug, and when used frequently and over a long time, can cause a marked decline in the user's mental and social well-being. She describes (2002:186-187) the following psychological consequences of dagga abuse: impaired concentration, demotivation, aggravation of existing emotional problems, interference with emotional growth, and anti-social behaviour. The use of dagga could also lead to panic attacks and paranoia (Stoppard 2000:47).

(d) The social effects of cannabis

Experts believe that the dagga available in South Africa today contains about ten times more THC than the dagga that was sold during the seventies. Due to the fact that the dagga is so powerful, users become addicted more quickly, and need to smoke far less of the drug in order to achieve the 'high' they are seeking (Searll 2002:182).

3.2.2 How often is the client using drugs, and how much?

According to The Casa Palmera Treatment Centre (2009a:1), the road to addiction is different for every person. The Drug Rehabilitation Advice Centre (Undated:1) states that although there is no absolute scientific formula for identifying when an individual's drug consumption has developed into a full-blown addiction problem, most rehabilitation counsellors agree that there are four distinct stages of drug use that may lead to addiction. The Drug Rehabilitation Advice Centre (Undated:1), as well as The Casa Palmera Treatment Centre (2009a:1), describe these four stages of drug use as: experimentation, regular use, risky use/abuse, and drug addiction or dependency. The Cape Town Drug Counselling Centre (2007:7), on the other hand, indicates three stages of drug use, namely experimentation, abuse, and addiction. According to The Cape Town Drug Counselling Centre (2007:7), it is also important to take note of the fact that the stages of drug use should be viewed as a continuum or a journey, rather than a step-by-step progression from experimentation to addiction. Not everyone in the experimentation- and regular use-stage will develop drug addiction, but individuals in the risky use/abuse stage of addiction are very likely to progress into full-blown addicts (The Casa Palmera Treatment Centre 2009a:1, The Drug Rehabilitation Advice Centre, undated:1).

The four stages of drug use, namely experimentation, regular use, risky use/abuse, and drug addiction and dependency, will be discussed below.

3.2.2.1 Experimentation

The first stage on the potential road to drug addiction, is the use of drugs without experiencing any negative consequences (The Drug Rehabilitation Advice Centre, undated:1). The Casa Palmera Treatment Centre (2009a:1) defines *experimentation* as the voluntary use of drugs without experiencing any negative social or legal consequences. According to The Cape Town Drug Counselling Centre (2007:7), experimentation-use occurs when one decides to take drugs for the first time, or perhaps twice, to try it out. Hutter (2010:1) states that, in order to alleviate emotional or physical pain, a person may start to experiment with drugs. Physically the user will generally experience good feelings, and once the drug wears off, most people return to feeling fine.

3.2.2.2 Regular use

According to The Cape Town Drug Counselling Centre (2007:8), many people move from experimentation to regular use. Some may be able to advance to the stage of regular use without developing any dependence or addiction. These individuals will be able to stop using the drug on their own (The Casa Palmera Treatment Centre 2009a:1).

Many individuals can stay at this stage for years, some their whole lives (RehabTODAY 2010:1).

Regular use, usually occurs on weekends or after work, with only occasional interferance with work, school or family life. It is also not just a social indulgence with friends, but rather a planned event that happens with or without friends (RehabTODAY 2010:1). During this stage the individual experiences some form of negative consequences as a direct result of having ingested any one particular drug, for example, he or she could be stopped for drunken driving, even if he/she does not normally drink excessively, and is not an alcoholic (The Drug Rehabilitation Advice Centre, undated:1).

3.2.2.3 Risky use/Abuse

The line between regular use and risky use/abuse is a very thin one, but is usually defined as the continued use of drugs, in spite of severe social and legal consequences (The Casa Palemera Treatment Centre 2009a:1). The negative consequences arising from the misuse of drugs has done nothing to curb the individual's appetite for drug ingestion, to the point of inebriation, even in the face of serious penalties, and possible broken relationships (The Drug Rehabilitation Advice Centre, undated:1). At this stage the warning signs of addiction will begin to appear, namely cravings, a preoccupation with drugs, and symptoms of depression, irritability, and fatigue, if the drug is not being taken (The Casa Palmera Treatment Centre 2009a:1).

3.2.2.4 Addiction

According to The Cape Town Drug Counselling Centre (2007:9), this stage is generally characterized by a loss of control, *e.g.,* by using more drugs more frequently than intended, or by repeated failed attempts to stop, or to use less. Denial and a lack of insight is usually present. Physical dependence on a drug is often intertwined with addiction (The Casa Palmera Treatment Centre 2009a:10). Taking drugs does not have the desired effect ('rush' or euphoria) any more, and are taken to make the user feel 'normal'. Addicts often remark that they can only function properly when drugged. When sober, addicts experience discomfort, as a result of withdrawal and cravings (The Cape Town Drug Counselling Centre 2007:9). Withdrawal symptoms and compulsive use are therefore typical characteristics of this stage. The user also continues to use drugs despite severe negative consequences to his or her relationships, physical and mental health, personal finances, job security, and criminal record (The Casa Palmera Treatment Centre 2009a:1). The addict's perception of reality changes – life revolves around the drug (The Cape Town Drug Counselling Centre 2007:9).

3.2.3 Conclusion

The first part of phase one of the treatment programme provided guidelines for therapists to determine the severity of the client's addiction.

To be able to determine the severity of the addiction, therapists first need to determine what substance or substances the client is using. To equip the therapist to do this, the different categories of psycho-active substances were discussed, followed by a description of the primary substances of abuse in South Africa.

Guidelines were also provided to enable therapists to determine how often and how much the client is using.

The last part of phase one of the treatment programme will provide guidelines to therapists on how to determine the level of care that the addicted clients need.

3.3. HOW TO DETERMINE THE LEVEL OF CARE NEEDED

Once he or she knows what the severity of the addiction is, the therapist will be able to determine the level of care that the client needs. According to NIDA (2009:1), the treatment of drug abuse and addiction is delivered in many different settings, using a variety of behavioural and pharmacological approaches.

For the purpose of this study the researcher will investigate early intervention, and out-patient and in-patient care facilities.

The researcher is also of the opinion that detoxification falls under the level of the care that the client may need during phase one of the treatment programme. Information regarding this aspect will accordingly be included.

3.3.1 Early intervention

Early intervention is a term generally used to describe the early efforts to intervene where an individual is seen as being at risk (The United States Department of Education, undated:1). According to Perkinson (2008:49), early intervention is designed to explore and address problems or risk factors that are related to substance use, and to assist clients in recognizing the harmful consequences of the inappropriate use of a substance. The early intervention is often brief, designed to assess the individual and to provide initial feedback about his or her drug use (The United States Department of Education, undated:1). Clients who need early intervention do not meet the diagnostic criteria of either drug abuse or drug dependency, but they have significant problems with substances (Perkinson 2008:49).

3.3.2 Out-patient treatment

Perkinson (2008:49) states that out-patient treatment takes place in a non-residential facility or in an office run by professionals in the field of addiction. Patients come in for individual or group therapy sessions, usually for less than 9 hours per week. According to NIDA (2009a:2), out-patient

treatment varies in respect of the kind and intensity of the services being offered. Coombs (2004:102) states that out-patient treatment programmes have gained in popularity since the 1990s, for several reasons. Many of the stimulant abusers who were treated in protected in-patient environments relapsed within weeks of being released from residential treatment. Out-patient treatment provided an opportunity to experience a learn-as-you-go approach to recovery, with the treatment programme providing structure and support as they resume their daily lives. According to The National Institute on Drug Abuse (NIDA) (2009:2), out-patient treatment costs less than in-patient treatment, and is often more suitable for working people.

Appendix B provides the criteria that a therapist may use to determine if out-patient treatment will be in the client's best interests.

3.3.3 In-patient treatment

In-patient treatment refers to structured treatment that is provided at a residential facility (Perkinson 2008:49). According to NIDA (2009:1), long-term residential treatment provides care twenty four hours a day, generally in a non-hospital setting. NIDA further states (2009:1) that addiction is viewed in the context of an individual's social and psychological deficits. The treatment in the in-patient setting focuses on assisting the clients to develop personal accountability and responsibility, and on helping them to lead socially acceptable lives.

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Appendix C provides the criteria that the therapist can use to determine if in-patient treatment will be in the client's best interests.

3.3.4 Detoxification

The detoxification-period is the period when a person is withdrawing from a substance (Blume 2005:46); the process when the body clears itself of drugs. It is often accompanied by unpleasant and sometimes fatal side-effects caused by the withdrawal (NIDA 2009:1). The severity of the withdrawal symptoms will depend on the drug abused and the extent of the dependence (Searll 2002:74). The process of detoxification is often managed with medication that is administered by a physician in an in-patient or an out-patient setting; it is referred to as *medically managed withdrawal* (NIDA 2009:1).

Appendix D serves as a guideline in respect of detoxification.

3.4 CONCLUSION

Chapter three consisted of a discussion of phase one of the treatment programme. The aim of phase one of the treatment programme is to provide guidelines to therapists on how to assist clients to reach abstinence from the psycho-active substance or substances that they are using.

To be able to assist clients to reach abstinence, the therapists, first of all, need to determine the severity of the client's addiction.

The first part of chapter three focused on providing therapists with guidelines to determine the severity of the client's addiction. After the therapists have determined the severity of the client's addiction, the level of care that the client needs has to be determined.

The second part of chapter three contained a discussion of the different options that are available for the treatment of addiction.

Chapter four will focus on phase two of the treatment programme. The aim of phase two is to provide the therapist with guidelines on how to assist clients to function effectively within their life-worlds.

CHAPTER 4

PHASE TWO OF THE TREATMENT PROGRAMME

Getting off addictive substances or processes is relatively straightforward and quick; learning how to stay off – and be comfortable doing so – is the difficult bit and that takes a lot longer.

- Dr Robert Lefever -

4.1 INTRODUCTION

Chapter four will comprise of a discussion of phase two of the treatment programme for addiction.

The aim of phase two of the treatment programme is to provide therapists with guidelines on how they could assist clients to function effectively in their life-worlds. To be able to do this, the therapists first need to realize the importance of conducting a bio-psycho-social interview with the clients. During this interview therapists will obtain information from the clients that will enable them to determine what the coping skills are that they need to focus on during phase two of the treatment programme.

The second part of chapter four will focus on information and guidelines on the different coping skills that the therapists can teach their clients during therapy.

The last part of the chapter will focus on a discussion of the different co-occurring disorders that is associated with addiction.

Chapter four will therefore consist of three parts, namely

- part one: the bio-psycho-social interview;
- part two: coping skills;
- part three: co-occurring disorders.

4.2 THE BIO-PSYCHO-SOCIAL INTERVIEW

The cornerstone of practising as a clinical health psychologist is conducting a comprehensive bio-psycho-social interview to evaluate the client's problem (Richard & Huprich 2009:358). According to Perkinson (2008:59), the purpose of the bio-psycho-social interview is to find out exactly what the problem areas are that need to be addressed in therapy. The purpose of the interview is, therefore, to gather the necessary information for the therapist to make a diagnosis (The Encyclopaedia of Mental Disorders 2010:1).

The first step in phase two of the treatment plan is to conduct the interview with the client, as stated above. Guidelines on how to construct a bio-psycho-social interview, as well as an example of the interview, are included in Appendix E of this study.

4.3 COPING SKILLS

Based on a literature research and her own experience, the researcher is of the opinion that clients suffering from substance addiction often experience problems with the following: stress (Stocker 2005:1), insomnia (Simon & Zieve 2009:1, Blume 2005:205), defence mechanisms (Alcoholism-Treatment.net. 2010:1), dealing with conflict in a constructive manner (Repetti, Taylor & Seema 2002:1), and relapse (Lakeview Health Systems 2010:1).

A discussion of each of these aspects will follow.

4.3.1 Dealing with stress

For the purposes of this study, the researcher will distinguish between stress and post-traumatic stress disorder (PTSD).

This section will consist of a discussion of stress, while post-traumatic stress disorder will be discussed later in this chapter, in the section dealing with co-occurring disorders.

Colman (2001:711) defines *stress* as "…psychological or physical strain or tension generated by physical, emotional, social, economic or occupational circumstances, events or experiences that are difficult to manage or endure".

Stress is a normal occurrence in the lives of people of all ages; only, the stressor that individuals experience differ

for each individual. What is stressful for one person may or may not be stressful for another. Individuals also respond to stress in different ways. Mild and acute stress may cause changes that are useful, but if the stress is prolonged or chronic, the changes it produces can become harmful (Volkow 2006:2).

According to Stocker (2005:1), comments in anecdotes like "Well, things were not going well at my job"; "My wife left me" or "The traffic was too heavy", are common in the drug abuse treatment community. Stocker further states (2005:1) that these anecdotes, as well as studies on animals, indicated an important correlation between stress and drug abuse relapse. The fact that it also seems as if addicts relapse in response to what other people may consider as mild stressors, could indicate that addicts are more sensitive to stress than non-addicts. It is therefore important that the therapist should assist the client in dealing with the stressors in his or her life-world in a healthy way.

Nora Volkow, Director of the National Institute on Drug Abuse in the United States of America (2006:4) indicates the following:

- Stressful events can profoundly influence the abuse of alcohol or other drugs. Stress is a major contributor to the initiation and continuation of alcohol or other drug abuse, as well as to substance abuse relapse after periods of abstinence.

- Young people exposed to severe stress may be more vulnerable to drug abuse. A number of clinical and epidemiological studies indicate a strong association between psycho-social stressors early in life (*e.g.*, due to the loss of a parent, or child-abuse) and an increased risk of depression, anxiety, impulsive behaviour, or substance abuse in adulthood.

  The above indicate the importance of equipping the client with skills to deal with stress in a healthy way.

  Appendix F serves as a guideline for therapist to use in teaching the client certain stress management skills.

4.3.2 Insomnia

The foolish man lies awake all night thinking of his many problems; When the morning comes he is worn out and his troubles are just as it they were.

-Norse proverb -

Adams (undated:1) defines *sleep* as a normal recurring state of changed consciousness or partial unconsciousness from which one can be readily aroused. According to Fast and Preston (2006:67), sleep is a powerful regulator of brain chemistry. Adams (undated:1) mentions that sleep is an essential part of life, and that it is as fundamental to our health and well-being as air, food and water. Fast and Preston (2006:67) agree with this presumption when they state that a night of regular, uninterrupted sleep helps to

ensure that the hormones and neurotransmitters can do their job, and provides the individual with the physical energy that he or she needs to get through the day.

Insomnia is the inability to get the amount of sleep that an individual needs to feel rested and to function well during the day (The University of Cincinnati 2010:1). Although the amount of sleep required varies in individuals, 'normal' sleep would consist of four to nine hours in a twenty four hour-period (Adams undated: 1,2). According to Saisan, De Benedictis, Barston & Segal (2008:5), knowledge in respect of the sleep stages and the sleep cycle may help individuals to get better sleep. They further state (2008:5) that a person's sleep is regulated by an internal body clock that is sensitive to light, the time of day, and other cues for sleep and awakening. As a person sleeps, his/her sleep pattern moves through different cycles throughout the night, moving back and forth between restorative sleep and more alert stages, and dreaming. As the night progresses, the individual spends more time in dream sleep and lighter sleep.

There exist two main types of sleep: rapid eye movement sleep (REM) and non-REM sleep (NREM). Rapid Eye Movement sleep (REM) occurs when most active dreaming takes place. The individual's eyes actually move back and forth during this stage. Non-REM sleep (NREM) consists of four stages of deeper sleep. Each sleep stage is important for overall quality sleep, but deep sleep and REM sleep are especially vital.

4.3.2.1 Sleep stages: the sleep cycle

A sleep cycle can be broken down into four distinct phases, based on the size and speed of the brainwaves that are generated by the sleeper (Adams undated:1). A typical night of sleep follows the following pattern (Saisan, *et al.* 2008:5,6):

(a) Stage one (drowsiness)

Stage one lasts about five to ten minutes. The eyes move slowly under the eyelids, the muscle activity slows down, and the individual is easily awakened.

(b) Stage two (light sleep)

The eye movement stops, the heart rate slows down, and the body temperature decreases.

(c) Stages three and four (deep sleep)

During these stages it is difficult to wake the individual. When they are awoken they do not adjust immediately, and often feel groggy and disorientated for several minutes. The bloodflow to the brain decreases in this stage, and redirects itself towards the muscles, restoring physical energy. Research also indicated that the immune functions increase during deep sleep.

(d) REM sleep (dream sleep)

About seventy to ninety minutes into the sleep cycle individuals enter into REM sleep. Every person usually has three to five REM episodes per night. This stage is associated with processing emotions, retaining memories, and relieving stress. Breathing is rapid, irregular and shallow, the heart-rate increases, and the blood pressure rises. Males may experience penile erections, and females clitoral enlargement.

4.3.2.2 Insomnia and substance abuse

Blume (2005:205) states that insomnia can be a common problem for individuals when they first give up their drug problem. Alcoholics often suffer from insomnia during withdrawal, and some individuals even suffer from insomnia for several years during recovery. Ten to fifteen percent of chronic insomnia cases result from the abuse of substances, especially alcohol, cocaine, and sedatives. Even though the use of alcohol promotes sleep, it tends to fragment sleep and cause wakefulness within a few hours. It also increases the risk of other sleep disorders, including sleep apnea and restless legs (Simon & Zieve 2009:1). Sleeping problems could also be related to the rebound effect of the drugs, or it may be related to rumination and regret (Blume 2005:205). According to Fast and Preston (2006:71), it has also been documented that drugs, like alcohol and tranquilizers, reduce the amount of time people spend in deep sleep.

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4.3.2.3 The treatment of insomnia

Adams (undated:5) states that various treatment alternatives should be discussed with the client, for example medication, acupuncture, yoga, tea/herbal remedies, biofeedback and meditation. According to Adams (undated:5), the most effective treatments are those that incorporate a combination of these therapies. It has become common practice for a physician to treat substance induced sleep disorders from a holistic perspective, using relaxation and herbal therapies with less medication. The medication most often prescribed include Vistaril, Elavil, Neurontin, Trazedone, Benedryl, Ambien, Sonata and Thorazine.

In addition to these treatments, clients are often assisted in restructuring their daily habits in such a way as to improve the quality of their sleep (Adams, undated:5).

Appendix G provides recommendations for good sleep hygiene that a therapist could use to assist a client with the improvement of his/her sleeping patterns.

4.3.3 Defence mechanisms

We are using our coping behaviours to survive. We don't see things too painful to see; we don't feel emotions too painful to feel. We don't realize our coping behaviours are self-defeating. In fact, we're often proud of our gestures.

- *Melody Beattie*

-

Colman (2001:189) defines a *defence mechanism* as "…a pattern of feeling, thought or behaviour arising in response to a perception of psychic danger, enabling a person to avoid conscious awareness of conflicts or anxiety-arousing ideas or wishes". According to Dayton (2007:82), people who feel emotionally, psychologically or physically wounded, and who are not able to address their emotional and psychological pain openly and honestly, may develop rigid psychological defences to manage the pain. The creation of a 'defence mechanism' is designed to provide psychological protection against the pain that can result from uncomfortable thoughts or fearful situations (Alcoholism-Treatment.net. 2010:1). Defence mechanisms, therefore, protect individuals from painful realities. They filter out the things they may not want to recognize, and they change these perceptions so that things feel more comfortable (Egetgoing, undated:1). The conclusion one can come to is that defence mechanisms operate to protect us from uncomfortable or unacceptable self-awareness (O'Connor 2010:1).

While defence mechanisms can be unhealthy, they can also be adaptive, and allow individuals to function normally (Cherry 2010:1). Defence mechanisms can serve the productive purpose of allowing individuals to function in the face of great stress and pressure, or in the wake of tragedy or trauma. By allowing individuals to filter out negative thoughts, the defence mechanisms give their conscious minds the 'breathing room' that is necessary to focus on matters that demand immediate and ongoing attention

(Alcoholism-Treatment.net. 2010:1). However, problems arise when these defence mechanisms are used excessively to avoid dealing with problems (Cherry 2010:1).

4.3.3.1 Defence mechanisms and addiction

Many individuals initially turn to substance abuse as a means of insulating themselves against physical or psychological pain. Due to the fact that the abuse of alcohol or other drugs will invariably lead to additional problems, these people often find themselves in the position of having to create another layer of defence to shield themselves against the effect of their behaviour (Alcoholism-Treatment.net. 2010:1). All defences distort reality to some extent, due to the fact that they 'tailor' reality to feel a little more comfortable. However, addiction distorts reality to a dangerous extent (Bennett & McNeese, undated:3). Doweiko (2009:44) describes *addiction* as a form of insanity that rests on a foundation of psychological defences. He also states (2009:44) that these defence mechanisms, together with self-deception, keeps the individual from becoming aware of the reality of his or her addiction.

There are a number of defence mechanisms that have been described by researchers (Cherry 2010:1), but the following ones are generally associated with addiction (Alcoholism-Treatment.net. 2010:2, Egetgoing, undated:1), namely denial, blaming, projection, isolation, rationalization, and minimizing.

These will subsequently be discussed.

(a) Denial

Denial is an outright refusal to admit or recognize that something has occurred or is occurring (Cherry 2010:1). Denial is useful to the addict, because it serves to cover up the extent of the problem, and allows the abuse to continue (Bennett & McNeese undated:5). The individual refuses to admit that a problem exists ("I could quit drinking whenever I want to – I just do not want to") (Alcoholism-Treatment.net. 2010:2). The addict also refuses to acknowledge that his or her drinking has become a problem ("My use is not that bad") (Egetgoing, undated:2010). While denial may save the individual from anxiety or pain, it requires a substantial investment of energy (Cherry 2010:2).

(b) Blaming

Blaming occurs when individuals transfer the responsibility for their behaviour to other people ("I would not drink if my spouse treated me right") (Egetgoing, undated:1), or "If you lived here, you'd drink too" (Bennett & McNeese, undated:7). Blaming therefore occurs when the addict is pointing fingers at others as the cause of his or her behaviour ("I would not drink so much if you would just quit nagging me") (Alcoholism-Treatment.net. 2010:2).

(c) Projection

Projection involves taking your own unacceptable qualities or feelings and ascribing them to other people (Cherry 2010:2, Alcoholism-Treatment.net. 2010:2). It is a powerful and often destructive tool whereby one takes unacceptable parts of yourself and attributes them to others (O'Connor 2010:1), for example, "Why is that stupid idiot being so hostile?" (Egetgoing, undated:1).

(d) Isolation

Although the use of drugs starts out as a social behaviour, addiction ends up driving a wedge between the addict and others (Bennett & McNeese, undated:6). *Isolation* occurs when individuals abandon their family and friends in order to pursue or maintain their addiction (Alcoholism-Treatment.net. 2010:2; Egetgoing, undated:1).

(e) Rationalization

Rationalization involves explaining unacceptable behaviour or feelings in a rational or logical manner, avoiding the true reasons for the behaviour (Cherry 2010:2). Individuals supply reasons that 'justify' their unhealthy behaviour, for example, "I do not want to drink so much, but it is the only way I can deal with the pressure at work and still keep my job" (Alcoholism-Treatment.net. 2010:2).

(f) Minimizing

Minimizing means attempting to downplay the severity or magnitude of the dependence (Alcoholism-Treatment.net. 2010:2; Egetgoing, undated:1), for example: "I only have a couple of drinks. It is not a problem." (Egetgoing, undated:1), or "I only have one or two drinks to wind down from work. It is no big deal." (Alcoholism-Treatment.net. 2010:2), or "I never drink before noon, I can't be an alcoholic." (Bennett & McNeese undated:7).

4.3.3.2 Addressing defence mechanisms

Part of recovery is looking at reality and taking responsibility for the uncomfortable consequences of addiction. This often means developing more mature defences that allow more flexible thinking, and more honest and wholesome ways of being in the world (Egetgoing, undated:1).

4.3.4 Conflict

Repetti, *et al.*, (2002:1) state that children who are lacking in social and conflict-management skills are most likely to turn to substance abuse or risky sexual behaviour. According to Alexander (2009:143), conflict is inevitable, because humans are unique. Maturity lies in finding ways to disagree without destroying relationships. Conflict is a healthy way of relating, and not something to be avoided. Many clients suffering from addiction have problems with

dealing with conflict in a healthy and constructive way. During the recovery process the client needs to lean effective skills in dealing with conflict.

Appendix H serves as a guideline that therapists could use in teaching a client these skills.

4.3.5 Relapse

Maybe we shouldn't call relapse "recycling". Maybe we should call it "cycles of growth", or maybe we should just call it growth.

- Melody Beattie -

In the treatment of addiction, *relapse* is referred to as the condition when one returns to using drugs or alcohol after a period of abstinence (Lakeview Health Systems 2010:1). Lapses, on the other hand, represent a return to the use of drugs, but not necessarily a return to a drug problem. A lapse tends to be more transitory than a relapse, but a lapse can represent a critical moment of decision for many clients (Blume 2005:264).

A relapse may happen to many individuals, it could happen to somebody who has been recovering for ten months or ten years. A relapse happens because it is a normal part of the recovery process (Beattie 1989:48).

4.3.5.1 Can a relapse be prevented?

A relapse does not suddenly happen without warning or without reason. Research into the process of a relapse has identified a rather predicable chain of events that can lead up to it (Blume 2005:260). It is also important to take note of the fact that for most clients the period between lapse and relapse is less than thirty days (Perkinson 2008:126).

For every addict certain identifiable sets of circumstances present a high risk of relapse (Capuzzi & Stauffer 2007:271). In the literature these risk factors are referred to as *triggers.* Clients need to understand how a trigger works, and how to deal with the triggers in their life-worlds. If the client learns how to deal with the triggers in his or her life, there is a big possibility that lapses or relapses can be prevented.

4.3.5.2 Triggers

4.3.5.2.1 What is a *trigger*?

Perkinson (2008:349) states that all behaviour occurs in a certain sequence.

The behaviour chain looks as follows:

Trigger ➡ Thinking ➡ Feeling ➡ Behaviour ➡ Consequence

It is the trigger that sets the whole process in motion, and the client needs to understand the importance of recognizing them, due to the fact that they influence his or her thinking, feeling, and behaviour, and leads to certain consequences that they will have to live with. Perkinson (2008:249) also states that much of the thinking clients do, happens very fast. The only way that clients will be able to recognize the 'thinking', is when they stop and think about it. A *trigger* can thus be defined as an aspect that sets the behavioural chain of the client in motion.

4.3.5.2.2 How to identify a trigger

The better clients are able to identify the triggers and to prepare in advance a repertoire of coping strategies designed to manage them without relapse, the more likely they will be to achieve a positive outcome (Capuzzi & Stauffer 2007:270). The high risk situations that can trigger a return to drugs usually fall into three categories, namely (1) strong or negative moods or emotions; (2) client-environment interactions that may stress the client in some way; and (3) interpersonal conflict (Blume 2005:262). About thirty five percent of people who relapse, do so when experiencing a negative feeling that they cannot cope with, while about twenty percent relapse in social situations, and about sixteen percent when in conflict with another person (Perkinson 2008:341,342,343).

4.3.5.2.3 How to deal with triggers

For clients to be able to deal with triggers, they should have been instructed well in the use of skills, have spent a significant time rehearsing how they will respond, and have practiced their responses under real conditions (Blume 2005:263).

The first step is to assist clients to identify their own triggers. Capuzzi and Stauffer (2007:272) provide the following guidelines in this respect:

- Keep a diary of emotional states, social interactions, cravings, and lapses/relapses.

- When the triggers that are most difficult for a client, and have been identified, habitual coping strategies for handling these situations need to be considered.

- Specific coping strategies must then be considered, planned, and implemented. This process will begin with brainstorming about what kind of strategies may be possible for each trigger.

- After generating a list of as many possible coping strategies as can be imagined, the therapist should then assist the client in the process of refining, modifying, combining, and improving a selected number of coping strategies.

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- Ideally these are then rehearsed.

4.3.6 Conclusion

The above section contained a discussion of the different areas where clients may experience problems during their recovery. Information and guidelines for therapists were provided to enable them to assist the clients where they may need assistance. After the bio-psycho-social interview, the therapists will be able to determine the areas were the clients need assistance. They will then be able to make use of the guidelines provided to assist the clients in their recovery during phase two of the treatment programme.

4.4 CO-OCCURRING DISORDERS (COD)

As many as six in ten substance abusers also have at least one other mental disorder, and even due to the high rate of co-occurring disorders (COD), the reasons why addiction and other mental disorders coincide so frequently are not fully understood (Volkow 2007:1). It is, however, true that individuals presenting with co-occurring disorders need the careful planning of treatment that addresses both substance abuse and mental health issues (Capuzzi & Stauffer 2007:180). Research increasingly supports the benefit of addtionally treating co-occurring disorders in the treatment plan, together with both medication and behavioural therapies (Volkow 2007:1).

According to Van Wormer and Davis (2008:362), the use of medication for both mental health and substance-use disorders is a complex issue, involving firstly, the interaction between specific psychiatric medications, and alcohol and drugs. Secondly, the under-medication for psychiatric symptoms may cause the client to relapse in substance misuse. To address this aspect, Van Wormer and Davis (2008:362) suggest that a physician should form part of the treatment team, and that the medication is included, and closely monitored, in the total integrated approach.

It is beyond the scope of this study to cover all the psychopathology that could come to the fore during treatment, and also of the effective treatments of the disorders. However, the researcher is of the opinion that the addiction counsellor has to be able to recognize the symptoms of the major psychiatric disorders associated with addiction, and either to include these aspects in the treatment, or to refer the client, so that the co-occurring disorders may be treated effectively.

4.4.1 Depression

Perkinson (2008:180) states that most chemically dependent individuals come for treatment with some degree of measurable depression, the mood ranging from mild to severe. According to The Casa Palmera Treatment Centre (2009b:1), thirty to forty percent of people with a substance-use disorder also have a mood disorder, such as depression. As was stated before, depression may lead to

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drug addiction, or the drug addiction could be the cause of the depression. Regardless of which came first, both disorders need to be treated simultaneously in order for an individual to fully recover. If left untreated, the depression may hinder the addiction-recovery process and may lead to relapse, while an untreated addiction problem may develop into depression, and consequently lead to a relapse (Buzzle.com. 2010:1). The addiction counsellor, therefore, needs to understand the importance of recognizing the symptoms of depression to be able to provide effective treatment. If the counsellor is not trained in treating depression, he/she has to refer the client, or work closely with a psychologist or psychiatrist in providing effective treatment for the client.

The information on the different forms of depression, as discussed below, was provided by The National Institute of Mental Health (NIMH) of the United States of America (2009:1):

(a) Major depressive disorder

Also called *major depression*, it is characterized by a combination of symptoms that interfere with a person's ability to work, sleep, eat, and enjoy once-pleasurable activities. Major depression is disabling and prevents a person from functioning normally. An episode of major depression may occur once in a person's lifetime, but more often, it recurs throughout a person's life.

(b) Dysthymic disorder

Also called *dysthymia*, it is characterized by its long term (two years or longer), but less severe symptoms may disable a person and prevent him/her from functioning normally or from feeling well. Persons with dysthymia may also experience one or more episodes of major depression.

Long (2011:1) states that the depressive symptoms occur for most of the day, in more days than not, for at least two years. During the two year period, any symptom-free interval can not last longer than two months. The diagnosis is not made if there are any *Hypomanic, Manic* or *Mixed Episodes* and if the depressive symptoms intensify to meet the full criteria for a *Major Depressive Episode*; the diagnosis should be changed to *Major Depressive Disorder.*

Some forms of depressive disorders exhibit slightly different characteristics than those described above, or they may develop under unique circumstances. However, not all scientists agree on how to characterize and define these forms of depression.

These forms of depression include:

(c) Psychotic depression

This disorder occurs when a severe depressive illness is accompanied by some form of psychosis, such as a break from reality, hallucinations and delusions.

(d) Post-partum depression

This disorder is diagnosed when a new mother develops a major depressive episode within one month after delivery. It is estimated that ten to fifteen percent of women experience post-partum depression after giving birth.

(e) Seasonal affective disorder (SAD)

This form of depression is characterized by the onset of a depressive illness during the winter months. The depression generally lifts during spring and summer.

(f) Bipolar disorder

Also called *manic-depressive illness*, it is not as common as major depression or dysthymia. *Bipolar disorder* is characterized by cycling mood changes – from extreme highs (*e.g.,* mania) to extreme lows (*e.g.,* depression).

Appendix I serves as a guideline for therapists in the assessment and treatment of depression.

4.4.2 Personality disorders

The Dictionary of Psychology (Colman 2001:548) defines *personality disorders* as "…a category of mental disorders, with onset no later than early childhood, characterized by pervasive, inflexible and enduring patterns of cognition, affect, interpersonal behaviour or impulse control that deviate markedly from culturally shared expectations and

lead to significant distress or impairment in social, occupational or other important areas of functioning".

According to Blume (2005:65), the personality disorders commonly found with drug abuse are: anti-social-, narcissistic- and borderline personality disorders.

The *Diagnostic and Statistical Manual of the American Psychiatric Association, Fourth Edition, Text Revision (DSM-IV-TR)* groups the personality disorders into three clusters (A,B,C) (Bienenfeld 2008:1). Anti-social, borderline and narcissistic personality disorders are all three categorized under cluster B, namely personality disorders characterized by dramatic, and/or overly emotional thinking or behaviour (Blume 2005:65).

The Mayo Foundation for Medical Education and Research (MFMER) (2008:2) indicates the following symptoms of people suffering from the above disorders:

(a) Anti-social (formerly, sociopathic) personality disorder

The symptoms include the following:

- a disregard for others;
- persistent lying or stealing;
- recurring problems with the law;
- repeatedly violating the rights of others;
- aggressive, often violent behaviour; and
- a disregard for the safety of the self or others.

(b) Borderline personality disorder

The symptoms include the following:

- impulsive and risky behaviour;
- volatile relationships;
- an unstable mood;
- suicidal behaviour; and
- a fear of being alone.

(c) Narcissistic personality disorder

Characterized by:

- believing that you are better than others;
- fantasizing about power, success and attractiveness;
- exaggerating your achievements or talents;
- expecting constant praise and admiration; and
- failing to recognize other people's emotions and feelings.

Appendix J serves as a guideline to therapists for the assessment and treatment of personality disorders.

4.4.3 Anxiety disorders

Another set of symptoms commonly observed among people with drug problems revolves around anxiety (Blume 2005:64). Anxiety is a normal reaction to stress; it helps the individual to cope with everyday stressful life events (NIMH 2010:1). Besides observing the more obvious symptoms of worry and restlessness in individuals,

exaggerated and extended fight-or-flight responses may be observed. These individuals are highly strung, uptight and on edge. They often express extreme fear or exaggerated concerns about something bad happening to themselves or to their family members (Blume 2005:64). When anxiety becomes an excessive, irrational dread of everyday situations, it is a disabling disorder (NIMH 2010:1).

According to Bourne (2001:5) the last two decades saw an explosion of knowledge about the different types of problems in respect of anxiety, and how to treat them.

The National Institute of Mental Health of the United States of America defines (NIMH 2010:7-12) the five major anxiety disorders as follows:

(a) The Generalized Anxiety Disorder (GAD)

The Generalized Anxiety Disorder is an anxiety disorder characterized by chronic anxiety, exaggerated worry and tension, even when there is little or nothing to provoke it. Individuals suffering from these disorders do not seem able to shake off their concerns, even though they usually realize that their anxiety is more intense than the situation warrants. GAD is diagnosed when an individual has been worrying excessively about a variety of everyday problems for at least six months. These people anticipate disaster, and are overly concerned about health issues, money, family problems, or difficulties at work. Their worries are accompanied by physical symptoms, especially fatigue, headaches, muscle tension, muscle aches, difficulty in

swallowing, trembling, twitching, irritability, sweating and hot flashes, or by feeling out of breath. They often have trouble falling asleep, or staying asleep. Twice as many women as men suffer from this disorder. The disorder develops gradually and can begin at any point in the life cycle, although the years of highest risk are between childhood and middle age (NIMH 2010:11,12).

(b) Obsessive-compulsive Disorder (OCD)

Individuals with obsessive-compulsive disorder have persistent, upsetting thoughts (obsessions), and make use of rituals (compulsions) to control the anxiety their thoughts produce, for example, repeatedly checking things, touching things (especially in a particular sequence), or counting. Some common obsessions also include having frequent thoughts of violence and of harming the loved-ones, persistently thinking about performing sexual acts with a person whom the person dislikes, or having thoughts that are prohibited on religious grounds. Persons suffering from this disorder may also be preoccupied with order and symmetry, have difficulty discarding things (so they accumulate), or hoard unnecessary items. Some people also often have the ritual of, for example, several times checking if the stove is turned off before leaving the house. The difference is that people suffering from the disorder perform the ritual, even though doing so interferes with their daily lives, and they find the repetition distressing. Although most adults recognize the fact that what they are doing is senseless, some adults and most children may not realize

that their behaviour is out of the ordinary. The symptoms may come and go, ease over time or get worse. If the disorder becomes severe, it may prevent the individual from doing his/her work or from carrying out his/her responsibilities. The disorder occurs roughly in equal numbers in men and women. It usually appears in childhood, in adolescence or in early adulthood. One-third of the adults develop the symptoms as children. Research indicates that the disorder may run in families (NIMH 2010:8,9).

(c) Panic disorder

Panic disorder is characterized by sudden attacks of terror, usually accompanied by a pounding heart, sweatiness, weakness, faintness or dizziness. The symptoms include feeling flushed or chilled, the hands may tingle or feel numb, they may experience nausea, chest pains or smothering sensations. Panic attacks usually produce a sense of unreality, a fear of impending doom, or of losing control. A fear of one's own unexplained physical symptoms may also present itself. Persons having panic attacks sometimes believe they are having a heart attack, are losing their minds, or are on the verge of death. They cannot predict when and where the attack will occur, and between attacks they worry intensely, and dread the next attack. Panic attacks can occur at any time, even whilst sleeping, and usually peak within ten minutes, although some symptoms may last longer. This disorder is twice as common in women as in men. Panic attacks often begin in late adolescence or early adulthood, but not everyone who

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experiences panic attacks will develop panic disorder. Many people have only one attack, and never another. The tendency to develop panic attacks appears to be inherited (NIMH 2010:7).

(d) Post-traumatic Stress Disorder (PTSD)

Post-traumatic Stress Disorder develops after a terrifying ordeal that involved physical harm, or the threat of physical harm. The individual who develops PTSD may have been the one who was harmed, the harm may have happened to a loved-one, or the person may have witnessed a harmful event that happened to loved-ones or to strangers. People with PTSD may easily be startled, become emotionally numb (especially with people with whom they used to be close), lose interest in things they used to enjoy, have trouble feeling affectionate, be irritable, become aggressive, or even violent. They avoid situations that remind them of the original incident, and anniversaries of the incident are often very difficult. PTSD symptoms seem to be worse if the event that triggered them was deliberately initiated by another person, as in a mugging or kidnapping. Most people experience flashbacks when they repeatedly relive the trauma in their thoughts during the day, or in nightmares when they sleep. Flashbacks may consist of images, sounds, smells, or feelings, and are triggered by ordinary experiences, such as a door slamming. Not every traumatized person develops PTSD. Symptoms usually begin within three months of the incident, but occasionally emerge years afterwards. The symptoms have to last more that a

month to be considered PTSD. Some people recover within six months, while others have symptoms that last much longer. In some individuals the symptoms become chronic. PTSD can occur at any age, including in childhood. Women are more likely than men to develop the disorder. There are also some evidence that susceptibility to the disorder may run in families (NIMH 2010:9,10).

(e) Social phobia (Social Anxiety Disorder)

Social phobia is diagnosed when a person becomes overwhelmingly anxious and excessively self-conscious in everyday situations. The symptoms include an intense, persistent and chronic fear of being watched and judged by others. These individuals also have a fear of doing things that will embarrass them. They may worry for days or weeks before a dreaded situation. The fear may become so severe that it interferes with their work, schoolwork, or other normal activities. It also makes it difficult to make friends. They realize that their fears about being with people are excessive, but they are unable to overcome them. Social phobia may be limited to one situation (*e.g.*, talking to people, eating or drinking, *etc.*), or it may be so broad that the individual experiences anxiety around almost anyone other than his or her family members. Physical symptoms, like blushing, profuse sweating, trembling, nausea, and difficulty to talk may be present. When these symptoms occur, persons with social phobia feel as though all eyes are focused on them. Women and men are equally affected. The

phobia usually begins in childhood or early adolescence (NIMH 2010:10).

Appendix K serves as a guideline to therapists in the assessment and treatment of anxiety disorders.

4.4.4 Psychotic disorders

Psychotic behaviour is the most obvious cluster of mental health symptoms to identify (Blume 2005:60). Persons suffering from psychotic disorders typically experience periods when they cannot distinguish between information from the outside world and information from the inner world of the mind (Van Wormer & Davis 2008:344). Individuals suffering from psychotic disorders persistently evaluate reality mistakenly. The hallmark of psychosis is hallucinations and delusions (Perkinson 2008:208).

(a) Hallucinations

Blume (2005:60) defines *hallucinations* as sensations that are not real. These sensations can be perceived by means of any of the senses. Auditory hallucinations are often perceived as voices, or a noise, that in reality do not exist. Sometimes these voices command the person to do things he or she does not want to do. Visual hallucinations, sometimes experienced as visions, amount to things that are not real. Hallucinations can also be tactile (touch-related), including the perception of feeling something that is not there.

Olfactory hallucinations involve smelling things that do not exist.

(b) Delusions

Miller (2009:1) states that *delusions* are false inaccurate beliefs the person holds on to even when he or she is presented with the accurate information.

Examples of delusions are:

- Grandiose delusions: The individuals believe their own importance or station in life, being grossly out of proportion to what really is the case, for example, a person may believe that he is Jesus Christ.

- Persecutory delusions: These individuals believe that there exists a conspiracy to harass, punish or attack them. They may also believe that the group to which they belong are being harassed or punished.

There are different types of psychotic disorders:

(a) Schizophrenia

People with this illness exhibit changes in behaviour and also other symptoms, such as delusions and hallucinations, that have been lasting longer than six months, usually with a decline in work, school and social functioning (MedicineNet 2010:1). To be diagnosed with scizophrenia, a person needs to have experienced at least two or more of

the following symptoms for at least a month, namely delusions, hallucinations, disorganized speech, being grossly disorganized, or demonstrating catatonic behaviour. Negative symptoms associated with schizophrenia include a flattened affect, apathy, and low motivation, a loss of pleasure, and limited content of speech (Van Wormer & Davis 2008:344).

Based on the symptoms mentioned, different types of schizophrenia can be identified, namely (Psyweb.com., undated:2):

- Paranoid schizophrenia

  These clients are preoccupied with delusions about being punished or persecuted by other people. However, their thinking patterns, emotions and speech remain normal.

- Disorganized schizophrenia

  These clients are usually confused and illogical, and their speech is cluttered. Their behaviour is disorganized, emotionless and inappropriate. These aspects lead to a limited ability to execute normal daily activities, like eating or taking a shower.

- Catatonic schizophrenia

  These clients have limited physical response. They normally become unresponsive and immobile due to their

unwillingness to move, resulting in exhaustion, malnutrition, and even self-inflicted injuries.

- Residual schizophrenia

  This type of schizophrenia is characterized by the decreasing severity of the symptoms of schizophrenia. Delusion, hallucinations, and other symptoms may be present, but are far less than when they were originally diagnosed.

(b) Schizo-affective disorder

People with this illness suffer from both schizophrenia and a mood disorder, such as depression or bipolar disorder (MedicineNet 2010: 1, Psyweb.com. undated:2). Schizo-affective disorder is therefore associated with psychotic and mood disturbances (Miller 2009:1).

(c) Schizo-phreniform disorder

People with this illness have symptoms of schizophrenia, with the symptoms having lasted for more than a month, but for less than six months (MedicineNet 2010:1, Psyweb.com., undated:2). There also does not exist any deterioration in the social status (Miller 2009:1).

(d) Brief psychotic disorder

Persons who suffer from this disorder exhibit sudden, short periods of psychotic behaviour, often in response to a very

stressful event, such as a death in the family. The recovery is often quick, usually within a month (MedicineNet 2010:1, Psyweb.com., undated:2). Psychotic symptoms last between one and thirty days (Miller 2009:1).

(e) Delusional disorder

People suffering from this illness have delusions involving real-life situations that could be true, such as being followed, or being conspired against, or having a disease. These delusions persist for at least one month (MedicineNet 2010:1, Psyweb.com., undated:2).

(f) Shared psychotic disorder

This illness occurs when a person develops delusions in the context of a relationship with another person who already has his or her own delusion(s) (MedicineNet 2010:1, Psyweb.com., undated:2). A healthy person therefore shares the delusions of a person with a psychotic disorder, such as schizophrenia. For example: A person with a psychotic disorder believes aliens are spying on him or her. The person with the shared psychotic disorder will also begin to believe in spying aliens. Aside from the delusions, the thoughts and behaviour of the person suffering from the shared psychotic disorder, are fairly normal (Cleveland Clinic 2009:1).

(g) Substance-induced psychotic disorder

This condition is caused by the use or withdrawal from some substances that may cause hallucinations, delusions or confused speech (MedicineNet 2010:1, Psyweb.com., undated:2).

(h) Psychotic disorder due to a medical condition

Hallucinations, delusions or other symptoms may be the result of another illness that affects the function of the brain, such as a head injury, or brain tumour (MedicineNet 2010:1, Psyweb.com., undated:2).

(i) Paraphrenia

This condition starts late in life, it therefore occurs in the elderly population (MedicineNet 2010:1, Psyweb.com., undated:2). It is a disorder similar to paranoid schizophrenia, but with better-preserved affects and rapport and much less personality deterioration (Ravindran, Yatham & Munro 1999:133-7).

Appendix L serves as a guideline to therapists for the assessment and treatment of anxiety disorders.

It is important that the addiction counsellor recognizes the symptoms of the major psychiatric disorders associated with addiction, and that he/she assists the clients suffering from co-occurring disorders in administering treatment, or that he/she refers the client, so that the co-occurring disorders can be treated effectively.

The above section included a discussion of the major psychiatric disorders associated with addiction, specifically depression, and personality, anxiety and psychotic disorders.

4.5 CONCLUSION

In chapter four a discussion was given of phase two of the treatment programme for addiction.

The aim of phase two of the treatment programme is to provide therapists with guidelines on how to assist their clients to function effectively in their life-worlds. To be able to do this, therapists need to know how to conduct a bio-psycho-social interview, and to teach their clients coping skills and how to deal with co-occurring disorders and substance abuse.

The information as stipulated above will equip the therapists to assist the clients to function effectively in their life worlds.

Chapter five will focus on phase three of the treatment programme. The aim of phase three is to take clients back to their family of origin to enable them to deal with certain aspects that could be the cause of their addiction.

CHAPTER 5

PHASE THREE OF THE TREATMENT PROGRAMME

-We visit yesterday long enough to feel and be healed-
-Beattie-

5.1 INTRODUCTION

Chapter five will focus on phase three of the treatment programme. In chapter five the researcher will make use of a literature review to compile a treatment programme that adresses the family of origin as a possible cause of addiction.

According to the relations theory, the inter-active process includes involvement, experience and the attribution of meaning by means of inner speech. Problematic behaviour like addiction, is a symptom of something that went wrong in the individual's intra-psychic structure. The individual's intra-psychic structure is formed by the intra-psychic process, and it is therefore not the intra-psychic structure that needs to be addressed and changed in the treatment programme, but the intra-psychic process. For this reason the treatment programme will focus on the intra-psychic process of the individual namely *involvement, meaning-attribution, experience* and *self-talk*.

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The family systems theory states that individuals cannot be understood in isolation from one another, but rather as a part of their family system. As members of the system they are intensely connected emotionally and affect each other's thoughts (*meaning attribution*), feelings (*experience*) and actions (*involvement*). Due to the fact that this study focuses on the family of origin as a cause of addiction the first part of chapter five will discuss the intra-psychic process in the family of origin. This will enable the researcher to compile a treatment programme that addresses the family of origin as a possible cause of addiction.

The researcher is of the opinion that when the client has gained insight into the intra-psychic structure and the family system that he or she grew up in, healing needs to take place. Only thereafter can a certain degree of self-actualization and improved relationships with the 'self' occur. The last part of chapter five will therefore focus on how the client can heal from the possible hurts of the past.

5.2 THE INTRA-PSYCHIC PROCESS IN THE FAMILY OF ORIGIN

A *family* is a group of interconnecting people, each of whom affects the other in profound ways. A family consists of a complex network of love, jealousy, pride, anxiety, joy, guilt, - a constant ebb and flow of the full range of human emotions (Forward 1989:157). It is therefore the nature of a family that its members are intensely connected emotionally.

The members have such a profound effect on each other's thoughts (meaning attribution), feelings (experience) and actions (involvement) that it often seems as if they are living under the same 'emotional skin' (The Bowen Theory, undated:1).

It is important to realize that the family system constituted the child's entire reality when he/she grew up. As a child each person made his/her own decisions about who he/she is and how he/she is supposed to interact with others, based on how their family system taught them to see the world (Forward 1989:157). Each family unit can be seen as a system where all the members are involved in this particular system where it functions either in a healthy or in a dysfunctional manner.

5.2.1 Involvement in the family system

During the discussion of the relations theory in chapter two it was stated that individuals get involved in certain events in their life-worlds through the 'self' and others. Involvement, therefore, refers to the act of giving attention to a person or object because a person wants to do so. Involvement also leads to the achievement of goals and to fulfilment within a person's life-world. Inadequate involvement affects an individual's cognitive structure, emotional life and value system and could promote under-actualization which, in turn, gives rise to anxiety, frustration, failure, *etc*.

5.2.1.1 Why the client needs to get involved

According to Black (2001:106), recovery from addiction begins when the client starts speaking the truth about the family he/she grew up in, referring to his/her reality, as well his/her experiences. The client needs to understand that he/she is not supposed to explore the past to attribute blame, but to discover and acknowledge reality. Black further states (2001:106) that if the client does not talk honestly about his/her experiences, he/she ultimately betrays himself/herself, and the health of the family.

To enable a client to speak the truth about the family system that he/she grew up in, and name his/her reality and his/her experiences of the past, he or she needs to gain insight in and understand his/her own involvement in the family system that he/she grew up in. This will enable him or her to understand any dysfunctions that occurred in his/her own family of origin.

According to the relations theory, it is impossible to gain knowledge regarding any aspect if an individual does not get involved with that aspect. By gaining insight into the dysfunctions of his/her family of origin, the client will also become involved in the therapeutical process. This involvement could be viewed as the beginning of the healing process.

<u>Session one: exercise 1: The treatment programme and the client's invovement in the family system and the therapeutical process</u>

The aim of exercise one of session one of the treatment programme will be to provide the client with insight into the important roles of the family of origin that he/she grew up in. The purpose of the exercise is also to make the client aware of any thoughts (meaning attribution) or emotions (experiences) regarding his/her family of origin. During session one, the therapist will make use of relaxation techniques, and while the client is in a relaxed state the therapist will read aloud information on the different roles of the family of origin. Thereafter the client needs to write down any thoughts or emotions that he/she experienced during the reading. The above exercise will provide insight into the different roles of a family system, and the client may begin to recognise certain dysfunctions in his/her family of origin.

5.2.1.2 The contributions of a family system

Healthy families have certain characteristics that distinguish them from dysfunctional families (Ferguson 2010:1). A healthy family system is supposed to make certain positive contributions in a child's life at certain times during the childhood years. When this happens the child grows up to be a well-adjusted person (Hurlock 1978:494). A dysfunctional family either fails to perform the tasks of the purpose of a family, or only manages to perform those tasks by means of

harmful or counter-productive methods. Thus the dysfunctional family system can be seen as a system that hurts the people in it (Sekouri 2010:1).

One of the characteristcs of a healthy family system is that important contributions are made during certain times in the child's development. Thereby the family becomes involved in the life-world of the child and self-actualization is promoted. It can be argued that a dysfunctional family system, on the other hand, does not make any or only some contributions and that the lack of positive contributions may hurt the family members.

The contributions of a family system include:

(a) Security

In a healthy family system feelings of security on grounds of being a member of a stable group may be experienced (Hurlock 1978:494). The members know that the family will maintain stability over time. They know that a positive family situation has the ability to withstand the disruptive forces that come with being alive, and this creates a sense of security among the members (Ferguson 2010:1).

Forward (2007:62) states that behaviour in dysfunctional homes are often inconsistent. The rules that apply the one day do not apply the next. Black (2001:xi) indicates that children who, for example, grow up with addiction live with fear, loneliness and confusion. According to Beattie (1989:114), children from dysfunctional families may have

been so deprived of protection and consistency that they believe people are generally untrustworthy.

(b) Needs

In a healthy family system needs are acknowledged, and family members try to find ways of meeting one another's needs (Chapman, undated:1). The children rely on the adults in the family to meet their physical and psychological needs (Hurlock 1978:494).

Children need to be able to depend on their parents to meet their physical and emotional needs in order to develop trust (Black 2001:34). Dayton (2007:48) indicates that if the parents are the source of their children's stress, the children are not only frightened, but the person they would normally go to for comfort and reassurance is lost to them. This can result in the child feeling confused and betrayed because the parent whom they need is unavaliable or causes pain and fear.

(c) *Imperfection*

Family members of a healthy family system know that everyone may not necessarialy approve of all their behaviour, but they know that they are loved nonetheless (Ferguson 2010:1). Sources of affection are always present, regardless of what the members do (Hurlock 1978:494). Love is not withheld as punishment. The members know that they are free to be the people that they are, without fear of ridicule or rejection (Ferguson 2010:1).

According to Whithfield (2006:37), some common parental conditions in dysfuctional family systems, include extreme rigidity, punitiveness, judgmentalness, perfection and cold or non-loving relationships. Black (2001:13) states that emotions in dysfunctional family systems are often not shared, and when they are expressed, it is done in a judgemental way, with blame being placed on one another.

(d) Curiosity

The foundation of a healthy family is based on learning and on embracing new things. The members encourage each other to take reasonable, emotional risks (Chapman, undated:1). Guidance in the development of socially approved patterns of behaviour is also provided (Hurlock 1978:494).

During adolescence the values and authority of parents are actively confronted by the children in the family system. In a reasonably stable family, parents are able to withstand much of the anxiety that these changes create. However, parents in a dysfunctional family system are not so understanding. They tend to experience this confrontation as a personal attack and they defend themselves by reinforcing their child's dependence and helplessness (Forward 1989:16). According to Black (2001:40), children from dysfunctional homes learn to focus on the environment, or on other people, or learn to detach themselves from their families, to enable them not to feel any emotions. These children learn

to deny their feelings and live emotionally isolated. Some learn to repress their feelings, while others simply do not feel. Black (2001:45) also states that children from a dysfunctional family system learn not to ask, and not to expect. If you ask for information or guidance, you may be ridiculed or shamed. If you ask for something that you need, you know it will be denied.

(e) Dependence

The healthy family constitutes the people a child can turn to for help in solving the problems he or she faces in his or her adjustment to life (Hurlock 1978:494). The members trust and count on one another. They do not feel an obligation, guilty or shame for being loyal to one another; they feel proud and privileged to be part of the family (Chapman, undated:1).

Forward (1989:162) states that members of a dysfunctional family system blindly obey family rules, because to disobey is to be a traitor to one's family. She (1989:163) further states that blind obedience to family rules leads to destruction and self-defeating behaviour.

(f) Guidance

The healthy family provides its members with guidance and help in learning skills – motor, verbal and social (Hurlock 1978:494). However, the family members are not expected to have all the answers. Members are allowed to let down

their guard at home and be ‘child-like’ from time to time (Chapman, undated:1).

The dysfunctional family does not provide its members with guidance and help with regard to the learning of skills. Parents rather provide their children with distorted beliefs and resist any external reality that challenges their own belief system (Forward 1989:159,161). According to The Impact Alaska Counselling Services (undated:1), the rules in a dysfunctional family system keep the members operating with masks and pretence. Over time this lack of authenticity results in deeply entrenched false beliefs in the family members, and even when the child is grown up, these thought patterns may be very difficult to break.

(g) Worthiness

Healthy families model attitudes of worthiness (Chapman, undated:1). Each member is committed to maintaining positive relations and regard for the different members. The members know that they are welcome, wanted, loved, and connected to the family (Ferguson 2010:1).

Beattie (1989:114) indicates that children from dysfunctional homes have been so deprived of love that they believe that they are not worthy of any love or devotion.

The treatment programme and the contributions of a healthy family (session one: exercise 2)

The second aim of session one is to make clients aware of the contributions of a healthy family system. This will enable them to determine if these contributions were made in their own families of origin. Clients may then begin to recognise the dysfunctions in their own families of origin. It is important to understand that individuals who were raised in a dysfunctional family system, often experience an absence of knowledge, awareness and understanding of what constitutes a 'healthy' family (Ferguson 2010:1). The dysfunctional system that they were raised in was their only reference, and for them no comparison existed with any other family. This may cause the client to be unaware of the dysfunctions within his family of origin. Thus, for the healing process to begin, the client needs to gain insight into these dysfunctions.

The treatment programme and the content of the next sessions (session one)

The last aim of session one is to provide the client with information on the different aspects that would be addressed in the treatment programme. This is done to provide the clients with a framework against which they can work during the next sessions.

5.2.1.3 Letter writing

The researcher agrees with Dayton (2007:235) where she indicates that *letter-writing* is an amazing tool that can help clients to process their emotions and gain relief from past hurts. The client needs to start writing letters to the members of his/her family of origin, at the beginning of the therapeutical process. After each session the client needs to continue with his/her letters. It is important for the client to understand that the letters are not meant to be sent to anyone. They have to bring the letters to the last therapeutical session.

5.2.1.4 Draw up a geneagram

Family systems therapists always begin treatment with a survey of the different family members (Papero 1990:68). This is referred to as a geneagram. Geneagrams are used to lay out a map of the family, using specific symbols to represent the different individuals and the nature of their relationships (Joseph 2010:140). By participating in the construction of the geneagram the client gains insight into his/her family processes. With the help of these insights, family members learn to appreciate that their behaviour is related to larger systemic processes. They also become aware of the influences of these processes in their own lives. Clients often also become aware of how their own behaviour influences the functioning of the family (Kilpatrick & Holland 2009:178).

The treatment programme and the family geneagram (session two: exercise 1)

The construction of a geneagram is often very time-consuming. The entire session two will thus be spent on the construction of the geneagram. The client needs to draw a geneagram of his/her whole family of origin, including persons who have already passed away. He/she also needs to answer relevant questions about him- or herself, for the therapist to determine the relationship with the 'self'.

5.2.1.5 Summary

The client's involvement with his or her family of origin will be investigated in the treament programme by providing the client with insight into the different roles of a family system, and also with information on the characteristics of a healthy family system. Therapists will also assist clients with the drawing of a family geneagram, and clients will start writing letters to the different members of their family of origin.

5.2.2 Experience in a family system

The relations theory proposes that an individual attributes meaning when he/she gets involved with aspects in his/her life world. This meaning that is attributed could be either positive or negative. The conclusion could therefore be made that by means of the client's involvement in his or her family of origin, positive or negative meanings are attributed to the

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family system. Thus, the client's experience of the family system will either be positive or negative, based on his/her experience in the family system.

The relations theory futher states that how the client experiences his/her family of origin will determine the quality of his/her relationships with the different members of his or her family of origin. If the client had positive experiences in his or her family of origin, it will result in positive relationships. However, if the client's experiences were negative, it would result in negative relationships with the members of his/her family of origin.

A person's experiences are also an indicator of how he or she experiences an identity in a specific situation. With regard to this study, the client's experiences within his/her family of origin will be an indicator of the way in which he or she experiences his or her identities in the family system. For example, his or her experiences could be an indicator of how he or she experienced him- or herself as a son or daughter, or a brother or a sister.

Tessina (2003:4) indicated that when an infant's brain cells develop during infancy, this development is influenced by the family environment, as well as by the emotional responses that are learned during this period. Dayton (2007:33) confirms this where she states that the emotional unconsciousness of the individual, in other words, the individual's web of gestures and meaning, is formed through his or her interaction with the environment, and with his or

her family members or caregivers. She further states (2003:4) that this lays the foundation for later emotional growth. Whether the family is happy and healthy, cold and withdrawn, violent or hostile, children do not ask whether it is right or wrong, they simply accept it as the "the way it is" (Tessina 2003:4).

Alexander (2009:45) indicated that the energy of life comes from our emotions, and that living to the full, does not mean living with repressed or hidden emotions. Rather, it indicates enjoying the emotions, but not being controlled by them.

In the light of the above, the researcher is of the opinion that clients who grew up in dysfunctional families need to be given the opportunity to gain knowledge regarding certain emotions. In her practice, and from the literature research, the researcher came to the conclusion that clients suffering from addiction often experience anger (Black 2001:124, Lerner 2004:108, Dayton 2007:177, Whitfield 2006:99), guilt (Black 2001:127, Grohol 2007:1, Whitfield 2006:43), shame (Beattie 1989:101; Black 2001:68) and 'frozen' emotions (Beattie 1989:83, Dayton 2007:3, Triposi, undated:1).

An investigation into these emotions, as well as aspects which will be included in the treatment programme, will follow in the section below.

5.2.2.1 Guilt

According to Whitfield (2006:43), *guilt* is the uncomfortable or painful feeling that results from doing something that violates or breaks down personal standards or values, or results from hurting another person, or from breaking an agreement or a law. Grohol (2007:1) describes the purpose of guilt as a warning sign of letting the individual know when he or she has done something wrong, in order to help him/her develop a better sense of his/her behaviour and how it affects him/herself and others. Guilt, therefore, concerns our behaviour. It has to do with feeling bad about something that we have done or have not done, that we were supposed to have done (Whitfield 2006:43).

Guilt that is useful and constructive is called *healthy* guilt (Whitfield 2006:44). Black (2001:155) refers to *healthy* or *true* guilt as a feeling of regret or remorse because of the individual's behaviour, for example, the person is responsible for being late, for lying or stealing. According to Grohol (2007:1), the function of 'healthy' guilt is to help an individual to grow and mature, when the individual's behaviour has been offensive or hurtful to others, or to him/herself. 'Healthy' guilt serves the purpose of trying to help redirect the individual's moral or behavioural compass.

However, when guilt is detrimental to the individuals' serenity, their peace of mind and their functioning – including their mental, emotional and spiritual growth – it is referred to as *unhealthy* guilt (Whitfield 2006:43,44). Black (2001:155) refers to *unhealthy* or *false* guilt as a feeling of

remorse that comes from believing that the individual is responsible for someone else's behaviour and actions. 'Unhealthy' guilt makes the individual feel bad for any little legitimate reason (Grohol 2007:1).

Guilt is a warning sign that most individuals learn to recognize through their normal childhood development (Grohol 2007:1). According to Black (2001:155), it is important for children to be able to distinguish the difference between 'healthy' and 'unhealthy' guilt. Whitfield (2006:44) is of the opinion that individuals who grew up in dysfunctional homes often possess a mixture of 'healthy' and 'unhealthy' guilt. He further states (2006:44) that 'unhealthy' guilt in dysfunctional family systems are usually not handled or worked through, but lingers on. Black (2001:128) indicates that adults who grew up in dysfunctional families have the tendency to accept all the guilt; and she states that this is a pattern that needs to be broken.

According to Whitfield (2006:44), guilt can be relieved by recognizing its presence and by working it through in a therapy session. Grohol (2007:1) states that 'healthy' guilt implies telling individuals that they need to do something to repair the relationships that are important to them. The researcher believes that clients sometimes recognize the presence of 'healthy' guilt in their lives, but do not know how to deal with it. The therapist, therefore, needs to assist the client in finding appropriate ways to deal with his/her 'healthy' guilt.

The treatment programme and guilt (session three: exercise 1)

Individuals who grew up in dysfunctional homes often experience a mixture of healthy and unhealthy guilt. To enable clients to deal with guilt during treatment, the therapists need to assist them to deal with 'healthy' and 'unhealthy' guilt in their lives.

5.2.2.2 Shame

According to Whitfield (2006:43), people often confuse *shame* with *guilt*. Beattie (1989:107) agrees with this notion where she suggests that clients need to recognize the difference. Whitfield (2006:43) states that in contrast to guilt, where individuals feel bad because of *doing* something wrong, they feel ashamed of *being* a wrong or bad person. According to Beattie (1989:108), 'healthy' guilt keeps individuals honest, and on track, while shame is worthless. She also states (1989:108) that guilt is resolvable, but shame is not, due to the fact that it only leaves an individual with a sense that all he or she could do is to apologize for his/her existence. Black (2001:65) describes *shame* as an accumulation of painful feelings that come with the belief that the individual is not good enough. Beattie (1989:107) came to the conclusion that a shame-based system means that the individual operates from the underlying belief that who he/she is or does, is not okay.

It is important to realise that we all have shame, that shame is universal to being human (Whitfield 2006:44).

However, Beattie (1989:102) states that shame is the trademark of dysfunctional families. She further states (1989:102) that shame is used to protect secrets and to keep them in place within the family system. By being secretive the expression of questions, concerns and feelings are prevented, and the family cannot communicate freely. According to her (1989:102), the secret may span all kinds of 'shameful' conditions, from family violence, to sexual abuse, to alcoholism. According to Fischer (in: Whitfield 2006:48), keeping a secret disables all the members of the family, whether they know the secret or not. Forward (1989:170) states that secrets help the parents in dysfunctional families to cope by turning their families into private little clubs to which no outsiders are admitted. This provides a bond to pull the family together, especially when the family balance is threatened. According to Whitfield (2006:48), even though the family may communicate poorly, its members are, nonetheless, highly connected emotionally through the denial of the secret, and the loyalty to keeping it.

Shame often results in an inability to set boundaries and compulsive behaviour. The section below will discuss these two aspects as a result of shame.

(a) Boundaries

According to Black (2001:65), if the layers of shame are pulled away, abandonment is typically found. The abandonment could be both physical and emotional, or only emotional. Black (2001:67) furthermore states that children

experience abandonment when their parents have a distorted sense of boundaries. Whitfield (2006:48) agrees with this statement when he describes the shame-based dysfunctional family as a system where everybody learns to mind everyone else's business. The result is a group of family members who are enmeshed, fused, or who have invaded or even overtaken one another's boundaries and personal space. According to Beattie (1989:105), shame can prevent an individual from setting boundaries in his/her own life.

The treatment programme and boundaries (session three: exercise 3)

The therapists need to teach their clients to set boundaries. First they need to explain to their clients why it is important to have good boundaries in place. When the clients have discovered the importance of boundaries, the therapist should assist them in the strengthening of their boundary setting skills.

(b) Compulsive behaviour

Whitfield (2006:50) states that when individuals experience shame, they often feel as if something is missing, that they are somehow incomplete. They are unhappy, tense, empty, distressed, and feel bad and/or numb. Beattie (1989:106) indicates that shame can make individuals feel crazy, and do crazy things. It hurts to believe it is not okay to be who you are. She further (1989:106) mentions that to protect themselves from pain, individuals may avoid shame by

turning it into other feelings that are safer and easier to handle, like rage, indifference, an overwhelming need to control, depression, confusion, alcoholism, drug dependency, workolism, *etc.* Individuals may also transform shame to blame, numbness or panic. Or they may deal with it by running from it. According to Meyer (2003:93), shame could be the source of many complex inner problems, such as alienation, compulsive behaviour, depression, a deep sense of inferiority or being a failure, isolation, loneliness, a lack of confidence, neurotic behaviour, perfection, timidity (fear of all types), and an inability to develop and maintain relationships.

Whitfield (2006:50) describes the result of shame (the cycle of shame) and compulsive behaviour as follows: individuals start to defend themselves against realizing their real needs and feelings. Their 'self', by now alienated and hidden from them, has an innate desire and energy to express itself. Secretly they want to feel its aliveness and its creativity. Held in for so long, its only way out is through a specific form of negative compulsive behaviour that has worked for them somewhere in the past. Such compulsive actions range across a wide spectrum of possible behaviours, from heavy drinking or drugs-taking, to short-term, intense relationships, to trying to control others. It may involve overeating, over-sexing, over-working, over-spending, or over-attending certain groups. When they do this they get a temporary relief from tension, suffering and numbness, even though they may feel some shame about it. And even though of short duration, the individual feels alive again, to a

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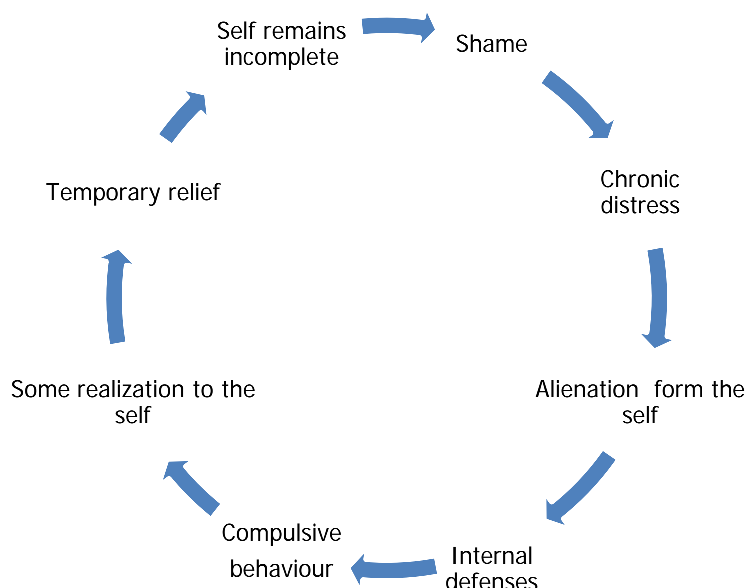
degree. According to Fischer (in: Whitfield 2006:51), the individual is once again left feeling shameful and incomplete.

The treatment programme and compulsive behaviour (session three: exercise 2)

It is expected from clients to indicate if they have ever suffered from any of the following obsessive behaviours: alcohol or drug abuse; overworking; over-exercising; over- or under-eating; too much sex; gambling; controlling; perfectionism; over-spending; over-attending certain groups; always looking for a new therapist.

The therapists need to explain the shame cycle to their clients:



5.2.2.2.1 Summary

To enable their clients to deal with shame during the implementation of the treatment programme, the therapists

will have to assist their clients to understand the importance of healthy boundaries, to teach them skills to set healthy boundaries, to assist them to recognise the presence of obsessive compulsive behaviour in their lives, and to explain the shame cycle to them.

5.2.2.3 Anger

A feeling of anger is natural to everyone, and can be considered to be a natural human emotion (Black 2001:125).

The next part of the discussion will focus on anger within the family of origin.

(a) Learned behaviour

What persons do with their anger, is learned, and can be reshaped to better meet the individual's own needs (Black 2001:125). Anger is one of the most common and important of our human feelings. Like other feelings, it is an indicator of what the client may have to attend to (Whitfield 2006:99). Lerner (2004:1) states that anger is a signal, and one worth listening to. Alexander (2009:38), on the other hand, believes that anger is perhaps the most difficult emotion to own and to process well.

One of the complications attached to anger is that many clients have been taught to repress it. They are hardly aware of the fact that they are angry, and have difficulty being able to admit it (Alexander 2009:38,39). According to

Lerner (2004:2), women learn to fear their own anger, firstly, because it brings about the disapproval of others, and secondly, it signals the necessity of change.

According to Dayton (2007:177), unresolved anger can be a secondary reaction to early relationship wounds. We remain angry because, deep down, we still feel hurt. Lerner (2004:1) agrees with this statement where she says that our anger may be a message that we are being hurt, that our rights are being violated, that our needs or wants are not being adequately met, or simply that something is not right.

Anger hurts, and it is an uncomfortable feeling. When anger sits within us and never gets worked through, or when we do not have constructive ways of processing it or dealing with it, we may try to get rid of it by projecting it at someone else, or to drown our frustrations, resentment and pain with alcohol, food, or by means of compulsive behaviour (Dayton 2007:179). Somatic or nervous symptoms may often accompany anger, such as trembling, shaking, a loss of appetite, or even a feeling of excitement (Whitfield 2006:100).

The treatment programme and learned behaviour (session four: exercises 1 and 3)

One of the aims of session four will be to assist the clients to gain insight into the method/s that they use to get rid of their anger. The clients need to indicate whether they suffer from depression; or physical ailments; make use of self-medication; over-eat; over-sleep; project feelings; make use

of compulsive behaviour; nervous symptoms, or feelings of excitement to get rid of their anger (Black 2001:125).

Another aim of the treatment programme is for clients to become aware of how they handled their anger when they grew up. The therapist, therefore, needs to assist the client to determine what he or she did with his or her anger when he or she grew up. The client needs to indicate if he or she swallowed it and did not become aware of it, played the piano extra hard, hit his or her brothers or sisters, or went to his or her room and cried. The client also needs to indicate what other family members did with their anger and if he/she was afraid he or she would go into a rage, start crying to the point of becoming hysterical, or was afraid of what would happen if he/she really acknowledged his/her anger (Black 2001:125,126).

(b) Passive aggressive anger

When we do not want to openly own our angry feelings, we may act them out. When anger is disowned but leak out around the edges, or is acted out in hidden, pathological or even devious ways, we refer to it as *passive aggressive anger*. This means that the behaviour contains aggression, but the aggressive feelings are not owned or dealt with openly. Some examples of passive aggressive anger are neglect, ignoring, the silent treatment, stonewalling, constant critism, chronic grouchiness, constantly being late, constant negativity, or even taking the ‘positive’ or ‘high’ road, as a way of one-upping or feeling superior to another

person. This kind of anger is confusing, because it is not always manifested, and the persons exhibiting these behaviours may quickly deny that they are angry when they are confronted. They disown the feeling inside of them, and are uncomfortable with the idea of their own anger, which is why it escapes through passive aggressive channels. Anger is often expressed by means of tense silence, through mutual blaming, or by means of one-sided blaming, coupled with one-sided acceptance (Black 2001:124).

The treatment programme and passive aggressive anger (session four: exercise 2)

Another aim of session four will be to provide clients with insight into the presence of passive-aggressive anger in the members of their family of origin, or in their own lives. Clients need to indicate if any of their family members made use of certain methods to indicate the presence of passive aggressive anger. They also need to indicate of they made use, or are still using any methods that could indicate the presence of passive aggressive anger.

(c) Dealing with anger

The researcher is of the opinion that people who grew up in dysfunctional families often do not realize how angry they are, or how useful it can be for them to recognize and express their anger. Many clients in recovery are afraid to express their anger, and this is one aspect that needs to be addressed by the therapist. According to Whitfield (2006:100), it could free the client to get in touch with and express his or her anger. Whitfield further states

(2006:100) that in environments where feelings may not be expressed, some clients felt as though they were the cause of the loss or trauma in that environment. They felt ashamed and guilty, but it was not fine to openly express these feelings either. They may then have felt even more angry, and if they tried to express that, they were squelched again. With repeatedly stuffing or repressing such feelings, one's inner 'self' is left feeling confused, sad, shameful, and empty. As these painful feelings build up and accumulate, they become intolerable.

The treatment programme and dealing with anger (session four: exercise 3)

To assist clients to deal with their anger, they have to become aware, first of all, of the things that angered them as children, and secondly, of the things that anger them as adults. The therapist then will take the client through certain steps to deal with his/her anger.

5.2.2.3.1 Summary

To assist clients to deal with the anger in their lives the therapists need to assist them to gain insight into the method or methods that they used to get rid of their anger, what they did with their anger when they grew up, as well as into the presence of passive-aggressive anger in the lives of the members of their family of origin, or in their own lives

The clients then need to indicate the methods that their family members use to to deal with passive aggressive anger,

as well as their own methods of dealing with passive aggressive anger.

The therapists also need to assist their clients to become aware of the things that angered them as children, and of the things that anger them as adults. They then need to assist their clients to deal with the anger in their lives.

5.2.2.4 Frozen emotions

Dayton (2007:3) states that emotions occur in an individual's body, as well as in his/her mind. Ingraham (2005:1) agrees with this where she describes an *emotion* as both a physical and a mental experience. She also states (2005:1) that an individual is able to store emotional experiences in his or her body tissue. Benor (2006:1) agrees, and states that when a certain part of the body is injured or tense because of a traumatic experience, the emotional memory of that experience may become imprinted in that part of the individual's body. Triposi (undated:1) refers to the above as *body memory,* which he defines as the energy of past experiences that is suppressed in the individual's body.

When an experience is threatening, painful or stressful, the primitive fight-or-flight response becomes active in the body and triggers the person to take action by either confronting the stressor (fight), or by escaping (flight). If they are unable to confront it or to escape, a secondary protective response, the *freeze* response, becomes active

(Triposi,undated:1). Dayton (2007:xv) agrees with the above and states that fear triggers an individual into self-protective responses like fight (anger, rage), flight (taking off, dissociating) or freeze (shutting down, withdrawing). According to Triposi (undated:1,3), the body cannot release stress and be in the 'freeze' response at the same time. The freeze response, therefore, prevents the body from relaxing and healing itself. It also creates a high degree of tension in the body.

Dayton (2007:4) describes what happens to a child who grows up in a dysfunctional family system, where the family itself becomes a source of ongoing stress. According to Dayton (2007:4,11,16), such a child finds him- or herself in a confusing and painful state, he/she wants to flee from or attack the very people whom he or she is dependent on for survival. Escape, however, is more or less impossible, and fighting implies a losing battle. So they do all that they can, namely they 'freeze', or shut down their inner responses by numbing or fleeing on the inside. These emotions live within these children in a frozen state if they are not elevated to a conscious level. As adults these individuals may freeze all over again when they find themselves in similar situations.

When a person relaxes enough for the protective tensions to be released, the release of the suppressed body memory occurs. This leads to unwinding. To *unwinding* can be referred as the involuntary movement that occurs during a release of body memory (Triposi,undated:1). Dayton (2007:11) is of the opinion that the frozenness of childhood

memories will wear off in the safety of a therapeutic environment. This will allow the client to process the feelings that he or she was never able to do. It will also enable the client to witness the events through the eyes of an adult, and will therefore lead to insight and understanding.

The treatment programme and frozen emotions (session five: exercise 3)

To assist the clients to deal with frozen emotions, therapists need to make use of relaxation techniques, encouraging clients to recall events from their childhood, and to assist them to follow the childhood event to an emotional conclusion. Clients then need to re-tell the childhood event from an adult perspective to enable the therapists to determine if they have gained insight into the event from their childhood.

5.2.3 Meaning attribution in the family system

According to the relations theory the attribution of meaning implies that the individual recognizes, knows, and understands. By means of the attribution of meaning, the individual is able to orientate him/herself in his/her life-world. It can therefore be regarded as an individual's personal understanding of his/her life-world. Through this orientation the individual is able to stand in certain relationships to objects and people that are important to him/her, as well as to him/herself.

With regard to this study meaning attribution refers to what the client recognises, knows and understands about the relationships with his or her members of his or her family of origin and with the 'self'.

The theory further states that meaning can be both denotative and connotative. *Denotative* meanings have a logical dimension, and make common understanding possible. *Connotative* meanings are uniquely personal in nature. An experience can be so intense that the denotative meaning is concealed by the attribution of connotative (illogical) meaning, and this then clouds the person's understanding.

With regard to this study the meaning attribution of the client with regard to his/her family of origin could be either *denotative or connotative.* If the meaning attribution is denotative in nature the client's understanding of his/her family of origin will be logical. However, if the client's meaning attribution of his/her family of origin is connotative in nature it could be so intense that the logical meaning is concealed and that the person's understanding is clouded. The client will then not have a logical understanding of his/her family of origin.

To be able to assist clients to gain insight into their understanding (meaning-attribution) of their family of origin, the beliefs and rules, as well as the client's self-talk will have to be addressed during treatment. To enable the

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therapist to include these aspects in the treatment programme an investigation into beliefs, rules and self-talk in a family system needs to be undertaken.

(a) Beliefs and rules

Forward (1989:158) states that the beliefs within a family system determine the attitudes, judgement, and perceptions of the different members of the system. These beliefs also mould the behaviour of the different members. Forward further states (1989:161) that beliefs within the family system could develop into the rules of the system. According to Ferguson (2010:1), the rules and expectations within a healthy family system are clear and consistent. The rules within this system are not chaotic and fluid. They can change as needed through negotiation and discussion, rather than at the whim of the most powerful person in the system. According to The Impact Alaska Counselling Services (undated:1), the rules in a dysfunctional family system keep the members operating with masks and pretence. Over time this lack of authenticity results in deeply entrenched false beliefs in the family members, and even after the child is grown up, these thought patterns may be very difficult to break.

According to Forward (1989:157), there are two types of beliefs or rules within a family system, namely *spoken* and *unspoken* beliefs or rules. When *spoken,* they are expressed or communicated directly. They are out there. The family members can hear them. These overly-expressed ideas have

the advantage of giving the children in the system something tangible to wrestle with when they become adults. Although these beliefs or rules may have become a part of the individual, the fact that they are stated makes them easy to examine and perhaps to discard, in favour of beliefs or rules that are more relevant to their lives. *Unspoken* beliefs or rules, on the other hand, can dictate many basic assumptions about life. They exist below the level of awareness. These beliefs or rules were implied by the way the individual's father treated his or her mother, or by the way either of the parents treated the individual as a child. Tessina (2003:4) provides a number of examples as *unspoken* rules within a dysfunctional family system, namely the angriest person gets what he wants, the person who suffers most, gets the attention, or boys are favoured. Black (2001:27) provides the following as examples of rules within a dysfunctional family system, namely "Do not talk", "Do not trust", "Do not feel", while Forward (1989:158) gives the following examples of beliefs within the dysfunctional system, namely "Children should respect their parents, no matter what", "There are only two ways to do things, my way, and the wrong way".

The treatment programme and beliefs and rules (session four and session five: exercise one)

The researcher agrees with Forward (2010:1), where she states that individuals who were raised in a dysfunctional family system, often experience an absence of knowledge, awareness and understanding of what constitutes a 'healthy'

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family. The reacher also believes that this is applicable to the meaning-attribution of clients as regards to their family of origin. Although the focus of session four is to address the anger of clients, a section on the beliefs and rules (meaning-attribution) is also included. However, exercises on meaning-attribution will only be included in session five. The inclusion of the above in session four is done to give clients time to become aware of and gain insight into the beliefs and rules of their family of origin, before it is addressed in more detail during session five.

The first aim of session five in dealing with the beliefs and rules of the family of origin will be to provide the client with examples of possible beliefs and rules within a dysfunctional family system. The focus will be on rules and beliefs of dysfunctional family systems, due to the fact that those are the beliefs and rules that harm clients. The client then needs to point out if any of these beliefs or rules existed or still exist in his/her family of origin, as well as other beliefs and rules that were not included in the examples.

(b) Self-talk

According to the relations theory, self-talk refers to the way a person talks to him/herself about him/herself. It needs not be a discussion or talk in the usual sense of the word; it needs not be spoken, and the person may not even be aware that he is talking to himself. It can also happen in the subconscious mind.

In respect of this study, self-talk will refer to the way that the client talks to him/herself regarding aspects of the family of origin. Due to the fact that these conversations could take place in the subconscious mind, the client may not be aware of his/her self-talk regarding his/her family of origin.

The theory also states that the individual is constantly busy evaluating his/her relations with objects and events in his/her life-world. This evaluation takes place by means of inner speech. An individual's self-talk is also influenced by his own subjective value system.

As regards this study, it may be concluded that the individual, when he/she grew up and even now as an adult, was constantly evaluating his/her relationships with the members of his family of origin as well as with the him-/herself. It is important to note that this evaluation is influenced by the client's subjective value system.

According to the relations theory, self-talk usually vacillates between positive and negative extremes. The way that an individual experiences the things in his/her life-world, the manner in which he/she gives meaning to them and becomes involved in them, will be influenced by these positive and negative extremes, and therefore influences the individual's self-concept. The individual is continuously busy with self-talk that may at times be positive and at other times negative, depending on how he/she feels about him-/herself. If the self-talk is continuously negative, the individual will become less and less accepting of him/herself.

As regards this study it may be concluded that the client's self-talk with reference to his/her family of origin vaccilates between positive and negative poles of the self-concept. The way that the client experiences his/her relationships in his/her family of origin, the way he/she gives meaning to them and becomes involved in them, will be influenced by his/her positive or negative self-talk. If the client's self-talk in respect of his/her family of origin is continuously negative, the client will become less and less accepting of him/herself.

According to Beattie (1989:84), it is important to decode and change the self-defeating messages (self-talk) that individuals pick up as children from the beliefs and rules in the family system. Black (2001:107) agrees with this, and mentions that if internalized beliefs are getting in the way of how individuals want to live their lives, the individuals need to take the responsibility for these beliefs, let them go and create new beliefs in their place. Forward (1989:162) indicates that unspoken rules have a tenacious hold on the individuals' lives, and to change them the individuals first need to understand them.

In the light of the above the researcher would like to mention that children who grew up in dysfunctional homes probably developed negative meanings (self-talk), based on the beliefs and rules of the system they grew up in. The therapist therefore needs to assist his/her client with the spoken and unspoken beliefs and rules from his/her family of origin. Clients need to recognize both the spoken and

unspoken beliefs and rules of the family system that they grew up in. They also need to gain insight into the fact that these beliefs and rules lead to certain messages (self-talk). The therapist has to assist the client to identify these messages.

The treatment programme and self-talk (session five: exercise 2)

The aim of this exercise is for clients to become aware of the fact that by means of our self-talk, certain messages are formed. The clients will be provided with a list of examples of beliefs and rules, and the messages that are formed from these beliefs and rules. The client then needs to draw two columns for each member of his/her family of origin. In the first column the clients must write down the beliefs and rules of their own families of origin. In column two the messages are to be written down that are the result of the belief or the rule.

5.2.4 Summary

In the first part of chapter five the intra-psychic process (involvement, experience and meaning-attribution) of the client in the family of origin was explained. During treatment the therapist will assist the client in his/her involvement, experience and meaning-attribution in his/her family of origin.

The next section of chapter five will focus on how therapists may assist their clients to heal from the hurts of the past.

5.3 HEALING FROM THE PAST

We either make ourselves miserable or we make ourselves strong. The amount of work is the same.

- Carlos Castaneda –

According to the family systems theory, the person who is brought for therapy, or who seeks therapy, is identified as having a problem (*identified patient)*. However, the identified problem is often in the system, and the system's problem is manifesting itself in one of its members. The researcher thus reasoned that an individual's addiction may be a symptom of problems within the family system that he/she grew up in (family of origin), and the addict is thus seen as the *identified patient*. For the client to be able to heal, problems that occured within the family of origin needs to be addressed.

The researcher is of the opinion that after the client has gained insight into the involvement, experience and meaning-attribution of the family system that he or she grew up in, healing needs to take place. Only thereafter can a certain degree of self-actualization and improved relationships with the 'self' and the members of his/her family of origin be reached. The researcher is further of the opinion that for healing to take place, clients need to grieve events of their

childhood and forgive certain members of their family of origin.

5.3.1 Grieve

If you suppress grief too much, it can well redouble.

-Moliére -

To grieve is a normal and necessary reaction to loss, but not necessarily a loss of life.

For the purposes of this study the definition of *loss* by Dayton (2007:197) will suffice, namely

"Loss is defined as the loss of a person, a part of the self, a period of life or life circumstances".

5.3.1.1 Childhood losses

Children who grew up in dysfunctional families suffer numerous losses over which they are often unable to grieve in a complete way. The negative messages that they get when they grieve, set up a major block, for example, "Do not feel", or "Do not talk about it" (Whitfield 2006:86). When people grieve, they naturally allow themselves to feel the anger, hurt, disorientation and sadness that are part of processing pain. People are often afraid to give in to grief, because they fear they will never emerge from it. When they, however, understand that their feelings are part of the healing process, and that by feeling them they can allow

themselves to dissipate, they begin to see light at the end of the tunnel (Dayton 2007:188).

Emotional wounds, like wounds to the body, need to be cleansed, so they can heal (Dayton 2007:187). According to Forward (1989:217), clients need to identify their losses in order to experience their grief. They also need to work through these feelings to release the hold that these feelings have over them. Clients experience a loss of the 'self' when they relegate emotional wounds into a sort of psychic silence (Dayton 2007:190). It is not until unresolved grief is experienced that individuals can get back on their feet again (Whitfield 2006:85).

Dayton (2007:191) states that if clients cannot mourn their losses they may

- stay stuck in anger, pain and resentment;
- loose access to important parts of their inner feeling world;
- project unfelt, unresolved grief into any situation, placing those feelings where they do not belong;
- loose their personal history along with the un-mourned person or situation; a part of them dies, too; or
- carry deep fears of subsequent abandonment.

What is the difference between *self-pity* and *grief*? According to Forward (1989:219), people who get stuck in self-pity wait around for someone else to fix their lives for them. They avoid personal responsibility. Grief is active, not passive. It gets you unstuck; it allows you to heal.

The treatment programme and childhood losses (session 6: exercise 1)

The first step of the grieving process is to identify losses by accurately naming them. To assist the client with the identification of his/her losses, the therapist will give examples of losses that the client could possibly have experienced during childhood so that he/she may be able to identify and name the losses he/she has experienced. Examples of the losses that children from dysfunctional families often experience, are the loss of feeling good about the 'self'; unconditional acceptance; feelings of safety; trust; joy and spontaneity; stability; support; nurturing, respectful parents; innocence or love.

5.3.1.2 The stages of grief

Grief has different stages.

For the purposes of this study, the researcher would like to withstand with the stages described by Dayton (2007:197), namely

Stage 1: Emotional numbness and shutdown

In this stage the client may go through a period of feeling emotionally numb. He/she is aware that something is wrong, but his/her feelings are shut down and out of reach.

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Stage 2: Yearning and searching

There is a deep yearning in this stage for what is lost, whether a stage of life, a part of the 'self', or a person, followed by searching for a way to replace the loss.

Stage 3: *Disruption, anger and despair*

In this stage, clients may experience feelings of anger, despair, sadness and disappointment that come and go, and at times are overwhelming. Their lives feel disrupted. Many losses that have anger and resentment attached to them can get confusing at this point. It may be easier to feel the anger, rather than the sadness beneath it. Clients may also have feelings like longing and relief, or rage and yearning.

Stage 4: Reorganization and integration

In this stage the client is able to articulate and experience either the natural, numbed or split-off emotion connected with the loss, and integrate it into the 'self' system. This is a stage of acceptance and letting-go.

Stage 5: *Spiritual growth and a renewed commitment to life*

In this stage the client comes to believe in life's intrinsic ability to repair and rebuild itself. He/she experiences first-hand that he/she can heal by reaching out and letting in the love and caring of willing people. The client's energy is freed, and he/she can reinvest it in life. The beauty of grief is that it frees our energy!

The treatment programme and the stages of grief (session six: exercise 2)

The therapists need to discuss the different stages of grief in order to enable the client to determine at what stage he/she is in the grieving process. To assist the client to deal with his/her grief, the client needs to write a letter to the child inside him/her. The therapist has to explain to the client that perhaps the little child inside him/her is scared or angry, and feels hopeless, and in the letter these emotions need to be acknowledged. Then the client needs to give the child the reassurance that everything is going to be fine.

5.3.1.3 Summary

To be able to grieve their childhood losses, the therapists will have to assist their clients to identify their childhood losses, explaining to them the different stages of grief, and by assisting them to deal with their grief by guiding them in the writing of a letter to their inner-child.

5.3.2 Forgiveness

Like recovery, family of origin work is a process. It's a healing process, an awareness process, a forgiveness process and a process of changing and becoming changed.

- Melody Beattie -

The final session of the treatment programme will focus on forgiveness. According to Meyer (2003:125), receiving forgiveness for one's past mistakes and sins, and forgiving

others for their mistakes and sins, are two of the most important factors in emotional healing. The researcher agrees with this statement and believes that before the wounds from the childhood years can be healed, the client needs to forgive. The researcher, however, disagrees with many therapists that forgiveness has to take place at the beginning of the healing process, but is of the opinion that the clients first need to get insight into what has happened in their past. The clients then have to remember the past, and examine their involvement, experience and meaning-attribution in the family system that they grew up in. Only after the clients have gone through this entire process will they reach the point where they are able to forgive.

According to Heavilin (1987:47), *forgiveness* can be defined as giving up your claim to avenge a wrong-doing. When clients forgive, they are simply saying, "I am releasing myself from the responsibility of vengeance". Piderman (2010:1) describes *forgiveness* as a decision to let go of resentment and thoughts of revenge. According to Jones (2006:1), forgiveness works through an ongoing willingness to give up certain claims against other individuals, and to give the gift of 'self' by making innovative gestures that offer a future not bound to the past. Jantz and McMurray (2003:181) state that forgiveness returns the client to a state of being in control, due to the fact that he/she is in total control of his or her power to forgive. According to Dayton (2007:231), people forgive for their own good. Barnes (1996:74) states that true forgiveness works becauseit changes the person that forgives, and not

necessarily the person that is forgiven, or the difficult circumstances.

5.3.2.1 The misconception about forgiveness

There exist many misconceptions about forgiveness, for example

Myth 1: When you forgive somebody your negative feelings will change into positive feelings.

Forgiveness does not mean that the client has forgotten all that has happened to him to her. It still hurts, but living obsessed with the pain only perpetuates the damage (Jantz & McMurray 2003:181). An author and professor of theology and ethics, Lewis B. Smedes, says (Leman 2007:144),

> *"Forgiving does not erase the bitter past. A healed memory is not a deleted memory. Instead, forgiving what we cannot forget creates a new way to remember. The memory can be changed from the person's past into a hope for the future."*

It is important to remember that forgiveness is a process, rather than an event (Dayton 2007:228). In Matthew 18:21-22, as described in the Holy Bible (1984:573), Jesus tells his followers to forgive people seventy times seven times. If one does the calculation, it adds up to four hundred and ninety times which you need to forgive the same person! According to Leman (2007:145), Jesus' admonition to forgive seventy times seven times, puts into context how long this process can take, and how difficult it may be. Dayton(2007:233) agrees with this where she states that

forgiveness is a decision to head in a certain direction, and that the individual may need to forgive many times.

Myth 2: When you forgive someone, the relationship will be restored.

The above is not necessarily true. The client may not even choose to continue to see the person whom he/she wants to forgive. The other person may also not be able to accept the client's forgiveness, or even care about it.

The researcher has often referred to the following anecdote:

> *I know of a woman who went through a bad time in her marriage and made a series of painful mistakes. She fell apart emotionally, the marriage split up and her husband was granted custody of their two young children. Although she wrote them faithfully, they were very angry and wanted nothing to do with her. Unfortunately, her ex-husband was very bitter and inflamed these feelings of anger. Eventually he moved them to a state so distant that she could barely afford to visit (although she tried). During this time, the woman worked very hard to rebuild her life. She relied on a competent counsellor and support groups. She also returned to the faith she had left behind many years earlier. On her knees she expressed her repentance to God and begged forgiveness for her part in all that had happened. She also wrote her children and asked their forgiveness for anything she had done to hurt them. After that, the problems continued. Her ex-husband was still hostile and he even used her requests for forgiveness to try to deny her visitation. Her children were still distant. They were so far away that visits were a severe financial hardship. So she went to her pastor with her pain and asked him: "I have asked God to forgive me and I really think he has. So why don't I feel forgiven and why is everything still so hard?" The wise pastor looked at her with great compassion and answered: "If you've asked the Lord for forgiveness, he has forgiven you. So maybe what you now need is not forgiveness, but the grace to*

*live with the consequences of your actions (*Barnes 1996:74)*.*

Barnes (1996:74) further states that forgiveness is not superglue for broken relationships. It is also not an eraser for hurtful remarks, or painful memories. Forgiveness also does not excuse individuals from having to cope with the consequences of their actions.

Myth 3: If we forgive the person, we agree or accept their behaviour.

According to Leman (2007:145), forgiveness is not saying that what happened was acceptable, or it is not excusing what has happened, instead it is allowing something new to grow. Forgiveness could mean that we do not agree with the other person's behaviour, and therefore we need to forgive him. Dayton (2007:230) agrees with this by stating that forgiveness does not mean condoning another person's bad behaviour.

5.3.2.2 The stages of forgiveness

In the magazine *Family Life Today*, the following four stages of forgiveness are identified (Smedes, in: Heavilin 1987:41):

Stage 1: Hurt

When someone causes you pain so deep and unfair that you cannot forget it, you are pushed into the first stage of the crisis of forgiving.

Stage 2: Hate

You cannot shake off the memory of how much you were hurt, and you cannot wish your 'enemy' well. You sometimes want the person who hurt you to suffer as you are suffering.

Stage 3: Healing

You see the person who hurt you in a new light. Your memory is healed; you turn back to the flow of pain and are free again.

Stage 4: Invitation

You invite the person who hurt you into your life; if he/she comes honestly, love can move you both toward a new healed relationship.

The fourth stage depends on the person you forgave as much as it depends on you; sometimes he/she does not come back, and you have to be healed alone.

In the light of the above the researcher would like to indicate that the therapists could assist their clients with *forgiveness* in their life-worlds by means of the following:

The treatment programme and forgiveness (session seven: exercise 1)

The therapist first needs to explain to the client the misconceptions regarding forgiveness, as well as the different stages of forgiveness. The client needs to bring the letters

that he/she has written to the session. The letters can be read aloud to the therapist so that the client can feel that he/she is heard. A chair could also be placed in the middle of the room. The client can imagine the person that the letter is addressed to sitting in the room. Then he/she can read the letter out aloud. The client then needs to complete the following in writing for each person that he wrote a letter to. He then has to read it out aloud:

On this day................(date), I forgive......................... for

....

The therapist needs to create a little ceremony where the client decides what he wants to do with the letter, for example, burn it, tear it up into little pieces, jump on it, or bury it. After the ceremony the therapist and the client can determine a way to celebrate the experience. Two examples of celebrating are by making a collage of the future, or remembering the positive aspects of his/her childhood.

5.3.2.3 Summary

To be able to gain insight into forgiveness, the therapist will have to assist the client by explaining the misconceptions of forgiveness, as well as the different stages of forgiveness. The client will then read his/her letters addressed to the members of his/her family of origin to the therapist, after which he/she will decide what he/she wants to do with the letters. During the final part of the session the therapist and

the client will celebrate the healing that took place during the treatment.

5.4 CONCLUSION

Chapter five consisted of a literature review of the intra-psychic process and how clients can heal from the past. The researcher made use of the information obtained from the literature review and compiled a treatment programme that addresses the family of origin as a possible cause of adiction. The treatment programme consists of the following seven sessions:

(a) The intra-psychic structure and the family of origin

Session	**Treatment programme**	**Intra-psychic structure**
Session 1	Family of origin	Involvement
Session 2	Family geneogram	Involvement
Session 3	Guilt Shame	Experience
Session 4	Anger Beliefs and rules	Experience Meaning-attribution
Session 5	Frozen emotions Self-talk	Experience Meaning-attribution

(b) Healing from the past

Session	Treatment programme
Session 6	Grief
Session 7	Forgiveness

The treatment programme will be implemented by the therapists during the empirical investigation of the study. The researcher wants to measure the effectiveness of the treatment programme by measuring the improved levels of self-actualization and the changes in the client's relationships with the 'self' and others, after treatment.

In Chapter six the researcher will focus on the research design of the study.

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CHAPTER 6

THE RESEARCH DESIGN

A research design is an action plan for getting from here to there.

- Yin 1989 -

6.1 INTRODUCTION

In the previous chapters the relations and family systems theories were discussed, as well as phases one, two and three of the treatment programme. Chapter six will focus on the research design of the study and provide the data-collection methods that the researcher made use of during the study.

The aim of this study was to develop a treatment programme that therapists could use to address the family of origin as a cause of addiction. The treatment programme consists of three phases. Phases one and two of the treatment programme were included in the study to provide therapists with guidelines on how to assist clients to reach abstinence and to function effectively in their life-worlds and phase three focused on the family of origin as a possible cause of addiction. Due to the fact that the aim of the study is the family of origin as a cause of addiction, the research design will focus on data-collection procedures

that will enable the researcher to determine the effectiveness of phase three of the treatment programme.

6.2 PROBLEM STATEMENT

Although addiction is treated by means of different treatment programmes in South Africa, the the researcher discovered that the level of self-actualization of the addicts, as well as the changes in their relationships, are questionable. A preliminary literature review indicated that the family of origin could be the cause of addiction.

This study will attempt to answer the following questions:

If the family of origin is treated as a cause of addiction by means of a treatment programme,

- will changes occur in the addict's level of self-actualization and in his or her relationships with others and with the 'self', after treatment;
- will therapists and clients consider the treatment programme as satisfactory;
- will the treatment programme be effective in assisting the addict to reach an improved level of self-actualization;
- will the treatment programme be effective in assisting the addict with changes in his or her relationships with other persons and with him/herself?

6.3 RESEARCH AIMS

The following were the research aims that directed the literature review of the study

- to gain a better understanding regarding the relations- and systems theories, due to the fact that these two theories serve as the theoretical framework of the study (Chapter two);
- to investigate existing treatment programmes in South Africa (Chapter two);
- to provide knowledge and guidelines to therapists on how they could assist their clients to reach abstinence (Chapter three);
- to provide knowledge and guidelines to therapists on how they could assist their clients to function effectively in their life worlds (Chapter four); and
- to investigate the role of the family of origin as a possible cause of addiction and to compile a treatment programme that addresses the family of origin that therapists could implement during treatment (Chapter five).

During the empirical investigation data was obtained regarding the implementation of the treatment plan. The treatment programme addressed aspects of the family of origin that could be the cause of addiction. The main aim of the empirical investigation was to determine the effectiveness of the treatment programme. To enable the researcher to determine the effectiveness of the treatment

programme, the following secondary research aims directed the empirical investigation:

- the satisfaction of therapists and clients regarding the treatment programme;
- therapists' and clients' views regarding the level of self- actualization reached by clients after treatment;
- therapists' and clients' views regarding changes in the clients relationships with 'others' after treatment;
- therapists' and clients' views regarding changes in the clients relationships with 'self' after treatment.

6.4 RESEARCH DESIGN

The research design consists of two parts namely the development of the treatment programme and the empirical investigation to evaluate the treatment programme.

6.4.1 The development of the treatment programme

To enable the researcher to develop a treatment programme, a literature review was undertaken to contribute towards a clearer understanding of the relations- and systems theories (chapter two) and the family of origin as a possible cause of addiction (chapter five).

Many of the therapists who took part in the study had extensive knowledge and training regarding substance abuse and the treatment of substance abuse, while other

therapists had very limited knowledge and training regarding these aspects. The reason for the inclusion of chapters three and four in the literature review was to explain and provide knowledge and guidelines regarding important aspects relevant to substance use, abuse and treatment. These chapters were therefore included to ensure that all therapists who took part in the study were provided with relevant, important knowledge on how to assist clients to reach abstinence (chapter three), as well as on how they could assist clients to function effectively in their life worlds (chapter four).

However, the purpose of this study was to investigate the family of origin as a cause of addiction. Therefore the knowledge obtained from the literature review on the relations- and systems theories (chapter two) and the family of origin as possible cause of substance abuse (chapter five), were used to compile a treatment programme that address the family of origin as a cause of addiction. The treatment programme is included in appendix O.

6.4.2 Empirical investigation

During the empirical investigation the effectiveness of the treatment programme was evaluated. Firstly, the researcher argued that the satisfaction of therapists and clients regarding the treatment programme could indicate the effectiveness of the treatment programme. Secondly, after the literature review of the relations theory, the researcher

concluded that the effectiveness of the treatment programme could also be determined by investigating changes in the clients' relationships, as well as in the level of self-actualization that client reached on completion of the treatment programme. The satisfaction of therapists and clients, therapists' and clients' views regarding the level of self-actualization reached, as well as changes in relationships with 'others' and the 'self' were therefore investigated.

The researcher reasoned that the use of a mixed method will answer a broader and more complete range of questions and add insight and meaning that might otherwise be missed when a mono-method approach is used. The mixed method would therefore provide the researcher with beter understanding regarding the effectiveness of the treatment programme at the end of the study. The researcher made use of a sequential mixed method design; a qualitative- and quantitative method to collect data were therefore both included. Traynor (undated:14) describe a mixed method design as a qualitative mini-study and a quantitative mini-study in one overarching design. Data were collected in two phases. In phase one questionnaires were completed by therapists and client's of therapists, while interviews were conducted with therapists during phase two of the data collection process. The two phases were done sequentially. The indications that have been identified from the results of the questionnaires (phase one) were used to guide the type of questions that were used during the interviews (phase two). The questionnaires therefore provided a basis for the

collection of the data during the interviews and the effectiveness of the treatment programme was determined by collecting and analyzing the two types of data.

The researcher was able to determine the effectiveness of the treatment programme from the data obtained from the quantitative (quan) phase of the investigation, while the data of the qualitative (qual) phase was used to gain better understanding and insight. The study therefore relied more on the quantitative (quan) than the qualitative (qual) investigation. In literature there is often reffered to this mixed method as QUANqual (Traynor undated:16).

A discussion of the data collection methods used during each phase will follow:

Phase one: Quantitative research method

The quantitative descriptive (survey) design was used in phase one. This method of data collection requires the use of questionnaires. The researcher developed two treatment questionnares; one for therapists and one for clients to collect data. The decision to use questionnaires during this phase was based on the fact the cost was relatively low. The time of completion for the implementation of the treatment programme was different for each therapist and by using this method of data collection, the different respondents were able to complete the questionnaires on completion of the programme. Clients received the treatment questionnaire for clients from their therapists;

therapist-client confidentiality was therefore protected during the collection of data.

Phase two: Qualitative research method

The case study method was used during phase two of the data collection process and interviews were conducted with therapists that took part in the study regarding their views on the implementation of the treatment programme. The results of the questionnaires (phase one) were used to guide the type of questions for the interviews (phase two). The researcher was therefore able to investigate certain outcomes and trends that came to the fore during the analysis of the data received from the questionnaires.

6.5 POPULATION AND SAMPLE

At the time of the implementation of the treatment programme, the researcher resided in Nelspruit. Based on financial, logistical and practical implications the researcher decided to contact organisations in Nelspruit and the surrounding areas regarding the implementation of the treatment programme. The population therfore consisted of therapists in Nelspruit and the surrounding areas.

The researcher contacted the Lowveld Psychological Association due to the fact that the study is done within the field of psychology, the members of the association are all registered psychologists at the Healths Professions Council

of South Africa and almost all the registered psychologists in Nelspruit and the surroundig areas are members of the association. SANCA's offices were contacted due to the fact that the social workers that are employed at SANCA, are knowledgeable in the field of addiction and are treating addicts on a regular basis.

A list of members were obtained from The Lowveld Psychological Association. After a meeting was held with the director of SANCA Nelspruit, a proposal regarding SANCA's involvement in the implementation of the treatment programme, was discussed at a SANCA National's research portfolio meeting. Permission to take part in the study was granted to SANCA's offices in Mpumalanga (Nelspruit, Piet Retief, Witbank).

Invitations, per e-mail, were send to the different members of the Lowveld Psychological Association and the social workers employed at SANCA's offices in Mpumalanga (Appendix Q). The invitations briefly explained the purpose of the study, as well as the expectations of the therapists who will consider to take part in the study. Therapists were invited to contact the researcher should they require more information. A counsellor who worked at a church in Nelspruit learnt about the study and requested to take part in the study due to the fact that she reguraly treats clients suffering from addiction. Based on her qualifications and her experience regarding the treatment of addicts, the researcher agreed to her participation in the study. Forty

two invitations were send and twenty two therapists agreed to participate in the study.

The researcher had no part in the selection of the clients that took part in the study. This was based on ethical considerations and especially based on therapist-client confidentiality. The selection of the clients was therefore done by each therapist individually and not by the researcher.

6.6 RESEARCH PROCEDURES

Twenty therapists attended a one day training session that was held in Nelspruit. Two therapists that initially indicated that they would be interested in taking part in the study did not attend the training. Each therapist received a manual, as well as a work book (Appendix P) that could be used during the implementation of the treatment programme.

The following aspects were included in the training of the therapists:

- The ethical code of conduct, provided by the Health Professions Act, 1974 (Act No. 56 of 1974); the section *Rules of Conduct Pertaining to Psychology*, was used as guideline during the implementation of the treatment programme.

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- A discussion on the motivation for and aims of the study, as well as the first two phases of the treatment programme.
- A discussion of the relations theory.
- A discussion of the role of the family of origin.
- A discussion of the different sessions in phase three of the treatment programme.
- Guidelines on the data collection process that would follow the implementation of the treatment programme.

After the training, eleven therapists indicated per e-mail that they would be able to implement the treatment programme at their work place. The other nine therapists reported that they will not be able to implement the treatment programme due to other work obligations, the implementation of the treatment programme appears to be very time consuming and the fact that they do not treat clients sufferring from addiction.

After a period of six months, nine therapists reported that they have been able to implement the treatment programme. The two therapists who could not implement the programme indicated that they were not able to do so, due to the fact that they had not treated any clients suffering from addiction in the previous six months.

At the completion of the treatment programme, data was collected to determine the effectiveness of the treatment programme. The collection of data occured in two phases. During phase one data was collected by means of

questionnaires and during phase two interviews were conducted with therapists that took part in the study.

6.7 RESEARCH INSTRUMENTS

The researcher made use of two treatment questionnaires and interviews during the collection of data. Appendix R serves as an example of the treatment questionnaire for the clients and appendix S as an example of the treatment questionnaire for therapists. Data was collected in two phase.

6.7.1 Questionnaires (Phase one)

During the selection of the questions for the two questionnaires, the researcher was guided by the literature review that was done in chapters two (theoretical framework) and five (family of origin) of the study, as well as the research aims of the study. The researcher strove to include questions that were brief and clear and not leading or negative in any way. The researcher also strove to use vocabulary that were understandable and familiar to all respondents.

Biographical information

The first, few questions in both questionnaires revolved around the biographical information of each respondent.

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General, non-threatening questions were therefore presented first and more sensitive, personal questions later in both questionnaires.

The main aim of the empirical investigation was to determine the effectiveness of the treatment programme. To enable the researcher to determine the effectivenss of the treatment programme, only relevant and significant questions regarding the following were included in both questionnaires,

- the satisfaction regarding the treatment programme of respondent;
- the views of respondents on the levels of self-actualization reached by clients;
- the views of respondents on the changes that took place in the clients' relationships with 'others'; and
- the views of respondents on the changes that took place in the clients' relationships with the 'self' need to be investigated.

Satisfaction with the treatment programme

The researcher argued that if therapists were satisfied with the treatment programme they will use the programme in future, a question to investigate therapists future use was therefore included in the questionnaire for therapists.

The researcher reasoned that clients' understanding of themselves after treatment, their view on if they benefitted from treatment and the outcomes of the different exercises

of the treatment programme could determine the satisfaction of clients regarding the treatment programme. If clients were able to achieve the outcomes of the different exercises it could be argued that they were satisfied with the programme. The researcher made use of the following knowledge of the literature review of the family of origin (Chapter five) and questions were included in the post treatment questionnaire for clients:

Table 6.1: Questions on the view of clients regarding the outcomes of the exercises

LITERATURE REVIEW	QUESTIONS
Children that grew up in dysfunctional family systems often experience chronic stress and as adults they might experience difficulty to relax. *Relaxation* exercises were therefore included.	I was able to *relax* during the exercises.
During the literature review it was noted that individuals who were raised in dysfunctional family systems, often experience an absence of knowledge, awareness and understanding of wat a 'healthy' family system is. To be able to heal from the past, clients needed to gain insight into the *differences between a healthy and a dysfunctional* system, to enable them to recognise and underderstand the dysfunctions in their own family of origin.	I understand the *difference between a healthy and a dysfunctional family system*.

LITERATURE REVIEW	QUESTIONS
To heal from *guilt* feeling from the past, clients need to first recognize the presence of guilt in their lives, secondly they need to name their guilt feelings and lastly they need to deal with their guilt in a therapeutical setting. Feeling of *guilt* is experienced when the person makes a mistake and is therefore the result of behaviour, while *shame* comes from the belief that 'who I am as a person is not okay'. People often confuse *shame* with *guilt*. To be able to heal, clients need to understand the difference between shame and guilt.	I was able to identify aspects that made me feel *guilty*. I was able to name my *guilt* feelings. I experienced a certain degree of release from my *guilt* feelings. I now understand the difference between *guilt* and *shame*.
Shame often leads to compulsive behaviour like overeating, over-sexing, over-working, over-spending. The compulsive behaviour leads to temporary relief from the shame feelings. However, the feeling of relief are short-lived and the shame returns. The above leads to a cycle of shame and compulsive behaviour. To enable clients to recognise shame in their lives, they first had to identify the presence of obsessive compulsive behaviour in their lives. *Shame* is experienced by children, when their parents have a distorted sense of boundaries. This lead to family members being enmeshed and invading or even overtaking each other's boundaries. This often results in individuals not being able to set their own boundaries. The conclusion could therefore be made that shame leads to a lack of boundaries and clients need to understand the importance of boundaries in their lives.	I was able to identify obsessive compulsive behaviours in my life. I gained more insight into setting healthy boundaries. My ability to set healthy boundaries has improved.

LITERATURE REVIEW	QUESTIONS
Anger is a natural human emotion, but what we do with our anger is learned. Many clients have been taught to repress their *anger* and do not realize how angry they really are or what is the causes of their angry feelings. To be able to adress their feelings of *anger,* clients first of all need to determine what they learnt as children to do with their *anger*. Secondly clients need to identify the things that angered them as children, as well as the things that *anger* them as adults. *Anger* is also an indicator that we need to attend to something and it is important for clients to express their anger during therapy.	I was able to determine what I did with my *anger* as a child. I was able to identify the things that *angered* me as a child. I was able to identify things that I, as an adult, feel *angry* about. I found some release from the *anger* I experienced as a child. I found some release from the *anger* I experienced as an adult.
Children who grew up in dysfunctional homes often shut down or freeze their inner responses. These emotions lives in the individual in a frozen state and needs to be elevated to to the individual's conscious level before healing can take place. Clients therefore need to deal with their *frozen emotions.*	I could deal with my *frozen emotions*.
Family *beliefs and rules* mould the behaviour of the children and even as adults these thought patterns still govern their lives. To understand how these beliefs and rules guided their own behaviour clients need to identify the beliefs and rules of their family of origin.	I could identify the parental beliefs and rules of the family I grew up in.

LITERATURE REVIEW	QUESTIONS
Clients also need to understand that beliefs and rules lead to certain messages (self-talk). These *messages (*self-talk) are often negative. For clients to gain insight into their own self-talk they need to be able to identify the messages caused by the beliefs and rules of their family of origin.	I could identify the *messages* from my childhood.
Children who grew up in dysfunctional families suffer numerous losses. For healing to take place clients first need to identify their losses and then they have to *grieve* these losses.	I was able to identify the losses from my childhood. I *grieved* the losses from my childhood.
Before the wounds from the childhood years can heal, clients need to be able to *forgive.*	I was able to *forgive* towards the end of the treatment programme.

Self-actualization reached

One of the aims of the relations theory is to be able to assist clients to reach a stage where they will be able to solve their own problems, function independently and be in a position where they do not need any form of addiction to be able to cope with life in general. To be able to reach the above, the clients should have reached a certain degree of self-actualization. The researcher therefore reasoned that for the treatment programme to be effective, changes should have taken place in the levels of self-actualization reached by the clients on completion of the treatment programme. Changes in the levels of self-actualization that the clients reached after treatment were therefore also

investigated to determine the effectiveness of the treatment programme. The researcher made use of the views of Vrey, Maslow and Fankl to determine the questions regarding self-actualization for the questionnaires and twenty five questions were included in both questionnares.

Table 6.2 : Questions on self-actualization regarding the characteristcis of Vrey

CHARACTERISTIC OF VREY	QUESTIONS
Completely involved in his/her life world.	The client focusses more on problem-solving than on only thinking about the problem.
Experiences intense pleasure , as well as deep sorrow.	The client is more spontaneous. The client's sense of humour has improved.
Not only involved in his/her own world, but also involved in lives of the people in his/her life.	The client is more other-oriented. More intimate relationships are present. The client is more accepting of others.
Realistic view of him/herself; accepts him/herself.	The client has a more realistic life-view. The client is more accepting of him/herself. The client is more accepting of his/her limitations and strenghts.

CHARACTERISTIC OF VREY	QUESTIONS
Focus his/her energy on problems and circumstances on the outside.	The client demonstrates an ability to rise above the environment rather than merely adjusting to it.

Table 6.3: Questions on self-actualization regarding the characteristics of Maslow

CHARACTERISTIC OF MASLOW	QUESTIONS
Self-actualized individuals exhibit more realistic perceptions of reality, and are more comfortable with them. They accept the good and the bad, the highs and the lows, and are able of telling the difference.	The client has a more realistic view of life.
An acceptance of themselves, of other people and the world around them. These individuals see reality as it is, and accepts responsibility for it. They are as objective as a subjective being can be in their perceptions.	The client is more accepting of himself/herself. The client is more accepting of others. The client is more accepting of aspects in his/her life world.
These self-actualizing individuals focus on solving problems rather than on merely thinking about them. They are also people who are generally strongly focused on problems outside themselves. They are concerned with the problems of society, and are willing to work in an effort to solve them.	The client focuses more on problem-solving than on only thinking about the problem.

CHARACTERISTIC OF MASLOW	QUESTIONS
Self-actualizing individuals need to be alone, and need solitude. They enjoy times of quiet reflection, and do not always need people around them.	There is a greater need for privacy. A greater degree of detachment from others is noticed.
These individuals are capable of doing things, and can make decisions on their own. They believe in themselves, and in who and what they are.	The client is able to function more independently. The client is able to function on his/her own. The client has a better understanding in who and what he/she is.
These individuals experience joy in the simple and the natural. To them the sunsets are always beautiful; they can still enjoy the games they played as children.	A less stereotypical appreciation of people, things, ideas is noticed.
These persons have a history of peak experiences which are profoundly spiritual, and which may be mystical or religious.	An improvement in the spiritual life of the client is observed.
These individuals identify with all of mankind. They are aware and sensitive to the people atound them.	The client is more other-orientated.
They have deeply loving and intimate relationships with a few people.	Intimate relationships are present.

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CHARACTERISTIC OF MASLOW	QUESTIONS
These individuals believe in the equality of all human beings, that every person has a right to his/her opinion, and that each person has his/her strengths, but also weaknesses.	The client developed more democratic values.
These individuals know the difference between means and ends, and between good and evil. They also do not twist these in a way that may hurt others.	An improvement in the client's ability to separate means from ends has been observed.
These people enjoy humour. They like to laugh and joke, but not at the expense of others. They are generally seen as good-natured, but are also capable of being very serious.	The client's sense of humour has improved (humour must be lively and not cruel).
These individuals are often highly creative, and their creativeness can be expressed in many dimensions.	The client is more creative.
These people are aware of the fact that they are not perfect, and that there are continuously new things to learn, and new ways to grow. They never stop striving.	The client is more accepting of his/her limitations and strengths.
A demonstrated ability, to rise above the environment, rather than merely adjusting to it.	The client demonstrates a beter ability to rise above the environment rather than merely adjusting to it.

Table 6.4: Questions on self-actualization regarding the characteristics of Frankl

CHARACTERISTICS OF FRANKL	QUESTIONS
The inability to reach self-actualization could lead to addiction.	The clients does not need substances to cope. The client does not need any form of addiction to cope.

Changes in relationships with 'others'

The relations theory states that as a social being, a person can never function in a vacuum. He/she stands in a relationship to God, objects, ideas and other people. According to the family systems theory, individuals need to be understood as a part of their family system. Due to the fact that this study investigates the family of origin as a cause of addiction, 'others' will refer to the members of the client's family of origin.

One of the aims of the relations theory is to assist clients with the establishment of positive, reliable, and efficient relationships with God, other people, ideas and objects in their life-worlds. The researcher is of the opinion that there exists a correlation between a dysfunctional family system and addiction. A dysfunctional family system can be seen as a system that hurts the people in it. For clients to heal they first need to gain insight into their relationship with

the members of their family of origin. The insight that clients gain often lead to changes in relationships.

The researcher therefore argued that the changes in the clients' relationships after treatment could be used as an indicator to determine the effectiveness of the treatment programme. Questions regarding the views of therapists and clients regarding insight gained into relationships, as well as the changes that occured after treatment were include in the questionnaires. The following questions were included in both questionnaires:

Table 6.5: Questions regarding the client's relationships with others

The client shows insight in his relationship with his/her mother.
There has been a change in the client's relationship with his/her mother.
The client shows insight in his/her relationship with his/her father.
A change in the relationship with his/her father has been observed.
The client shows insight in his/her relationship with his/her siblings.

A change in the client's relationship with his/her siblings has been observed.
The client gained insight into his/her relationships with objects in his/her life-world.
There is a change in the client's relationship with objects.
There is a change in the client's relationship with ideas.

Relationship with the 'self'

A person also stands in relationship with the 'self'. During treatment therapists also aim to assists clients with the establishment of a positive, reliable, and efficient relationship with the 'self'. According to Vrey the 'self' of a person describes the *gestalt* of who and what that person is and what he/she can call his/her own. The 'self' includes the ideas, attitutdes, thoughts and values of a person. Raath en Jacobs define the self as the core of a person's life, the world in which he/she lives and how he/she perceives it. Dayton refers to the 'self' as our thoughts, concerns, dreams, fears and aspirations. The conclusion could therefore be drawn that the 'self' refers to 'what the person thinks of him/herself', 'how the person feels about him/herself' and what the person knows about him/herself'. The 'self' is also not static, but dynamic and therefore

changes. The researcher reasoned that if the treatment programme was effective, changes would have taken place in clients' relationships with the 'self'. The following questions were therefore included to determine if changes in the 'self' occured after treatment:

Table 6.6: Questions regarding the client's relationship with the 'self'

The client is more accepting of himself /herself.
There a positive change in the client's self-talk.
The client is more aware of his/her own ideas.
The client is more aware of his/her own emotions.
The client is more aware of his/her own attitudes.
The client is more aware of his/her own thoughts.

Likert Scale

The researcher made use of the *Likert scale* and the following five-point range was used by respondents to indicate their rank-order of agreement or disagreement during the completion of the quetionnaires: (1) SA = strongly agree; (2) A = agree; (3) U = undecided; (4) D = disagree; (5) SD = strongly disagree.

Cover letter

A cover letter were included by which respondents were provided with the purpose of the questionnaire, as well as clear and precise written directions and instructions on answering questions. Before the questionnaires were handed to the respondents the questionnaires were sent to the statitical department of UNISA to be reviewed by experts in the field.

6.7.2 Interviews (phase two)

During the second phase of the data collection process the researcher conducted one-to-one interviews with two of the therapists who took part in the study.

6.7.2.1 Selection of questions

During the construction of the questions for the interviews, the researcher made use of data obtained from the

treatment-questionnaires of phase one of the data-collection process.

Questions one to five

During the selection of the first five questions for the interviews, five cross-reference frequency tables were used as a guideline. It should be borne in mind that since the number of observations was very restricted, no statistical significant tests could be conducted. Indications of possible trends and tendencies can only be speculated, but deductions should be regarded as indications/guidelines/ possibilities. No statistical significance can, however, be attached to the results reported in this study. The indications identified below may be used to guide the type of questions to be used in the interview schedule, and if treated as 'possible indications', reported as research findings of the quantitative component of the research. The indications that are stated below, are treated as 'possible' indications, and are reported as research findings of the quantitative component of the research. The following frequency tables were uses:

Table 6.7: Substances still being taken

Frequency Row percentage	Client	Therapist
Yes	2 40.00	2 22.22
No	3 60.00	7 77.78
Total	5	9

Two clients and two therapists indicated the use of substances, while three clients and seven therapists indicated that there were no substance-use during treatment. The therapists seem to be more positive than the clients that substance abuse was reduced (2/5 = 0.40 for clients and 2/9 = 0.22 for therapists, for the ratio of 'yes, still using' to 'no, not using any more').

Question 1: The therapists seem to be more positive than the clients that substance abuse has reduced. Do you think that the therapists are more optimistic than the clients with regard to the reduction in substance abuse? Are clients more cautious to assume that addiction is 'cured'?

Table 6.8: Time-period free from substances

Frequency Row percentage	Client	Therapist
< less than 6 months	0 0.00	3 33.33
7-12 months	1 20.00	4 44.44
13-18 months	1 20.00	0 0.00
25 and more months	1 20.00	1 11.11
Total	3	8
Number unaccounted	2	1

Three therapists indicated that their clients had been free from substance use for a period of less than six months, one client and four therapists indicated that the client had been free from substance use for a period between seven to twelve months, one client indicated that he/she had been

free from substance use for a period between thirteen to eighteen months, while one client and one therapist indicated that the client had been free from substance use for a period of more that twenty five months. Two clients and one therapist did not answer the question. It seemed as though the majority of the clients were free from substance abuse for shorter periods of time, according to the therapists, and that the clients might perhaps perceive themselves to be free for longer periods of time. The deduction is based on the fact that all 7 the clients were perceived by the therapists to have been free of drugs for less than 12 months, whereas the clients themselves perceived them to be free for longer periods, namely all 3 indicated for periods of 12 months and more.

Question 2: It seems as though the majority of clients are free from substance abuse for shorter periods of time, according to therapists, and the clients may perceive themselves to be free from drugs for longer periods of time. Do you perceive the therapists to be more guarded with respect to the time period that clients can stay free of addictions than is perhaps perceived by the clients?

Table 6.9: The number of clients who had attended a rehabilitation centre

Frequency Row percentage	Client	Therapist
Yes	1 20.00	2 22.22
No	3 60.00	7 77.78
Total	4	9
Number unaccounted for	1	0

One client and two therapists indicated that the client has attended a rehabilitation centre before the implementation of the treatment programme, while three clients and seven therapists indicated that the client did not attend a rehabilitation centre prior to the implementation of the treatment programme. One client did not answer the question. The clients and the therapists both indicated that only a small proportion of the clients attended rehabilitation (approximately 0.25 in both the clients' and the therapists' views).

Question 3: The clients and the therapists both seem to indicate that only a small proportion of the clients attend rehabilitation. Apparently only a small number of addicted clients attend rehabilitation – why? Does rehabilitation focus on alcoholism, or do the clients feel that they do not need rehabilitation? Does the low proportion attending rehabilitation indicate that the clients negate their problem? Can/does the treatment programme address this?

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Table 6.10: Co-occurring disorders

Frequency Row percentage	Client	Therapist
Yes	3 60.00	2 40.00
No	1 20.00	5 83.33
Total	4	7
Number unaccounted for	1	2

Three clients and two therapists indicated the presence of co-occurring disorders, while one client and five therapists indicated that no co-occurring disorders were present during the implementation of the treatment programme. One client and two therapists did not answer the question

It seemed that the clients perceived other disorders to occur together with the addiction problems (ratio of 3/1=3), while the therapists did not seem to experience the same trend (ratio of 2/5 = 0.4).

Question 4: Apparently the clients perceive other disorders to occur with addiction problems, while therapists do not seem to experience the same trend. Why do you think therapists and clients have seemingly different notions of co-occurring disorders? Does the treatment programme address this possible discrepancy in perceptions? Does the treatment programme make provision for the treatment of other co-occurring disorders?

Table 6.11: How the treatment programme was experienced

Frequency Row percentage	Client	Therapist
Positively	4 80.00	9 100.00
Neutral feeling	1 20.00	0 0.00
Total	5	9

Four clients and nine therapists indicated their participation in the study as positive, while one client indicated his or her participation as neutral. The therapists and the clients all seemed to experience the treatment programme very positively.

Question 5: The therapists and clients all seem to experience part three of the treatment programme very positively. How did you experience part three of the treatment programme?

Questions six to twelve

The main aim of the empirical investigation was to determine the effectiveness of the treatment programme. To enable the researcher to determine the effectiveness of the treatment programme the satisfaction with the treatment programme, changes in the levels of self-actualization reached by clients and changes in the relationships of the clients with others and the 'self' have to be

investigated.Based on the above the following questions were included in the interviews:

Question 6: Part three of the treatment programme seems to be effective. Did you perceive part three of the treatment programme to be the main contributor to the successful recovery from addiction?

Question 7: The self-actualization and relationship scores of the clients who have overcome their addiction seemed a little less positive than the scores of those who have not. Does this conclusion make sense?

Question 8: The longer the time period that clients are free from substance abuse, the lower their self-actualization and their relationships. Does this make any sense?

Question 9: Part three of the treatment programme seems to be more effective for those persons who did not attend a rehabilitation institution. Is this true??

Question 10: With co-occurring disorders part three of the treatment programme is slightly less effective. Is this seemingly logical tendency realistic?

Question 11: Part three of the treatment programme seemed to be slightly less effective after the treatment programme was completed. Could such a seemingly contradictory finding be explained?

Question 12: Part three of the treatment programme seems to be most effective in 1-4 sessions. Would you agree that such a finding is probable?

6.7.2.2 Selection of respondents

The selection of the two therapists for the interviews was based on the differences in profession, work place and experience in the field of substance abuse. Interviews were conducted with the following two therapists:

Therapist one: The first therapist is a social worker with thirteen years' experience. For the past four years she has been employed at an out-patient rehabilitation centre. She treats clients with substance abuse addiction on a daily basis. Previously she was employed at Child Welfare for eight years, and at the Lowveld Association for Persons with Disabilities for a year.

Therapist two: The second therapist is an educational psychologist in private practice, and has been practicing for five years. She does not have any experience in the treatment of clients with substance abuse addiction.

6.8 ETHICAL CONSIDERATIONS

Different ethical considerations applied to therapists and clients.

6.8.1 Ethical considerations for therapists

The following ethical aspects applied to therapists during the implementation of the treatment programme.

Informed consent

Therapists that took part in the study provided consent regarding their own participation in the study per e-mail to the researcher.

During the training of the therapists the researcher indicated that therapists were to be guided by the ethical code of conduct, provided by the Health Professions Act, 1974 (Act No. 56 of 1974); the section *Rules of Conduct Pertaining to Psychology.* Appendix N provides the relevant guidelines of the act. Although therapists had to consider the whole act during the implementation of the treatment programme, special attention had to be paid to:

The cient's right to confidentiality: Therapists need to safeguard confidential information obtained in the course of research, subject only to the exceptions set forth as limits to confidentiality.

Written consent: Therapists could only disclose information obtained during the research after written informed consent was obtained from the clients that took part in the research.

Limits on intrusion on privacy: Therapists should only include information relevant to the purpose of the study to the researcher.

Disclosures: Therapists may disclose confidential information, with the permission of their clients, during the implementation of the treatment programme when they are mandated by law to do so or to protect a client or others from harm.

Disguising confidential information used for research purposes: Therapists should take reseanable steps to disguise personal identifiable information regading their client to the researcher.
Maintenance, dessemination and keeping of records: the keeping of records should allow for replication of the research design and analysis and ensure compliance with the law.

Minimise harm: should a therapist at any stage during the implementation of the treatment programme become aware that any of the procedures have harmed the client, such a therapist should take reasonable steps to minimise harm.

6.8.2 Ethical considerations for clients

At the training, therapists were provided with a letter of consent which their clients had to complete. It was emphasized by the researcher that each therapist should

discuss the ethical aspects applicable to the research with their own client before the commencement of therapy. The discussion should included:

Developmental nature of the treatment: Clients were informed that the treatment programme formed part of a doctoral study and that the aim of the implementation of the treatment programme will be to determine the effectiveness of the treatment programme.

Voluntary participation: Clients were informed that they are free to participate or to withdraw from the research at any stage. However, therapists need to explain the foresee-able consequences of withdrawing from the treatment programme from a therapeutical point of view, before the completion of the treatment programme.

Written consent: Written consent that information regarding the therapeutic sessions are made avaliable to the researcher were to be obtained from each client by the therapist.

Appendix M serves as an example of a consent form for clients. The therapists were requested to ask the clients to complete the consent form before the comencement of therapy.

6.9 RELIABILITY

It should be borne in mind that the number of observations in the empirical investigation of this study was very restricted – due to the restrictions which the field of study placed on the availability of the respondents, as well as the fact that the implementation of the treatment programme was very time consuming. The constructs in both questionnaires could therefore not be tested for reliability. The indications identified from the results of the completed questionnares were used to guide the type of questions that were used in the interview schedule, and it was treated as 'possible indications' and was reported as research findings of the quantitative component of the research. Had more observations been available, item analysis to evaluate the internal consistency of the three constructs/or aspects of the success of the treatment programme in overcoming addiction could first have been established (the calculation of the Cronbach alphas in the internal consistency reliability testing).

6.10 Validity

The following procedures were followed to ensure high levels of validity:

(a) Content validity

The satisfaction of respondents, the level of self-actualization reached, as well as changes in the relationship with the 'self' and the relationships with 'others' determined the effectiveness of the treatment programme. Questions regarding these constructs were therefore included in the two treatment questionnaires. Before the final decision regarding the content of the questionnaires, the researcher made use of peer review to ensure content validity.

(b) Construct validity

The selection of the constructs were based on the literature review, however to ensure construct validity the researcher made use of the opinions of experts in the field regarding these constructs, before the construction of the questionnaires and interviews. A thorough discusion on self-actualization, relationship with the 'self' and the relationships with others were included in the training of therapists. A lot of emphasis was placed on the above discussion to ensure the understanding of therapists regarding these constructs. Therapists were also requested to explain these constructs to their clients during the implementation of the treatment programme.

(c) Honesty of participants

During the training the researcher requested therapists to only include information relevant to the purpose of the study to the researcher. Reasonable steps to disguise any personal identifiable information regading the therapists and their client's were also taken during the collection of data. The above was done to ensure honesty of both therapists and clients during the completion of questionnares.

(d) *Participants approached*

Psychologists from the Lowveld Psychological Association were approached, due to the fact that the study is done within the field of psychology, the members of the association are all registered psychologists at the Healths Professions Council of South Africa and almost all the registered psychologists in Nelspruit and the surroundig areas are members of the association. SANCA's offices were contacted due to the fact that the social workers that are employed at SANCA, are knowleagable in the field of addiction and they are treating addicts on a regular basis.

(e) *Objectivity of the researcher*

Therapists indicated per e-mail that they were interested in participating in the study, while clients were selected by each therapist individually. The treatment programme was also implemented by each therapist at their own work place

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and the researcher was not involved in the implementation of the treatment programme. Data was obtained from the completed questionnaires. The above was done to ensure the objectivity of the researcher during the data collection process.

(g) *Sampling*

E-mails were send to psychologists from Nelspruit and the surrounding areas, as well as to social workers from SANCA's offices in Mpumalanga. Therapists that were willing and able to take part in the study responded per e-mail. The selection of the respondents were therefore not random, but there inclusion in the study was based on their willingness to participate.

The researcher was not able to take aspects like the training and experience of therapists into consideration in the selection of the sample. Counsellors, social workers, educational and clinical psychologists participated in the study. Due to the differences in their training, as well as in their work experience, their points of departure were different. These differences included aspects such as, for example, the terminology used, their knowledge of substance abuse, their treatment of clients with substance abuse disorders, and their knowledge in respect of the diagnosis and treatment of clients with co-occurring disorders. To try and adress the above, phases one and two were included in the training of the therapists to provide therapists with knowledge regarding substance use and

abuse (Chapter three), as well as the treatment of substance abuse (Chapter four).

6.11 LIMITATIONS

The following limitations are relevant to this study:

(a) Number of the observations

The number of observations during the empirical investigation was limited due to the restrictions which the field of study placed on the availability of the respondents. The implementation of the treatment programme was also time-consuming; not only did therapist have to attend a one day training session and treat clients on a regular basis, they also had to read up and prepare for each session and take part in the data-collection process. The above lead to the fact that some of therapists were reluctant to take part in the study. Due to the limited number of observants, no statistical significant tests could therefore be conducted. Some of the clients were reluctant to complete the treatment questionnaire for clients. The researcher is unsure what the reason for their reluctance was.

(b) *Social desirability*

Both therapists and clients were informed of the experimental nature of the treatment programme. They were also informed

that the purpose of the completion of the questionnaires were to determine the effectiveness of the treatment programme. The possibility that both therapists and clients may have had the desire to please the researcher by saying that the programme was experienced positively should be considered as a possible limitation to the study.

(c) *Differences between clients*

Very few control systems were put into place during the empirical investigation. The researcher was therefore not able to make comparisons between clients due to the big differences that existed between them. Examples of these differences are:

Differences regarding substance abuse: Some clients were off drugs for a relatively long period before treatment of phase three started, while others were off for less than six months, some were not using drugs while others were still on drugs and some attended rehabilitation while others did not.

Treatment programme: The number of sessions that were used to complete the programme differed vastly and some clients completed all the sessions while others only completed a few sessions.

Conditions of clients before the start of treatment: The researcher did not have benchmark information regarding the treatment of clients before the implementation of the

treatment programme for example co-occurring disorders, severity of addiction, coping skills, relationships etc.

6.12 CONCLUSION

Chapter six was a discussion of the research design that was implemented during the research and included explanations of the sampling methods and – procedures, research instruments, research procedures, ethical aspects, reliability, validity and limitations of the study. In the following chapter the results emanating from the data that were collected during the empirical investigation on the implementation of the treatment programme, will be discussed.

CHAPTER 7

THE RESULTS OF THE EMPIRICAL INVESTIGATION

7.1 INTRODUCTION

Based on information obtained from the literature research, a treatment programme that addresses the family of origin as a cause of addiction (phase three) was compiled by the researcher. After the treatment programme was compiled, invitations were sent to psychologists in Nelspruit, SANCA offices in Mpumalanga and a counsellor at a church, to attend a training session on the implementation of phase three of the treatment programme. Twenty therapists attended the training session, after which eleven therapists indicated that they would be able to implement phase three of the treatment plan. After a period of six months, nine therapists reported that they were able to implement phase three of the treatment programme.

The main aim of the empirical investigation was to determine the effectiveness of the treatment programme and to be able to do this, the researcher had to investigate

- satisfaction of the treatment programme by both therapists and clients;

- changes in the level of self-actualization reached after treatment;
- changes in the clients' relationships with others; and
- changes in the clients' relationships with the 'self'.

During the empirical investigation the data were collected in two phases. During phase one the data were collected by means of two questionnaires. One questionnaire was developed to obtain data from the clients of therapists who had attended the sessions of the treatment programme. A second questionnaire was developed to obtain data from the therapists who implemented the treatment programme. All nine the therapists who took part in the study completed the questionnaire, while only five of the nine clients completed the questionnaire. During the second phase of the data collection process the researcher conducted interviews with two of the therapists who took part in the research study.

It should be borne in mind that the number of observations in the empirical investigation of this study was very restricted – due to the restrictions which the field of study placed on the availability of the respondents. No statistical significant tests could therefore be conducted. Indications of possible trends and tendencies can only be speculated, but deductions should be regarded as indications/ guidelines/ possibilities. No statistical significance can, however, be attached to the results reported in this study. The indications obtained from the results are therefore treated as 'possible' indications, and are reported as

research findings of the quantitative component of the research.

Chapter seven will focus on the results obtained from the empirical investigation of the study. The discussion will be divided into three parts

- the results obtained from the quantitative investigation;
- the results obtained from the qualitative investigation; and
- a summary of the results from the empirical investigation.

7.2 RESULTS OF QUANTITATIVE INVESTIGATION

During phase one of the data collection process the researcher made use of two treatment-questionnaires to collect data. One questionnaire was completed by therapists and the other questionnaire by clients of therapists. The following section will provide a discussion of the results from the questionnaires and will be discussed under the following headings

- biographical information;
- satisfaction of the treatment programme;
- views on changes in self-actualization;
- views on changes regarding relationships with 'others'; and
- views on changes regarding the relationship with the 'self'

7.2.1 BIOGRAPHICAL INFORMATION

Biographical information was obtained from the two questionnaires that were completed by therapists and clients.

7.2.1.1 Therapists

The following data were obtained from the questionnare for therapists:

Profession: One counsellor, five social workers, one clinical psychologist and two educational psychologists took part in the study.

Work place: Of the therapists who participated in the study, three worked in private practice, one at a hospital, one at a church, five at an out-patient rehabilitation centre, and three at an in-patient rehabilitation centre. It is important to note that the question on workplace was formulated as a multiple response question; the same therapist could be employed at two institutions at the same time, for example, at a hospital, and in private practice.

Working at institutions that only treat substance abuse: Five of the therapists work at institutions that only treat substance abuse and have been employed at these

institutions between one to three years. The other four do not work at institutions that only treat substance abuse.

Experience as a therapist: Five therapists have been practising between one and five years, two between six and ten years, one has been practising between sixteen and twenty years, and one for more than twenty years.

Experience in working with clients suffering from substance abuse: In a year four therapists treated clients with substance abuse problems on a regular basis, one often treated these clients, three seldom treated these clients, and one therapist has never treated a client with substance abuse problems.

The following data concerning the training and the implementation of the treatment programme were receive from the data of the treatment questionnaire for therapists:

The number of therapists who received training: All nine the therapists who took part in the study received training before the implementation of the treatment programme.

The number of therapists that believed training was necessary: All nine the therapists believed that training was necessary before the implementation of the treatment programme.

The number of therapists who were able to implement the treatment programme: All nine the therapists were able to implement the treatment programme at their workplace.

The number of therapists that will use the treatment programme in future: All nine therapists will use the treatment programme in future. Eight of the therapists will use the treatment programme when they deal with aspects other than substance abuse in treatment, and not only for the treatment of addiction. One therapist did not answer the question.

7.2.1.2 Clients

The second questionnaire was developed to obtain data from the clients of the therapists, who had attended the sessions of the treatment programme. The following biographical information were obtained from the clients who completed questionnaires:

Gender: One male respondent and four female respondents completed the questionnaire.

Age: One respondents was between the ages of twenty-two to twenty-seven, one between thirty-four to thirty-nine and four clients were older than forty years of age.

The following data regarding substance use and abuse were obtained from clients:

Continued use of substances: Two clients indicated the use of substances during the implementation of phase three of the treatment programme, while three clients indicated that

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there were no substance-use during the implementation of the treatment programme.

Time-period free from substances: One client that he/she had been free from substance use for a period between seven to twelve months. One client indicated that he/she had been free from substance use for a period between thirteen to eighteen months, while one client indicated that the he/she had been free from substance use for a period of more that twenty five months.Two clients did not answer the question.

The number of clients who had attended a rehabilitation centre: One client indicated that they did attend a rehabilitation centre before the implementation of the treatment programme. Three clients indicated that they did not attend a rehabilitation centre before the implementation of the treatment programme. One client did not answer the question.

Co-occurring disorders: Three clients indicated the presence of co-occurring disorders, while one client indicated that no co-occurring disorders were present during the implementation of the treatment programme. One client did not answer the question.

7.2.2 SATISFACTION WITH THE TREATMENT PROGRAMME

The following were the views of therapists and clients regarding the satisfaction of the treatment programme:

7.2.2.1 The view of therapists

The researcher reasoned that the future use of the treatment programme could be an indication of therapists' satisfaction with the programme. All the therapists who took part in the study indicated that they will use the treatment programme in future. The conclusion could therefore be made that the therapists were satisfied with the treatment programme.

7.2.2.2 The view of clients

The researcher reasoned that if clients had a better understanding of themselves after treatment, they will be satisfied with the treatment programme. On completion of treatment 80% of clients indicated that they have a better understanding of themselves. The conclusion could therefore be made that clients were satisfied with the treatment programme.

The researcher reasoned that the satisfaction of clients regarding the treatment programme could be determined by their view on if they benefitted from treatment. After

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treatment 80% of clients indicated that they benefit from the treatment programme. The conclusion could therefore be made that clients were satisfied with the programme.

The researcher reasoned that the outcomes of the different exercises of the treatment programme could determine the satisfaction of clients regarding the treatment programme. If clients were able to achieve the aims of the different exercises it could be argued that they were satisfied with the programme. Table 7.1 presents the views of clients regarding the outcomes of the different excercises of the treatment programme:

Table 7.1: Clients' views regarding the excercises of the treatment programme

Excercises	% Agree	% Unsure	% Disagree	% Total
Relax in relaxing-exercises	80	20	0	100
Different un/healthy family system	80	20	0	100
Identity guilt aspects	80	20	0	100
Name guilt feelings	100	0	0	100
Release guilt feelings	100	0	0	100
Different guilt and shame	80	20	0	100
Identify obsessive compulsive behaviour	100	0	0	100
Set healthy boundaries	100	0	0	100
Boundary-setting improved	100	0	0	100
Anger release as child	80	20	0	100
Identify childhood anger objects	100	40	0	100
Release childhood anger	60	40	0	100
Identify adult anger	80	20	0	100
Release child and adult anger	80	20	0	100
Identify parental beliefs and rules	80	20	0	100
Identify messages in childhood	80	20	0	100
Cope frozen emotions	80	20	0	100
Identify childhood losses	80	20	0	100
Grieved childhood losses	60	40	0	100
Able to forgive	80	20	0	100
n = 5				

It was interesting to take note of the fact that all the questions were answered by all the clients. One could reason that clients understood the different aspects that were addressed in the exercises of the treatment programme. It is also noted that none of the clients disagreed with any of the questions. One could therefore argue that clients benefit from the excercises and were therefore satisfied with the content, as well as the implementation of the excercises during treatment. A discussion of clients' views regarding the different excercises will follow:

Relaxation: After treatment 80 % of clients indicated that they were able to relax during the relaxation excercises.

Differences between a healthy- and a dysfunctional family system: On completion of the treatment programme 80% of clients indicated that they understood the difference between a healthy and a dysfunctional family system. It could therefore be concluded that the insight gained by clients will enable them to heal from the hurts of the past.

Guilt: After treatment 80% of clients reported that they were able to identify guilt feelings, 100% were able to name their guilt feelings and 100% experience a release from their guilt feelings. It could be concluded that the guilt feelings of clients were addressed by the treatment programme and that clients experienced a certain degree of release regarding their guilt feelings during treatment.

Whitfield (2006:44) is of the opinion that individuals who grew up in dysfunctional homes often possess a mixture of 'healthy' and 'unhealthy' guilt. He further states (2006:44) that 'unhealthy' guilt in dysfunctional family systems are usually not handled or worked through, but lingers on. Black (2001:128) indicates that adults who grew up in dysfunctional families have the tendency to accept all the guilt; and she states that this is a pattern that needs to be broken. The fact that 80% of clients were able to identify guilt feelings during treatment confirmed the above beliefs of both Whitfield and Black.

According to Whitfield (2006:44), guilt can be relieved by recognizing its presence and by working it through in a therapeutical session. This belief of Witfield was confirmed by the fact that 100% of clients were able to name their guilt feelings and experience release from it, during treatment.

Shame: On completion of the treatment programme 80% of clients indicated that they understood the difference between shame and guilt, 100% of clients were able to identify the presence of obsessive compulsion in their lives and 100% of clients indicated that they gained insight into the importance of boundaries, as well as that their skills to set boundaries have improved.

According to Beattie (1989:105), shame can prevent an individual from setting boundaries in his/her own life. The fact that 100% clients indicated that their skills to set

boundaries have improved could be an indication that shame was effectively addressed during the treatment programme.

Anger: On completion of treatment 80% of clients were able to determine what they did to express their anger as children; 80% of clients were able to identify what cause their anger as adults, but only 60% were able to identify the things that angered them as children, 80% of clients were able to experience some release from the anger that they experienced as adults, but only 60% were able to experience release from their childhood anger.

It is noted that only 60% of clients were able to identify and experience release from their childhood anger. It therefore appears that it is more difficult for clients to deal with anger from childhood. Alexander (2009:38) believes that anger is the most difficult emotion to own and process well. Alexander (2009:38,39) also states that one of the complications attached to anger is that many clients have been taught to repress their anger. They are hardly aware of the fact that they are angry, and have difficulty being able to admit it. The findings of the empirical investigation with relevance to childhood anger is confirmed by the beliefs of Alexander.

Frozen emotions: On completion of treatment 80% of clients were able to deal with their frozen emotions. Dayton (2007:11) is of the opinion that the frozenness of childhood memories will wear off in the safety of a therapeutic environment. This will allow the client to process the

feelings that he or she was never able to do. It will also enable the client to witness the events through the eyes of an adult, and will therefore lead to insight and understanding. The opinion of Dayton was confirmed by the fact that 80% of clients were able to deal with their frozen childhood experiences.

Beliefs, rules and messages: On completion of treatment 80% of clients were able to identify the beliefs and rules of their family of origin and 80% of clients were able to identify messages from their childhood.

Grieve: On completion of treatment 80% of clients were able to identify there losses, but only 60% of clients were able to grieve their childhood losses. Whitfield (2006:86) states that children who grew up in dysfunctional families suffer numerous losses over which they are often unable to grieve in a complete way. The negative messages that they get when they grieve, set up a major block, for example, "Do not feel" or "Do not talk about it". According to Dayton (2007:188), people are often afraid to give in to grief, because they fear they will never emerge. The above could explains could explain the fact that although 80% of clients were able to identify their childhood losses, only 60% were able to grieve their losses.

Forgiveness: On completion of treatment 80% of clients were able to forgive.

The conclusion could therefore be made that with the exception of the exercises on anger and grieve, between 80% to 100% of clients were able to achieve the outcomes of the exercises of the treatment programme. The conclusion could therefore be made that clients were satisfied with the treatment programme.

7.2.2.3 Conclusion

With regard to the above discussion, the conclusion could be made that both therapists and clients were satisfied with the treatment programme.

7.2.3 VIEWS ON CHANGES IN SELF-ACTUALIZATION

The researcher wanted to investigated changes that occured in the levels of self-actualization reached by clients after treatment. The views of therapists and clients regarding the changes that occured in self-actualization will be discussed in the section below:

7.2.3.1 The view of therapists

A general view

Therapists were asked if clients have reached self-actualization after the implementation of the treatment

programme. Table 7.2 contains the results regarding this question:

Table 7.2: Was self-actualization reached? (therapists)

	Frequency	Percent	Cumulative frequency	Cumulative percentage
Agree++	8	88.89	8	88.89
Agree	1	11.11	9	100.00

On completion of treatment 100% of therapists agreed that self-actualization was reached by clients.

A more detailed view

The following section will include a more detailed discussion of the significant changes in the different levels of self-actualization reached by the clients after treatment. As was mentioned earlier the characteristics of Vrey, Maslow and Frankl were used as a guideline to determine the level of self-actualization reached. Table 7.3 presents the results about the views of therapists regarding the level of self-actualization that was reached:

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TABLE 7.3: The view of thrapists regarding the level of self-actualization that was reached

Characteristics of self-actualization	% Agree	% Unsure	% Disagree	% Total
Physical health improved	67	22	0	89
Setting of realistic goals improved	100	0	0	100
Accepts him/herself more readily	89	11	0	100
More accepting of others	100	0	0	100
More accepting of the aspects of life	78	22	0	100
Realistic as regards limitations/ strengths	100	0	0	100
Understands who he/she is	100	0	0	100
More other-orientated	67	33	0	100
Realistic towards life	89	11	0	100
More spontaneous	89	0	0	89
Focuses on problem solving	78	22	0	100
Needs privacy	33	33	22	88
More detached from others	78	0	11	100
Functions independently	89	0	11	100
Less stereotype appreciation	78	0	11	89
Improved spiritual life	89	11	0	100
More intimate relationships	78	11	11	100
More democratic values	89	11	0	100
Separates means from ends	89	11	0	100
A sense of humour	89	0	0	89
More creative	78	11	0	89
Rises above the environment	89	11	0	100
Functions on his/her own	78	22	0	100
No need for substances	78	11	11	100
No addiction as coping mechanism	78	11	11	100
n = 9				

On completion of the treatment programme between 89% to 100% of therapists agreed that there has been an improvement regarding the following characteristics of their clients:

*Ability to set realistic goals (*Maslow - self-actualizers see reality as it is, and accepts responsibility for it).

*Acceptance of him/herself (*Vrey - self-actualizers have realistic views of themselves and accept themselves as they are).

*Acceptance of others (*Maslow - self-actualizers are aware of and sensitive to the people around them).

*Acceptance of his/her limitations and strengths (*Vrey - self-actualizers accept their inabilities and their limited abilities do not influence their self-concepts in a negative way).

*Understanding of who he/she is (*Maslow - self-actualizers believe in themselves, and in who and what they are).

*Realistic view of life (*Maslow - self-actualized individuals exhibit more realistic perceptions of reality. They accept the good and the bad, the highs and the lows, and are able of telling the difference).

*Spontaneity (*Maslow - self-actualizers exhibit spontaneity, simplicity and naturalness).

*Ability to function more independently (*Maslow - self-actualizers are capable of doing things, and can make decisions on their own).

*Spirituality (*Maslow - self-actualizers have a history of peak experiences which are profoundly spiritual, and which may be mystical or religious).

*Democratic values (*Maslow - self-actualizers believe in the equality of all human beings, that every person has a right to his/her opinion, and that each person has his strengths, but also his weaknesses).

*Ability to separate means from ends (*Maslow - self-actualizers know the difference between means and ends, and between good and evil. They also do not twist these in a way that may hurt themselves or others).

*Sense of humour (*Maslow - self-actualizers enjoy humour. They like to laugh and joke, but not at the expense of others).

Ability to rise above the environment rather than merely adjusting to it (Maslow - self-actualizers maintain a strong individuality. They are not so absorbed that they cannot evaluate, for example, their culture objectively, so that they can make decisions about what is best for them and for those whom they care about; Vrey - self-actualizers are able to focus their energy on problems and circumstances outside themselves.

On completion of the treatment programme between 11% to 22% of therapists disagreed that there have been improvements in their client's,

- need for privacy;
- ability to function independently;
- stereotypical appreciation of people, things and ideas;
- number of intimate relationships;
- ability to not need substances; and
- ability to not use substances as a coping mechanism.

On completion of treatment between 80% to 100% of therapists agreed that there have been improvements in the level of self-actualization reached in thirteen of the twenty-five questions regarding self-actualization that were included in the questionnaire. Between 11% to 22% of therapists disagreed that there have been improvements shown in six of the twenty-five questions. It could therefore be concluded that therapists agreed that there was an improvement in self-actualization on completion of treatment.

7.2.3.2 The view of clients

Table 7.4 presents the results of the views of clients regarding the levels of self-actualization that were reached after treatment:

TABLE 7.4: The view of clients regarding the level of self-actualization that was reached

Characteristics of self-actualization	% Agree	% Uncertain	% Disagree	% Total
Physical health improved	60	40	0	100
Setting of realistic goals improved	100	0	0	100
Accepts him/herself more readily	100	0	0	100
More accepting of others	80	20	0	100
More accepting of the aspects of life	40	40	20	100
Realistic as regards limitations/ strengths	80	20	0	100
Understands who he/she is	100	0	0	100
More other-orientated	80	0	0	80
Realistic towards life	100	0	0	100
More spontaneous	80	20	0	100
Focuses on problem solving	80	20	0	100
Needs privacy	80	0	20	100
More detached from others	60	0	20	80
Functions independently	80	0	0	80
Less stereotype appreciation	0	0	0	0
Improved spiritual life	100	0	0	100
More intimate relationships	60	20	20	100
More democratic values	0	0	0	0
Separates means from ends	60	20	0	80
A sense of humour	80	0	20	100
More creative	80	20	0	100
Rises above the environment	80	20	0	100
Functions on his/her own	80	20	0	100
No need for substances	40	40	20	100
No addiction as coping mechanism	60	20	20	100
n = 5				

On completion of the treatment programme between 80% to 100% of clients agreed that their has been an improvement in his/her:

*Ability to set realistic goals (*Maslow - self-actualizers see reality as it is, and accepts responsibility for it).

Acceptance of him/herself (Vrey - self-actualizers have realistic views of themselves; Maslow - self-actualizers see reality as it is, and accepts responsibility for it. They are as objective as a subjective being can be in their perceptions).

*Acceptance of his/her own limitations and strengths (*Vrey - self-actualizers accept themselves as they are and their inabilities and limited abilities do not influence their self-concept in a negative way).

*Understanding of who he/she is (*Maslow - self-actualizers believe in themselves, and in who and what they are).

*Orientation towards others (*Vrey - self-actualizers is not only involved in their own life, but also in the lives of the people who make up part of their life-world).

Realistic view towards life (Maslow - self-actualized individuals exhibit more realistic perceptions of reality, and are more comfortable with them. They accept the good and the bad, the highs and the lows, and are able of telling the difference).

*Spontaneity (*Maslow - self-actualizers exhibit spontaneity, simplicity and naturalness).

*Ability to focus more on solving a problem rather than merely thinking about the problem (*Maslow - self-actualizers focus on solving problems rather than on merely thinking about them).

*Need for privacy (*Maslow - self-actualizing individuals need to be alone, and need solitude. They enjoy times of quiet reflection, and do not always need people around them).

*Ability to function independently (*Maslow- self-actualizers are capable of doing things, and can make decisions on their own).

*Spiritual life (*Maslow - self-actualizers have peak experiences which are profoundly spiritual, and which may be mystical or religious).

Sense of humour (Maslow - self-actualizers enjoy humour. They like to laugh and joke, but not at the expense of others).

Creativity (Maslow - self-actualizers are often highly creative, and their creativeness can be expressed in many dimensions).

*Ability to raise above the environment rather than merely adjusting to it (*Maslow - self-actualizers maintain a strong

individuality. They are not so absorbed that they cannot evaluate, for example, their culture objectively, so that they can make decisions about what is best for them and for those whom they care about; Vrey - self-actualizers are able to focus their energy on problems and circumstances outside themselves).

Ability to function on his/her own (Maslow - self-actualizers are capable of doing things, and can make decisions on their own).

On completion of the treatment programme 20% of clients disagreed that there have been an improvement in their

- acceptance of the aspects of life;
- need for privacy;
- detachment to others;
- number of intimate relationships;
- sense of humour;
- ability to not need substances;
- ability to not use substances as a coping mechanism.

Two of the questiones were left unanswered by all the respondents. It could be argued that the concepts 'stereotyped' and 'democratic values', that were included in these questions, were not understood by the respondents.

On completion of treatment between 80% to 100% of clients agreed that there have been an improvement in the level of self-actualization reached in fithteen of the twenty-five

questions that were included in the questionnaire. While 20% of clients disagreed that changes occured in seven of the twenty five questions. It could therefore be concluded that clients agreed that there was an improvement in self-actualization on completion of treatment.

7.2.3.3 Conclusion

With regard to the above discussion, the conclusion could be made that both therapists and clients agreed that there was an improvement in the self-actualization of clients on completion of treatment.

7.2.4 VIEWS ON CHANGES IN THE RELATIONSHIPS WITH 'OTHERS'

One of the aims of the relations theory is to assist clients to establish positive, reliable and efficient relationships with God, other people, objects and ideas in their life worlds. The study focused on the family of origin as a cause of addiction and the relationships with 'others' will therefore refer to the relationship of the client with the members of his/her family of origin, God, objects, thoughts and ideas.

The researcher is of the opinion that their exists a correlation between a dysfunctional family system and addiction. A dysfunctional family system can be seen as a system that hurts the people in it. For clients to heal, they

first need to gain insight into their relationship with 'others'. The insight that clients gain often leads to changes in relationships. The researcher therefore argued that the changes in the clients relationships after treatment could be used as an indicator to determine the effectiveness of the treatment programme. The views of therapists and clients regarding the changes that occured after treatment with regard to the clients relationships with 'others' will be discussed in the section below:

7.2.4.1 The view of therapists

Table 7.5 presents the results of therapists' views regarding the changes in their clients' relationships with 'others' after treatment.

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Table 7.5: **The view of therapists regarding the changes in the relationships with 'others'**

Relationship with 'others'	**% Agree**	**% Uncertain**	**% Disagree**	**% Total**
Insight into relationship with mother	89	11	0	100
Change in relationship with mother	56	11	11	78
Insight into relationship with father	67	11	22	100.0
Change in relationship with father	33	56	11	100.0
Insight into relationship(s) with sibling(s)	89	11	0	100.0
Change in relationship(s) with sibling(s)	56	44	0	100.0
Insight into relationships with objects	78	22	0	100.0
Changes in relationships with objects	78	22	0	100.0
Changes regarding ideas in life	100	0	0	100.0
Changes in relationship with God **n = 9**	89	11	0	100.0

Insight after treatment

After treatment between 78% to 100% of therapists indicated that their clients have gained insight into their relationships with their mothers, siblings and objects. According to therapists 67% gained insight into their relationship with their father, while 56% gained insight into

their relationship with their siblings. It should be noted that 22% of clients disagreed that they gained insight into their relationship with their fathers. It could therefore be concluded that according to therapists, clients gained insight into their relationships with others after treatment.

Changes after treatment

According to therapists between 56% to 100% of clients experienced changes in their relationships with their mothers, siblings, objects, ideas and God, while only 33% of clients experience changes in their relationships with their fathers. It should be noted that 56% of clients were uncertain of changes in their relationships with their fathers and 44% of clients were uncertain of changes in their relationships with their siblings. The fact that not all the therapists answered the question regarding changes in the clients relationship with their mothers should also be noted. Based on the above the conclusion could be made that according to therapists changes occurred in clients' relationships with others after treatment.

7.2.4.2 The view of clients

Table 7.6 presents the results of clients' views regarding the changes in their clients relationships with 'others' after the implementation of the treatment programme.

Table 7.6: The view of clients regarding the changes in the relationships with 'others'

Relationship with 'others'	% Agree	% Uncertain	% Disagree	% Total
Insight in mother relationship	80	20	0	100
Mother-relationship changed	60	0	20	80
Insight in father relationship	80	20	0	100
Father-relationship changed	60	40	0	100
Insight in sibling(s) relationship	100	0	0	100
Sibling(s)-relationship changed	60	20	20	100
Insight in relationship with objects	60	20	0	80
Object-relationship changed	60	20	0	80
Ideas in life changed	100	0	0	100
Relationship with God changed	100	0	0	100
n = 5				

Insight after treatment

Between 60% to a 100% reported that they gained insight into their relationships with their mothers, fathers, siblings and objects. It could be concluded that clients gained insight into their relationships with others after treatment.

Changes after treatment

Between 60% to 100% of clients indicated changes in their relationships with their mothers, fathers, siblings, ideas and God. It should be noted that 40% of clients reported that they are uncertain about changes in their relationships with their fathers and 20% of clients disagreed that changes occurred in their relationships with their mothers. Based on the above it could be concluded that according to clients changes occurred in their relationships with others after treatment.

7.2.4.3 Conclusion

Both therapists and clients agreed that changes occurred in clients' relationships with others after treatment. The following regarding clients relationships with their fathers should be noted,

- 33% of therapists reported changes;
- 60% of clients reported changes;
- 56% of therapists were uncertain about changes;
- 40% of clients were uncertain about changes; and
- 11% of therapists disagreed that changes occurred.

7.2.5 VIEWS ON RELATIONSHIPS WITH 'SELF'

The researcher wanted to investigated change that occurred in the relationships with 'self', after the implementation of

the treatment programme. The views of therapists and clients regarding the changes that occurred with regard to the relationships with 'self' will be discussed in the section below:

7.2.5.1 The view of therapists

Table 7.7 presents the results of therapists' views regarding the changes in their clients' relationships with 'self' after treatment.

Table 7.7: The view of therapists regarding the changes in the relationships with 'self'

Relationship with 'self'	% Agree	% Uncertain	% Total
Accepting of the 'self'	100	0	100.0
Self-talk more positive	100	0	100.0
Aware of own ideas	100	0	100.0
Aware of own emotions	100	0	100.0
Aware of own attitude	100	0	100.0
Aware of own thoughts	100	0	100.0

According to all the therapists changes ocurred in clients' acceptance of themselves, self-talk, awareness of own ideas, emotions, attitudes and thoughts, after treatment. It could therefore be concluded that changes in the relationship with the self occurred after treatment.

7.2.5.2 The view of clients

Table 7.8 presents the results of clients' views regarding the changes with 'self' after the implementation of the treatment programme.

Table 7.8: The view of clients regarding the changes in the relationships with 'self'

Relationship with 'self'	% Agree	% Uncertain	% Total
Accepting of the 'self'	100	0	100
Self-talk more positive	80	20	100
Aware of own ideas	80	0	80
Aware of own emotions	80	0	80
Aware of own attitude	100	0	100
Aware of own thoughts	100	0	100

After treatment between 80% to 100% of clients reported changes in their acceptance of themselves, self-talk, awareness of their own ideas, emotions, attitudes and thoughts. It could therefore be concluded that changes in the relationship with 'self' occurred after treatment.

7.2.5.3 Conclusion

Both therapists and clients agreed that changes occurred in all the aspects that were investigated regarding the relationship with the 'self. The conclusion could therefore be made that according to both therapists and clients changes have occurred in the relationship with the 'self', after treatment.

7.2.6 Summary of results from quantative investigation

With regard to the results of the quantitative investigation, it can be concluded that,

- both therapists and clients were satisfied with the treatment programme;
- both therapists and clients agreed that there was an improvement in self-actualization after treatment;
- both therapists and clients agreed that changes occurred in clients' relationships with others after treatment; and
- both therapists and clients agreed that changes have occurred in the relationship with the 'self', after treatment.

7.3 RESULTS OF QUALITATIVE INVESTIGATION

During phase two of the data collection process the researcher made use of interviews. The indications that have been identified from the results of the questionnaires were used to guide the type of questions that were used during the interviews.

7.3.1 THE INTERVIEWS

The following section will provide the questions asked and answers obtained from the therapists during the interviews.

Question 1

The therapists seem to be more positive than the clients that substance abuse has reduced. Do you think that the therapists are more optimistic than the clients with regard to the reduction in substance abuse? Are clients more cautious to assume that addiction is 'cured'?

Therapist one:

"I was very positive right from the beginning of the implementation of the treatment programme. My client was cautious in the beginning, but became more positive as the programme continued. In general, I would say that the therapists need to be very positive for the sake of the client, in order to motivate the client to go through the whole process of stopping and maintaining abstinence. Clients know that they must stop, but the road to recovery is scary and uncertain. Although they are motivated, they do not know how to achieve abstinence."

Therapist two:

"I agree that the therapists are more positive than the clients. The clients often find a replacement that is more socially acceptable. My client, for example, stopped her alcohol abuse, but started smoking."

Question 2

It seems as though the majority of clients are free from substance abuse for shorter periods of time, according to therapists, and the clients may perceive themselves to be free from drugs for longer periods of time. Do you perceive the therapists to be more guarded with respect to the time period that clients can stay free of addictions than is perhaps perceived by the clients?

Therapist one:

"I believe that the perception of 'free from substances' differs between the therapists and the clients. The therapists see 'free' as total abstinence, while clients see themselves as 'free' even though they may have taken a drink or two per occasion, or they may switch to another drug, like prescribed medication. The clients do not realize that switching to another type of substance still amounts to the same problem. Even though the clients often learn in therapy about the dangers of switching, they still see themselves as being 'free' for a certain time which, in fact, differs from the perception of the therapist. I think denial from the client's side is definitely one of the reasons for the different perceptions between the clients and the therapists."

Therapist two:

"The therapists are more objective. The clients will boost themselves to feel more empowered. It gives the clients more confidence to say that they are 'free' for a certain period of time. The therapists focus more on the actual time the clients are 'free'. I also do not know whether the clients are always honest with the therapists."

Question 3

The clients and the therapists both seem to indicate that only a small proportion of the clients attend rehabilitation. Apparently only a small number of addicted clients attend rehabilitation – why? Does rehabilitation focus on alcoholism, or do the clients feel that they do not need rehabilitation? Does the low proportion attending rehabilitation indicate that the clients negate their problem? Can/does the treatment programme address this?

Therapist one:

"I agree that only a small number of clients attend rehabilitation. Most people do not realize that they have an addiction problem and that they need help. The negative stigma about rehabilitation … and people could be scared to go to rehabilitation…..rehabilitation is also very expensive. People also want quick solutions. The clients are uninformed; many abuse alcohol, and are not aware that they have a problem. Ignorance…..lack of knowledge. The treatment programme can definitely address this. My client did not go to rehabilitation, but the treatment programme motivated her to go."

Therapist two:

"The clients are not willing to attend the rehabilitation sessions; they have not made the necessary mind-shift. The clients are also not prepared to deal with their addiction; they cannot help themselves and are stuck with the problem. The treatment programme can address this. It gives the clients the opportunity to talk about their addiction."

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Question 4

Apparently the clients perceive other disorders to occur with addiction problems, while therapists do not seem to experience the same trend. Why do you think therapists and clients have seemingly different notions of co-occurring disorders? Does the treatment programme address this possible discrepancy in perceptions? Does the treatment programme make provision for the treatment of other co-occurring disorders?

Therapist one:

"It is easier for a client to admit that he/she has depression than to admit that he or she is an addict. There is a stigma to addiction. It can also be that the therapists treating addiction are not trained to recognize co-occurring disorders. It can also be that the symptoms of addiction are often the same as for co-occurring disorders. Sometimes it is difficult for the therapist to determine what is the primary cause of the client's behaviour."

Therapist two:

"Clients often use co-occurring disorders as an excuse for their addiction. It gives them an excuse to continue with their addiction even if they have an underlying co-occurring disorder."

Question 5

The therapists and clients all seem to experience part three of the treatment programme very positively. How did you experience part three of the treatment programme?

Therapist one:

"Of great value. I enjoyed the structured format. My client previously went through a lot of therapy. It was the first time that she went through a structured process, and she benefited a great deal from it. With other psychologists she just sat and sometimes talked without working towards an outcome or a goal."

Therapist two:

"Very thorough, addressing all the problem areas. It forced the client to go back and address all the possible causes of addiction or the underlying problems….provided good guidelines."

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Question 6

Part three of the treatment programme seems to be effective. Did you perceive part three of the treatment programme to be the main contributor to the successful recovery from addiction?

Therapist one:

"It should form part of other therapeutical processes."

Therapist two:

"Fifty percent was due to the client's willingness, and fifty percent due to the treatment programme."

Question 7

The self-actualization and relationship scores of the clients who have overcome their addiction seemed a little less positive than the scores of those who have not. Does this conclusion make sense?

Therapist one:

"It could be true. Persons in the early stages of recovery normally undergo many positive changes. As a result, they stop their abuse. Then it seems as if they experience many positive and drastic results within themselves."

Therapist two:

"Denial influences the results. A client that is still abusing will boost him/herself. The clients who are free from addiction are more aware of the consequences of their actions and will be more realistic regarding their addiction."

Question 8

The longer the time period that clients are free from substance abuse, the lower their self-actualization and their relationships. Does this make any sense?

Therapist one:

"In practice it is not always the case. Initially there is a lot of support from the support system, but when long-term recovery is reached, the support system forgets that the client still needs to fight the addiction every day."

Therapist two:

"I am unsure, and think that it will depend on the client's support system. The support system, close relatives and the acceptance of the community all have a bigger influence than the time that the client is free from the substances."

Question 9

Part three of the treatment programme seems to be more effective for those persons who did not attend a rehabilitation institution. Is this true??

Therapist one:

"I do not agree. The persons who had attended rehabilitation before will benefit from the treatment."

Therapist two:

"I do not agree. The treatment programme ought to be more effective for those clients who attended rehabilitation. The fact that they attended rehabilitation indicates that they are motivated to work on their addiction…big need to talk."

Question 10

With co-occurring disorders part three of the treatment programme is slightly less effective. Is this seemingly logical tendency realistic?

Therapist one:

"I am unsure. I feel that all people will benefit from the content of the treatment programme, regardless of whether they have a co-occurring disorder. I feel that the clients become aware of personal aspects and how to deal with their emotions."

Therapist two:

"If it is an untreated co-occurring disorder the treatment programme will be less effective ……also if the client does not have effective coping skills in place."

Question 11

Part three of the treatment programme seemed to be slightly less effective after the treatment programme was completed. Could such a seemingly contradictory finding be explained?

Therapist one:

"The first part of the treatment programme contains very valuable information. It provides a lot of insight to the clients."

Therapist two:

"The fact that the clients know the number of sessions beforehand may affect the last part of the treatment programme. After-care should also be provided….not in a group-therapy session, but in activities like art or pottery classes…the clients have a big need to talk, and for a safe place where they can receive support."

Question 12

Part three of the treatment programme seems to be most effective in 1-4 sessions. Would you agree that such a finding is probable?

Therapist one:

"The first four sessions were of great value."

Therapist two:

"The immediate or underlying problems are addressed in the first four sessions, and the client is still vulnerable and willing to explore possibilities and to work on the underlying problems."

7.3.2 Conclusion

Both respondents agreed that therapists were more positive than clients that substance abuse can be reduced. The one respondent was of the opinion that this is due to the fact that the therapists need to motivate the clients, while the clients were uncertain and scared, and did not know how to attain abstinence. The second respondent mentioned that the clients often find a replacement for their substance abuse.

Both respondents agreed that the therapists were more guarded with respect to the time period that clients can stay free from addiction, than perceived by the clients. The one respondent ascribed this to the fact that the therapists view 'free' as total abstinence, while the clients allowed themselves some abuse and still considered themselves 'free'. The other respondent indicated that the clients tell themselves that they are 'free' in order to feel empowered.

Both respondents agreed that only a small number of the clients attended the rehabilitation centres. The one respondent ascribed this to the fact that most individuals with an addiction problem do not realize that they have a problem, that there is a stigma attached to rehabilitation centres, and that the clients want quick solutions. The second respondent indicated that many people are not prepared to deal with their addiction.

Both respondents agreed that the treatment programme can address the problem that only a small number of clients go for rehabilitation.

Both respondents agreed that the therapists and the clients have different opinions on co-occurring disorders. Both respondents indicated that it was socially more acceptable for a client to admit that he/she suffers from a co-occurring disorder, than to admit that he or she is addicted. The one respondent was also of the opinion that the therapists are not always trained in diagnosing the symptoms of co-occurring disorders.

Both respondents experienced the treatment programme positively. The one respondent regarded the programme as valuable, and appreciated its structured format, while the other respondent regarded the treatment programme as thorough, and believed that it addressed the causes of addiction. Although both respondents experienced the treatment programme positively, both of them did not consider the treatment programme as the only contributor to the successful recovery of addiction. The one respondent mentioned that the treatment programme should form part of other therapeutic processes, and the other respondent said that 50% of the success was due to the client's willingness to cooperate, and 50% was due to the treatment programme.

Both respondents agreed that the self-actualization and relationship scores of the clients who have overcome their addiction may be less positive than those of the clients who

have not. The first respondent ascribed this to the fact that the clients, in the early stages of recovery, normally undergo many positive changes as a result of the fact that they have stopped their abuse. The second respondent agreed with this opinion, and stated that clients who are free from addiction will be more aware of the consequences of their addiction, and will therefore be more realistic about changes that occur.

Both respondents were unsure of the fact that the results obtained from the completed questionnaires indicated that the longer the time period that clients were free from substance abuse, the lower were their self actualization and relationships scores. Both respondents ascribed this to the fact that the clients' support systems are not able to provide the necessary support on a permanent basis.

Both respondents disagreed as far as the question is concerned whether the results obtained from the questionnaires indicated that part three of the treatment programme seemed more effective in the case of those persons who did not attend a rehabilitation institution. Both respondents thought that the clients who did attend the rehabilitation centres would benefit from the treatment programme.

The one respondent was uncertain whether a client who was suffering from a co-occurring disorder would benefit from phase three of the treatment programme. She, however, stated that clients would benefit from the treatment programme, regardless of whether they have a co-occurring

disorder. The second respondent agreed with the findings, and indicated that an untreated co-occurring disorder would make phase three of the treatment programme less effective.

The one respondent thought that the first part of the treatment programme contained valuable information, and provided a lot of insight to clients. She ascribed this to the fact that the results from the questionnaires indicated that phase three of the treatment programme seemed to be slightly less effective after the treatment programme was completed. The second respondent stated that the fact that the clients were aware of the number of sessions at the beginning of the treatment could have affected the last part of the treatment programme.

7.4 SUMMARY OF RESULTS

According to the results of both the quantitative- and the qualitative investigation it can be concluded that:

Satisfaction with the treatment programme

With regard to the satisfaction with the treatment programme, the investigation proved that both therapists and clients were satisfied with the treatment programme and experienced the treatment programme as positive. The structured format was appreciated, the programme was regarded as thorough. The treatment programme could

however not be regarded as the only contributor of successful recovery of addiction. Other therapeutical processes, as well as the willingness of clients to take part in the process should also be taken into consideration.

Self-actualization, relationships with others and 'self'

With regard to the improvement of self-actualization and changes in relationships with others and with the 'self', both therapists and clients agreed that improvements and changes have occurred after treatment. It however appears as if self-actualization and relationship scores of clients who have overcome their addiction may be less positive than those of the clients who have not. This could be ascribed to the fact that clients, in the early stages of recovery, normally undergo many positive changes as a result of the fact that they have stopped their abuse or that clients who are free from addiction will be more aware of the consequences of their addiction, and will therefore be more realistic about changes that occur.

Conclusion regarding effectiveness of the treatment programme

The main aim of the empirical investigation was to determine the effectiveness of the treatment programme. The researcher reasoned that if therapists and clients were satisfied with the treatment programme, if improvements occurred in self-actualization, and if changes occurred in relationships with others, as well as relationships with the

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'self', the researcher could conclude that the treatment programme was effective. The results of the empirical investigation proved that both therapists and clients were satisfied and that the above improvements and changes have occurred after treatment. Based on the results of the empirical investigation the conclusion could therefore be made that the treatment programme is effective.

7.5 CONCLUSION

Chapter seven focused on the results of the empirical investigation. The aim of empirical investigation was to determine the effectiveness of the treatment programme by investigating the satisfaction of therapists and clients, the occurrance of improvements and changes with regard to self-actualization, relationships with others and the 'self'. The results of the empirical investigation give some indication that the treatment programme is effective.

In chapter eight, the last chapter of the study, the conclusions in respect of the study will be presented, recommendations will be made, and the limitations of the study will be discussed.

CHAPTER 8

SUMMARY, RECOMMENDATIONS AND LIMITATIONS

8.1 INTRODUCTION

Chapter eight is the final chapter of this study. The first part of chapter eight will consist of a summary of the rationale for the study, and the aims of the research. It will then be followed by a description of the research methodology, and an explanation of the results that were obtained. The limitations of the study, as well as recommendations for further research will also be indicated. To end the chapter, final conclusions will be made.

8.2 MOTIVATION FOR THE STUDY

As part of her training to register as a psychologist, the researcher did her internship at a rehabilitation centre in Nelspruit. During this time, as well as while practising as a registered psychologist in private practice afterwards, she became aware of the following,

- the increased use of legal and illegal drugs in South Africa;
- a shortage of treatment facilities that treat substance abuse, especially facilities for adolescents;
- the limited knowledge and inadequate training of psychologists and social workers in respect of the treatment of clients suffering from substance abuse;
- a need for a treatment programme in South Africa that addresses the family of origin as a cause of addiction.

8.3 THE AIMS OF THE RESEARCH

The main aim of the study was to develop a treatment programme that addresses the family of origin as a cause of addiction. The study was divided into two parts, namely

- a literature review; and
- an empirical investigation.

8.3.1 The literature review

To enable the researcher to provide knowledge to therapists regarding important aspects relevant to substance use, abuse and treatment, a literature review was undertaken regarding:

- how therapists could assist clients to reach abstinence (phase one); and
- how therapists could assist clients to function effectively in their life world (phase two).

To enable the researcher to gain knowledge to compile the treatment programme a literature review was undertaken regarding:

- the systems- and relations theories, due to the fact that these two theories served as the theoretical framework of the study; and
- the family of origin.

Based on the knowledge obtained from the literature review regarding the theoretical framework and the family of origin, a treatment programme that addressed the family of origin as a cause of addiction (phase three), was compiled.

8.3.2 The empirical investigation

Therapists received training regarding the treatment programme and after training the treatment programme was implemented. During the empirical investigation data was obtained regarding the implementation of the treatment programme. The main aim of the empirical investigation was to determine the effectiveness of the treatment programme. To enable the researcher to determine the effectiveness of the treatment programme, the following secondary research aims directed the empirical investigation:

- the satisfaction of therapists and clients regarding the treatment programme;
- therapists' and clients' views regarding the level of self-actualization reached by clients after treatment;
- therapists' and clients' views regarding changes in the clients' relationships with 'other' after treatment; and
- therapists' and clients' views regarding changes in the clients' relationships with 'self' after treatment.

8.4 THE RESEARCH METHODOLOGY AND A SUMMARY OF THE RESULTS

The research methodology consisted of two parts, namely

- the literature review;
- an empirical investigation.

8.4.1 The literature research

Chapters two, three, four and five consists of a literature review, and forms the first part of this study.

8.4.1.1 Chapter two: Theoretical framework and existing treatment programmes in South Africa

The family systems theory and the relations theory served as the theoretical background against which phase three of the treatment programme was developed.

With regard to the family systems theory, the researcher concluded that an individual's addiction could be a symptom of problems within the family system in which he/she grew up (family of origin) and the addict is thus seen as the *identified patient*. For the client to be able to heal, problems that occured within the family of origin needs to be addressed.

With regard to the relations theory, the researcher concluded that problematic behaviour like addiction, is a symptom of something that went wrong in the individual's intra-psychic structure. The individual's intra-psychic structure is formed by the intra-psychic process, and it is therefore not the intra-psychic structure that needs to be addressed and changed in the treatment program, but the intra-psychic process. For this reason the treatment program focused on the intra-psychic process of the individual namely *involvement, meaning attribution, experience* and *self-talk*. Change in the intra-psychic process will lead to change in the intra-psychic structure and this will result in changes in the individual's relationships, as well as the level of self-actualization reached by the individual. The researcher therefore reasoned that if the treatment programme is effective, changes will

occur in the individual's relationships with the 'self', God, others, objects and ideas, as well as the level of self-actualization reached. The researcher will therefore be able to determine the effectiveness of the treatment programme by investigating these two aspects after the implementation of the treatment programme.

8.4.1.2 Chapter three: Phase one of the treatment programme

Chapter three focused on phase one of the treatment programme. Research was done on how the therapists could assist the clients to attain abstinence from the substances that they were using.

Based on the research, the researcher came to the conclusion that the therapists could assist their clients to attain abstinence by determining

- the severity of the client's addiction; and
- the level of care that the client needs.

8.4.1.3 Chapter four: Phase two of the treatment programme

Chapter four focused on phase two of the treatment programme. Research was done to determine how the therapist could assist the clients to function effectively within their life-worlds.

The researcher concluded that to be able to assist the clients to function effectively within their life-worlds the therapists need to

- conduct a bio-psycho-social interview with the client to determine the areas where assistance was needed;
- teach the clients different coping skills to address the problem areas that came to the fore during the bio-psycho-social interview;
- diagnose and treat the co-occurring disorders that are associated with addiction.

8.4.1.4 Chapter five: Phase three of the treatment programme

Chapter five focused on phase three of the treatment programme. Phase three took the clients back to investigate certain happenings that occurred in their families of origin. Research by means of a literature study and against the framework of the relations theory (involvement, experience and meaning-attribution) was done to determine how the therapists could assist clients to heal from the pain caused by their families of origin.

Against the above background of the literature study, the treatment programme was compiled by the researcher. The treatment programme consisted of seven sessions. The following aspects were included in the different sessions

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Intra-psychic structure and the family of origin

Session 1: The family of origin (involvement)
Session 2: Family geneogram (involvement)
Session 3: Guilt (experience)
Shame (experience)
Session 4: Anger (experience)
Beliefs and rules (meaning attribution)
Session 5: Frozen emotions (experience)
Self-talk (meaning attribution)

Healing from the past

Session 6: Grief
Session 7: Forgiveness

The above treatment programme was implemented by the therapists during the empirical investigation of the study.

8.4.2 The empirical investigation

Chapters six and seven consisted of the empirical investigation and the results of the investigation.

8.4.2.1 Chapter six: The research design

Chapter six focused on the methods that were used to collect the data to determine the outcomes of the treatment programme.

After the treatment programme was compiled by the researcher, invitations were sent to psychologists and counsellors in Nelspruit and the surrounding areas, as well as to the SANCA offices in Mpumalanga, to attend a training session on the implementation of phase three of the treatment plan.

Twenty therapists attended the training session. After a period of six months, nine therapists reported that they were able to implement the treatment plan.

After the implementation of the treatment programme, the researcher made use of qualitative and quantitative research methods to collect data. This procedure consisted of two phases, namely

Phase one - during phase one the researcher made use of quantitative research methods. The nine therapists who took part in the study completed a treatment questionnaire for therapists, while five of the clients who participated in the study completed a treatment questionnaire for clients.

Phase two – during phase two the researcher made use of qualitative methods of the data collection. Interviews were

conducted with two of the therapists who took part in the study.

8.4.2.2 Chapter seven: The results of the empirical investigation

Chapter seven focused on the results of the empirical investigation. According to the results of both the quantitative- and the qualitative investigation it was concluded that:

With regard to the satisfaction with the treatment programme, the investigation proved that both therapists and clients were satisfied with the treatment programme and exprienced the treatment programme as positive. The structured format was appreciated, the programme was regarded as thorough and it addresses the causes of addiction. The treatment programme could however not be regarded as the only contributor of successful recovery of addiction. Other therapeutical processes, as well as the willingness of clients to take part in the process should also be taken into consideration.

With regard to self-actualization, relationships with others and with the 'self' both therapists and clients agreed that changes have occurred after treatment. It however appears as if self-actualization and relationship scores of clients who have overcome their addiction may be less positive than those of the clients who have not. This could be ascribed to

the fact that clients, in the early stages of recovery, normally undergo many positive changes as a result of the fact that they have stopped their abuse or that clients who are free from addiction will be more aware of the consequences of their addiction, and will therefore be more realistic about changes that occur.

The main aim of the empirical investigation was to determine the effectiveness of the treatment programme. The researcher reasoned that if therapists and clients were satisfied with the treatment programme and if changes occurred in self-actualization, relationships with others, as well as relationships with the 'self', the researcher could conclude that the treatment programme was effective. The results of the empirical investigation proved that both therapists and clients were satisfied and that the above changes have occurred after treatment. Based on the results of the empirical investigation the conclusion could therefore be made that the treatment programme is effective.

8.5 THE LIMITATIONS OF THE STUDY

The following limitations are indicated:

(a) Number of the observations

The number of observations during the empirical investigation was limited due to the restrictions which the

field of study placed on the availability of the respondents. The implementation of the treatment programme was also time-consuming; not only did therapist have to attend a one day training session and treat clients on a reguraly basis, they also had to read up and prepare for each session and take part in the data-collection process. The above lead to the fact that some of therapists were reluctant to take part in the study. Due to the limited number of observants, no statistical significant tests could therefore be conducted. Some of the clients were reluctant to complete the treatment questionnaire for clients. The researcher is unsure what the reason for their reluctance was.

(b) Only phase three of the treatment programme was implemented

The therapists only implemented phase three of the treatment programme. The researcher is of the opinion that if the therapists had completed the entire treatment programme with their clients (phases one, two and three), the effectiveness of the whole treatment programme could have been determined from the therapists' as well as the clients' points of view.

(c) The difference in training and work experience

Counsellors, social workers, educational and clinical psychologists participated in the study. Due to the differences in their training, as well as in their work experience, their points of departure were different. These

differences included aspects such as, for example, the terminology used, their knowledge of substance abuse, their treatment of clients with substance abuse disorders, and their knowledge in respect of the diagnosis and treatment of clients with co-occurring disorders. The researcher is of the opinion that this could have influenced some of the results obtained during the empirical investigation of the study.

(d) *Social desirability*

Both therapists and clients were informed of the experimental nature of the treatment programme. They were also informed that the purpose of the completion of the questionnaires were to determine the effectiveness of the treatment programme. The possibility that both therapists and clients may have had the desire to please the researcher by saying that the programme was experienced positively should be considered as a possible limitation to the study.

(e) *Differences between clients*

Very few control systems were put into place during the empirical investigation. The researcher was therefore not able to make comparisons between clients due to the big differences that existed. Examples of these differences are:

Differences regarding substance abuse: Some clients were off drugs for a relatively long period before treatment of phase three started, while others were off for less than six

months, some were not using drugs while others were still on drugs and some attended rehabilitation while others did not.

Treatment programme: The number of sessions that were used to complete the programme differed vastly and some clients completed all the sessions while others only completed a few sessions.

Conditions of clients before the start of treatment: The researcher did not have benchmark information regarding the conditions of clients before the implementation of the treatment programme for example co-occurring disorders, severity of addiction, coping skills, relationships etc.

8.6 RECOMENDATIONS

The researcher would like to make the following recom-mendations:

(i) The implementation of the treatment programme

All the therapists who took part in the study were able to sucessfully implement the treatment programme in their workplace, therapists and clients also seemed to have experienced the treatment programme positively. The treatment programme also proved to be effective for the treament of the family of origin as a cause of addiction.

It is therefore recommended that the treatment programme could be used as part of a treatment programme by therapists in different settings to treat addiction.

(ii) A longitudinal study

Further longitudinal research into the implementation of the treatment programme will not only enable therapists to implement all three phases of the treatment programme, but the number of observations would also increase. The effectiveness of the entire treatment programme could therefore be established, and statistical significant tests could be conducted to determine the effectiveness of the treatment programme.

(iii) Training in respect of substance abuse

Due to the escalation of substance abuse in South Africa, training for the treatment of clients suffering from substance abuse should be included in the training of all counsellors, social workers and psychologists.

(iv) Training before the implementation of the treatment programme

All the therapists who took part in the study agreed that training before the implementation of the treatment programme is necessary. Aspects like the training and work experience of the therapists taking part in the study should be taken into account and, if necessary, certain aspects

such as knowledge of the different psychoactive substances, and the diagnosis and treatment of co-occurring disorders should be addressed in more detail during training. This will ensure that the point of departure of all the therapists are the same at the start of the implementation of the treatment programme.

(v) The family members of the client

Many of the clients' family members invest a lot of energy, enormous amounts of money, and emotional support in their efforts to assist the client suffering from substance abuse. Often these individuals lack the knowledge on how to effectively assist the client. Guidelines for therapists on how to support and guide these family members could also be included in the treatment programme. This will not only empower the family members, but the clients will also benefit, due to the fact they will be receiving effective support.

(vi) Counselling in respect of finances

Clients suffering from substance abuse often enter treatment with severe financial problems. Financial counselling should consequently be included in phase two of the treatment programme.

8.7 CONCLUSION

The aim of this study was to compile a treatment programme that addresses the family of origin as a cause of addiction.

The first part of the study consisted of a literature review that was based on the three phases of the treatment programme. The family systems theory and the relations theory were included in the literature study due to the fact that it formed the theoretical framework of the empirical investigation of the study. Existing treatment programmes in South Africa were also included in the literature review.

The three phases of the treatment programme included

- phase one - how therapists could assist their clients to reach abstinence;
- phase two - how therapists could assist the clients to function effectively in their life-worlds;
- phase three - how therapists could assist clients to heal from the pain caused by their families of origin.

The effectiveness of phase three of the treatment programme was investigated during the empirical investigation. The results indicated that both the therapists and the clients experienced the treatment programme positively, improvements in self-actualization and changes in relationships with the 'self' and others occurred. The conclusion can therefore be made that if the family of origin is treated as a cause of addiction, there is an improvement

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in the levels of self-actualization of clients, as well as changes in the client's relationships with others and the 'self'. The family of origin could therefore be viewed as a cause of addiction.

The problem statement that was formulated in chapter one of the study was thus answered.

At the beginning of the study the researcher indicated that the use, abuse and addiction to legal and illegal substances were world-wide on the increase, and the situation was no different in South Africa.

She also mentioned that

- approximately 80% of children in South Africa will have experimented with drugs before matriculating, and 15% of these first time-users will become addicted (Narconon 2008:1);
- in a survey conducted in Cape Town in 2003, it was indicated that 45% of high-school learners had already 'tried' drugs, and 32% continued to use them (Gouws, *et al.* 2008:223);
- according to the World Drug Report 2011 (UNODC 2011:4), the overall number of drug users appears to have increased over the last decade to some 210 million people;
- globally, the United Nations Office on Drugs and Crime (UNODC 2011:4), estimates that between 149 and 272 million people, or 3,3% to 6,1% of the population aged

15 to 64 used illicit substances at least once during 2010;

- drugs are seeping into and affecting every area of our existence – our children, our health, our well-being, the crime situation, the economy, even life itself (Searll 2000:xiii & xv);
- it is likely that the search for alternative states of consciousness will always be with us. People have both enjoyed such substances, and suffered in their pursuit, and probably always will (Less & Scanlon 2006:31).

The researcher included the above again in the conclusion to emphasize the importance and the need for the treatment of addiction.

Consequently, the researcher is of the opinion that the treatment programme that was developed in this study will benefit addicts, their family members, and the therapists working in the field of addiction. In conclusion, the researcher further believes that the treatment programme will not only have a positive influence on the effective treatment of addiction, but it will no doubt also address the problem of addiction in South Africa.

BIBLIOGRAPHY

Adams, D.B. (Undated). *Insomnia and Alcohol and Substance Abuse.* Retrieved May 2, 2010, from http://www.oasas.state.ny.us/AdMed /FYI/ FY IlnDepth - Insomnia. Cfm

Alcoholism-Treatment.net. (2010). *Defence Mechanisms and Substance Abuse.* Retrieved September 1, 2010, from http://www.alcoholism. treatment.net/articles

Alexander, I. (2009). *You Can't Play The Game If You Don't Know The Rules. How Relationships Work.* Oxford: Lion Hudson.

Amen, G.A. (1998). *Change Your Brain, Change Your Life. The Breakthrough Program for Conquering Anxiety, Depression, Obsessiveness, Anger, and Impulsiveness.* New York: Three Rivers Press.

Arterburn, S. & Burns, J. (2007). *How to Talk to Your Kids About Drugs*. Oregon: Harvest House Pulishers.

Ary, D., Jacobs, L.C. & Razavieh, A. (2002). *Introduction to Research in Education.* 6 th edition. Belmont: Wadsworth Group.

Barnes, E. (1996). *Heal My Heart, Lord.* Oregon: Harvest House Publishers.

Beattie, M. (1989). *Beyond Co-dependency And Getting Better All the Time.* Genter City: Hazelden Foundation.

Bell, J. (2005). *Doing Your Research Project. A Guide for First-Time Researchers in Education, Health and Social Science.* 4 th edition. New York: Open University Press.

Bennett, M.D. & McNeese, R. (Undated). *Introduction to Substance Abuse.* First Steps Recovery and Wellness Centre. Retrieved December 21, 2010, from http://www.nebhands.edu/files/introduction

Benor, D.J. (2006). *Body Memory and Energy Cysts.* International Journal of Healing and Caring. Retrieved August, 8, 2010, from http://www. Wholistic healing research.com. BodyMemoryandEnergyCysts.html

Bienenfeld, M.D. (2008). *Personality Disorders.* Retrieved March, 2, 2010, from htpp://www. emedicine.medscape.com/article/294307-overview

Black, C. (2001). *It Will Never Happen to Me. Growing Up with Addiction as Youngsters, Adolescents, Adults.* 2nd edition. Denver: MAC Publishing.

Blume, A.W. (2005). *Treating Drug Problems.* New Jersey: John Wiley & Sons.

Bourne, E.J. (2001). *Beyond Anxiety and Phobia.* Oakland: New Harbinger Publications.

Boyum, R. (2010). *Characteristics of a Self-Actualizing Person*. Retrieved May 27, 2010, from http://www.selfcounseling.com/help/personalsuccess/ selfactualization.htm

Buddy, T. (2008). *Addiction Relapse Similar to Other Chronic Diseases.* Retrieved May 20, 2010, from http://alcoholism.about.com/cs/relapse/a/ blcaron 03080

Buddy, T. (2009a). *A Guide Toward an Entire New Way of Life.* Retrieved September, 2011, from http://alcoholism.about.com/cs/info/a/999810 21.htm

Buddy, T. (2009b). *The Twelve Steps of AA and Al-Anon.* Retrieved September 10, 2010, from http://alcoholism.about.com/cs/info/a/999810 21.htm

Buzzle.com. (2010). *Depression and Addiction: How are they Related?* Retrieved April 4, 2010, from http://www.buzzle.com/.../depression-and-addiction-how-are-are-they-related. html

Capuzzi, D. & Stauffer, M.D. (2007). *Foundations of Addictions Counselling.* Harlow: Pearson Education.

Chapman, T. (Undated). *The Power of Parental Influence.* Retrieved July 20, 2010, from http://www.teensavers.com/what-is-a-healthy-family

Cherry, K. (2010). *Defense Mechanisms and Ego Anxiety.* Retrieved September 1, 2010, from http://psychology.about.com/od/theoriesofpersonality/ss/defense mech8.htm

Cleveland Clinic. (2009). *Diseases and Conditions.* Retrieved October 5, 2011, from http://my.clevelandclinic.org/disorders/psychotic_disorder/hic_shared_psychotic_disorders_aspx

Cohen, L., Manion, L. & Morrison, K. (2000). *Research Methods in Education.* London: Routledge Palmer.

Cohen, R.J. & Swerdlik, M.E. (2002). *Psychological Testing and Assessment. An Introduction to Test and Measurement.* 5 th edition. Boston: McGraw-Hill.

Colman, A.M. (2001). *Dictionary of Psychology.* New York: Oxford University Press.

Connolly, S. (2000). *Need to Know Heroin.* Oxford: Heinemann Library.

Coombs, R.H.C. (2004). *Handbook of Addictive Disorders. A Practical Guide to Diagnosis and Treatment.* New Jersey: John Wiley & Sons, Inc.

Dayton, T. (2007). *Emotional Sobriety. From Relationship Trauma to Resilience and Balance.* Florida: Health Communications.

De Miranda, S. (1987). *Dwelms en Dwelmmisbruik in Suid-Afrika.* Pretoria: Van Schaik.

De Miranda, S. (1998). *Drugs and Drug Abuse.* Johannesburg: Michael Collins Publications.

De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (2005). *Research at Grass Roots for the Social Sciences and Human Services Professions.* 3 rd edition. Pretoria: Van Schaik Publishers.

Dilts, B.D. (2011). *What is NLP?* Santa Cruz: NLP University. Retrieved September 11, 2011, from http://www.nlpu.com/NewDesign/NLPU_WhatisNLP.html?

Doweiko, H.E. (2009). *Concepts of Chemical Dependency.* Retrieved December 21, 2010, from http://www. books. google.co.za

Drug Wars. (Undated). *Dagga or Cannabis.* Retrieved September 4, 2009, from http://www.drug wars.co.za/dagga.html

Edmonds, L. & Wilcocks, L. (2000). *Teen Drug Scene. A Guide for Parents and Schools.* 3 rd edition. Pinegowrie: Little Oak Publications.

eDrug Rehab. (2009). *Suicide and Substance Abuse: Know the Risks.* Retrieved August 22, 2010, from http://www.edrugrehab.com/suicide-and-substance-abuse-know-the-risks

Egetgoing. (Undated). *Drug and Alcohol Information.* Retrieved August 31, 2010, from http://www.egetgoing.com/drug_addiction/commondefense.asp

Fast, J.A. & Preston J. (2006). *Take Charge of Bipolar Disorder. A 4-Step Plan for You and Your Loved Ones to Manage the Illness and Create Lasting Stability.* New York: Wellness Central.

Ferguson, P. (2010). *There Really is Such a Thing as a Healthy Family – Description For Recovering Families.* Retrieved July 20, 2010, from http://www.Ezine Articles.com /?expert=Peggy_Ferguson

Finello, K. (Undated). *The Role of Fathers with Daughters and Sons.* Retrieved September 16, 2010, from http://www.parents.com/parenting/ better-parenting/style/the-role-of-fathers-with daughters-and-sons

Forward, S. (1989). *Toxic Parents. Overcoming their Hurtful Legacy and Reclaiming your Life.* New York: Bantam Books.

Gouws, E., Kruger, N. & Burger, S. (2008). *The Adolescent.* 3 *rd* edition*.* Johannesburg: Heinemann Publishers.

Grohol, J. (2007). *Five Tips for Dealing with Guilt.* Retrieve July 31, 2010, from http://www.psychcentral.com/blog/archives/2007/11/27/5-tips-for-dealing - with guilt

Heavilin, M.W. (1987). *Roses in December. Comfort for the Grieving Heart.* Oregon: Harvest House Publishers.

Hersh, S.A. (2008). *The Last Addiction. Why Self-help is not Enough.* Colorado: Waterbrook Press. Retrieved March 9, 2010, from http://www.drugabuse.gov/NIDANotes/NNVol13N2/Brain.html

Hurlock, E.B. (1978). *Child Development.* 6 th edition. Auckland: McGraw-Hill.

Hutter, J. (2010). *Breaking the Life Cycle of Addiction is Possible.* Retrieved August 20, 2010 from http://www.recoveryconnection.org/cycle-of-addiction.php

Impact Alaska Counselling Services. (Undated). *Dysfunctional Family Rules and Roles.* Retrieved August 13, 2010, from http://www. Impact salaska.com/articles/ dysfunctional-family-ruls and roles

Ingraham, P. (2005). *The Body Remembers.* Retrieved August 8, 2010, from http://www.save yourself.ca/articles/tissue-memory.php

Jacobs, L.J. (1981). *'n Ondersoek na die Doeltreffendheid van die Empiries-Opvoedkundige Teorie vir Pedodiagnose en Pedoterapie.* Pretoria: Universiteit van Suid-Afrika.

Jacobs, L.J. (1982). *Selfkonsep, Diagnose en Terapie.* Pretoria: H & R Academica.

Jacobs, L.J. & Lessing AC. (2000). *Die Relasieteorie as Basis vir Terapie.* Educare, 29(1 & 2). Pretoria: Universiteit van Suid-Afrika.

Jantz, G.L. & McMurray, A. 2003. *Healing the Scars of Emotional Abuse.* Michigan: Fleming H. Revell.

Jones, L.G. (2006). *Forgiveness.* Retrieved August 12, 2010, from http://www.Practicing ourfaith.org /prctforgeveness.html

Joseph, S. (2010). *Theories of Counselling and Psychotherapy. An Introduction to the Different Approaches.* New York: Palgrave McMillan.

Kadden, R.M. (2002). *Cognitive Behaviour Therapy for Substance Dependence: Coping-Skills Training.* Connecticut: University of Connecticut School of Medicine. Retrieved September 11, 2010, from http://www. bhrm.org/guidelines/ CBTKadden.pdf

Karson, M. (2006). *Using Early Memories in Psychotherapy. Roadmaps to Presenting Problems and Treatment Impasses.* Oxford: Rowman & Littlefield Publishers.

Kilpatrick, A.C & Thomas, P.H. (2009). *Working With Families. An Integrative Model by Level of Need.* 5 th edition. Boston: Pearson Education.

Lakeview Health Systems. (2010). *Relapse Prevention Planning.* Retrieved May 20, 2010, from http://www.lakeviewhealth.com/adiction-relapse.php

Lefever, R. (2008). *Break Free From Addiction Using the Twelve-step Programme.* London: Carlton Publishing Group.

Leman, K. (2007). *What your Childhood Memories Say About You and What You Can Do About It.* Illinois: Tyndale House Publishers.

Lerner, H. (2004). *The Dance of Anger. A Woman's Guide to Changing the Pattern of Intimate Relationships.* London: Element.

Lessa, N.R. & Scanlon, W.F. (2006). Wiley Concise Guides to Mental Health. *Substance Use Disorders.* New Jersey: John Wiley & Son.

Long, W.P. (2011). *Dysthymic Disorder.* Internet Mental Health. Retrieved October 5, 2011, from http://www. mentalhealth.com/dis/p20-mdoc4.htm/

Louw, I.S. (2004). *Opvoedkundig-Sielkundige Kriteria vir die Evaluering van Rehabilitasieprogramme vir Dwelmafhanklike Adolessente in Suid-Afrika.* Ongepubliseerde doktorale verhandeling. Johannesburg: Randse Afrikaanse Universiteit.

Mans, P. (2000). *Drugs. A Streetwise Guide.* Wellington: Lux Verbi.

MedicineNet. (2010). *Psychotic Disorders.* Retrieved April 19, 2010, from http://www.medicinet. com/psychotic disorders/article.htm.

MedlinePlus. (Undated). Retrieved April 19, 2010, from *Psychotic Disorders.* http:www.nim.gov/medlineplus/psychoticdisorders.html

Meyer, J. (2003). *Beauty for Ashes. Receiving Emotional Healing.* New York: Warner Faith.

Miller, J.L. (2009). *Psychotic Disorders.* Retrieved May 2, 2010, from http://www.athealth. com/Consumer/disorders/Psychotic.html

Miller, W.R. (1999). *Enhancing Motivation for Change in Substance-Abuse Treatment.* US National Library of Medicine. Retrieved September 11, 2011, from http://www.ncbi.nlm.nih.gov/books/NBK14856/

Nace, E.P. & Tinsley, J.A. (2007). *Patients with Substance Abuse Problems. Effective Identification, Diagnosis and Treatment*. New York: Library of Congress Cataloging-in-Publication Data.

Narconon Johannesburg. (2005). *Heroin and Methadone.* Retrieved May 1, 2007, from http://www.file://E:\NarcononSouthAfrica-Heroin&Metha-done.htm

Narconon Johannesburg. (2008). *Drug Education.* Retrieved April 4, 2009, from http://www.stopaddiction.co.za

Narcanon. (2009). *Narcanon Drug Rehabilitation Centre.* Retrieved September 10, 2011, from www.drugno.com

O'Connor, R. (2010). *Denial is Just Another Defense Mechanism.* Retrieved December 21, 2010, from http://www.mental-health-matters.com

Ormrod, J.E. (2008). *Educational Psychology. Developing Learners.* 6th edition. Upper Saddle River: Pearson Education.

Panse, S. (2009). *Emotional Development in Infants.* Retrieved July 15, 2010, from http://www.brighthub.com/education/earlychildhood/articles/44243. aspx

Papalia, D.E. & Olds, S.W. (1985). *Psychology. International Student Edition.* New York: McGraw-Hill.

Papero, D.V. (1990). *Bowen Family Systems Theory.* Massachusetts: Allyn & Bacon.

Perkinson, R.R. (2008). *Chemical Dependency. A Practical Guide.* 3 rd edition. Los Angeles: SAGE Publications.

Piderman, K. (2010). *Forgiveness: Letting Go of Grudges and Bitterness.* Retrieved August 12, 2010, from http://www.mayoclinic.com/health/ forgiveness/MHOO00131

Plüddemann, A., Myers, B.J. & Parry, C.D. (2009). *Fact Sheet – Methamphetamine.* Alcohol and Drug Research Unit, Medical Research Council. Retrieved March 9, 2010, from http://www.sahealthinfo.org/ admodule/methamphetamine.pdf

Psyweb.com. (Undated). *Schizophrenia.* Retrieved April 23, 2010, from http://www.psyweb.com.m disord/jsp/schid.jsp

Purkey, W. (1988). *An Overview of Self-Concept Theory for Counsellors.* Retrieved June 24, 2009, from http://www.chiron.valdosta.edu/whuitt/ files/selfconchtml

Raath, M.C. & Jacobs, L.J. (1993). *Dynamics of the Self-concept.* Pretoria: Academica.

RehabTODAY. (2010). *Identifying the Abuse Cycle: Do You Need Drug Addiction Treatment? Part 2.* Retrieved October 1, 2011, from http://rehab-international.org/blog/identifying-the-abuse-cycle-do-you-need-drug-addiction-treatment-part -2

Ravindran, A.V., Yatham, L.N. & Munro, A. (1999). Paraphrenia redefined. *Can J Psychiatry,* 44(2), 133-7. Retrieved October 6, 2011, from http://www.ncbi.nlm.gov/pubmed/10097832

Repetti, R., Taylor, S. & Seema, T. (2002). *Psychological Bulletin. Vol. 128.* Retrieved October 27, 2010, from http://www. sfhelp. org/gwc /news/ ucla.htm

Bestpfe.com

Richard, D.C.S. & Huprich, S.K. (2009). *Clinical Psychology: Assessment, Treatment and Research.* London: Academic Press.

Roets, H.E., Kruger, D., Lessing, A.C. & Venter, M.A. (2002). *Voorligting in Opvoedkundige Konteks. Hons.BEd. met Spesialisering in Skoolvoorlgting. OSV451-3.* Pretoria: Universiteit van Suid-Afrika.

South African Health Information. (2008). *Fact Sheet - Heroin Use in South Africa.* Retrieved October 25, 2010, from http://www.sahealthinfo. org/admodule/ heroin.htm

SACENENDU. (2009). *South African Community Epidemiology Network on Drug Use.* Retrieved August 21, 2010, from http://www.saheathinfo.org/ad module/sacendureport 15. pdf

Saisan, J., De Benedictis, T., Barston, S. & Segal, R. (2008). *Understanding Sleep.* Retrieved May 7, 2010, from http://www.helpguide. org/life/ sleeping.htm

Schuckit, M.A. (2000). *Drug and Alcohol Abuse*. New York: Plenum Publishers.

Scott, E. (2005). *Flight-Or-Fight Response.* Retrieved July 21, 2010, from http://www.stress.about.Com/od/stressmanagementglossary/g/Fightor Flight.htm

Searll, A. (2002). *Get High on Life.* 2 nd edition. Cape Town: Struik Publishers.

Sekouri, C. (2010). *What is a Dysfunctional Family?* Retrieved July 21, 2010, from http://www.improving-relationships.suite101.com/article.cfm/what-is-a dysfunctional family?

Simon, H. & Zieve, D. (2009). *Insomnia: Causes of Chronic Insomnia.* University of Maryland Medical Centre. Retrieved May 7, 2010, from http://www.Umm.edu/ patiented/articles/what causes chronic insomnia 0000273.htm

Smith-Acuna, S. (2011). *Systems Theory in Action. Applications to Individual, Couples and Family Therapy.* New Jersey: John Wiley & Sons.

Smith, R. (2008). *NLP (Neuro-Linguistic Programming).* Retrieved September 11, 2011, from http://www.businessballs.com/nlpneuron-linguisticprogramming.html

Stocker, S. (2005). *Studies link Stress and Drug Addiction*. Retrieved March 22, 2010, from http://www.drugabuse.gov/NidaNotes/NNVol14N1/Stress. html

Stoppard, M. (2000). *Dwelm Info Lêer van Alkohol en Tabak tot Ecstasy en Heroien.* Londen: Dorling Kindersley.

Sunshine Coast Health Centre. (2011). *Addiction as a Chronic Bio-psychosocial Phenomenon.* Retrieved September 10, 2011 http://www. sunshinecoasthealthcentre. ca/biopsychosocial.html

Teen Challenge International. (2011). *The Program.* Retrieved September 10, 2011, from http:// teenchallengeusa.com/program

Teen Challenge Western Cape. (Undated). *Teen Challenge Western Cape.* Retrieved September 10, 2011, from www.teenchallenge. co.za/TeenChal.ppt

Tessina, T. (2003). *It Ends with You; Grow Up and Out of Dysfunction.* Retrieved July 21, 2010, from http://www.enotalone.com/article/22429. html

The Bowen Theory. (Undated). *Bowen Theory.* Retrieved July 19, 2010 http://www. The bowen center.org/pages/theory.html

The Cape Town Drug Counselling Centre. (2007). *Families and Drugs.* Cape Town: The Cape Town Drug Counselling Centre.

The Cape Town Drug Counselling Centre. (Undated). *The Facts About Drugs.* Cape Town: The Cape Town Drug Counselling Centre.

The Casa Palmera Treatment Centre. (2009a). *The Four Stages of Drug Addiction.* Retrieved August 22, 2010, from http://www.casapalmera .com/ articles/the-four-stages-of-drug-addiction

BESTPFE.COM
List of research project topics and materials

The Casa Palmera Treatment Centre. (2009b). *The Relationship between Drug Addiction and Depression*. Retrieved April 6, 2010, from http://www.casapalmera.com/.../the-relation-between-drug-addiction-and-depression

The Drug Rehabilitation Advice Centre. (Undated). *Stages of Addiction.* Retrieved August 22, 2010, from http://www.drugrehabadvice. org/stagesofaddiction.html

The Encyclopaedia of Psychology. (2001). *Self-actualization.* Retrieved May 27, 2010, from http://findarticles.com/p/articles/mig2699/ is_ 0003/ai_2699000305

The Encyclopaedia of Mental Disorders. (2010). *Assessment and Diagnosis.* Retrieved August 31, 2010, from http://www.minddisorders. com/A-Br/Assessment-and-diagnosis.html

The Holy Bible. (1984). *The Holy Bible. King James Version.* Nashville: Thomas Nelson Publishers.

The Mayo Foundation for Medical Education and Research (MFMER). (2008). *Personality Disorders.* Retrieved April 12, 2010, from http://www.mayoclinic.com/print/personlality-disorders/DS00562/MEAT HOD=print&DSECTION=all.

The National Institute on Drug Abuse (NIDA) of the United States of America. (2009). *Drug Addiction Treatment in the United States.* Retrieved August 20, 2010, from http://www.nida.gov/ podat/TreatmentsUS.html

The National Institute on Drug Abuse (NIDA) of the United States of America. (2010). *NIDA Info facts: Cocaine.* Retrieved October 24, 2010, from http://www.nida.nih.gov/InfoFacts

The National Institute on Drug Abuse (NIDA) of the United States of America. (Undated). *NIDA InfoFacts: Methamphetamine.* Retrieved April 8, 2009, from http://www.nida.nih.gov/InfoFacts

The National Institute of Mental Health (NIMH) of the United States of America. (2009). *What are the Different Forms of Depression?* Retrieved April 5, 2010, from http://www.nimh.nih.gov/ health/publications/depression/what-is-depression.htm

The National Institute of Mental Health (NIMH) of the United States of America. (2010). *Anxiety Disorders.* Retrieved April 19, 2010, from http://www.nimh.nih.gov/health/topics/anxiety-disorders/ index.html

The University of Cincinnati. (2010). *Insomnia: How to Get a Better Night's Sleep.* Retrieved May 2, 2010, from http://www. net well ness.org/ healthtopics/substanceabuse/insom-nia.cfm

The United States Department of Education. (Undated). *Early Intervention.* Retrieved August 22, 2010, from http://www.highered center.org/ environmentalmanagement/ intervention/early.

The Victor Frankl Institute. (Undated). *The Official Website on Logo-therapy and Existential Analysis*. Institute Vienna. Retrieved May 23, 2009, from http//www.logotherapy.univie.ac.at/e/logo therapy.html

Traynor, V. (Undated). *Mixed Methods. UNSW Research Capacity Building Program.* Retrieved August 1, 2011, from www.nswphc.unsw.edu.av/ pdf/ShortCourseResMetIul06/ppts/Mixed methodsVanessaTraynor.pdf

Triposi, J. (Undated). *The Habit to Freeze.* (from the book: Freedom from Body Memory). Retrieved August 8, 2010, from http://www.body memory. com/article_habit_to freeze. html

United Nations Office on Drugs and Crime (UNODC). (2011). *World Drug Report.* Review September 11, 2011, from http://www.

unodc.org/documents/dataandanalysis/WDR2011/Global_and_regional_overview.pdf

Van Wormer, K. & Davis, D.R. (2008). *Addiction Treatment. A Strength Perspective.* 2 nd edition Belmont: Thomas Higher Education.

Van Zyl, J.M.V. (1983). *Die Selfkonsep van die Alkoholis.* Ongepubliseerde meester's skripsie, Universiteit van Stellenbosch, Stellenbosch.

Volkow, N.D. (2006). *NIDA Community Drug Alert Bulletin – Stress and Substance Abuse*. Retrieved March 23, 2010, from http:/www.drug abuse.gov/StressAlert/StressAlert.html

Volkow, N.D. (2007). *Addiction and Co-occurring Mental Disorders.* Volume 21, Number 2. Retrieved May 4, 2010, from http://www.nimh.nih.gov/ health/publications/depression/how-is-depression-detected-and-treated. html

Vrey, J.D. (1975). *Die Rol van die Selfkonsep in Selfaktualisering.* Intreerede. Pretoria: Unisa. 23 September 1975.

Vrey, J.D. (1979). *Die Opvoedeling in sy Selfaktualisering.* Pretoria: Universiteit van Suid-Afrika.

Whitfield, C.L. (2006). *Healing the Child Within.* Expanded and Updated Edition. Florida: Health Communications.

Wilcocks, L. (2002). *Alcohol Abuse. How to Help Someone you Love.* 4 th edition. Pinegowrie: Little Oak Publications.

APPENDIX A

South African Community Epidemiology Network on Drug Use (SACENDU)

Statistics regarding the primary substances of abuse from January 2005 to June 2009:

1. Cape Town: Primary substance of abuse for the period January 2005 to June 2009

	Jan - Jun 2005	Jul - Dec 2005	Jan - Jun 2006	Jul - Dec 2006	Jan - Jun 2007	Jul - Dec 2007	Jan - Jun 2008	Jul - Dec 2008	Jan - Jun 2009
	%	%	%	%	%	%	%	%	%
Alcohol	34	25	30	26	30	30	30	28	27
Dagga/Mandrax	9	6	3	3	3	3	3	3	3
Dagga	10	11	8	10	10	13	11	13	14
Crack	5	8	6	5	4	4	5	6	3
Cocaine	3	3	-	-	-	-	-	-	-
Heroin	10	14	14	10	11	13	13	13	11
Ecstasy	<1	<1	<1	<1	<1	<1	<1	<1	<1
OTC / PRE	2	<1	1	2	1	1	1	1	1
Other (solvents etc.)	<1	0	<1	<1	1	<1	1	<1	<1
Speed/crystal methamphetamine	26	35	37	42	41	36	36	35	41
"Cat" (Methcathinone)	-	-	<1	<1	<1	<1	<1	<1	0
Inhalents	-	-	-	-	-	-	-	1	1

2. Gauteng: Primary substance of abuse for the period January 2005 to June 2009

	Jan - Jun 2005	Jul - Dec 2005	Jan - Jun 2006	Jul - Dec 2006	Jan - Jun 2007	Jul - Dec 2007	Jan - Jun 2008	Jul - Dec 2008	Jan - Jun 2009
	%	%	%	%	%	%	%	%	%
Alcohol	47	52	48	48	46	47	47	48	45
Dagga/Mandrax	7	3	3	1	1	2	2	2	2
Dagga	22	21	21	21	21	19	22	23	28
Crack	6	7	8	7	9	10	13	9	7
Cocaine powder	3	3	3	4	4	4	-	-	-
Heroin	8	8	8	10	11	10	8	6	7
Ecstasy	< 1	< 1	< 1	< 1	< 1	< 1	< 1	< 1	< 1
OTC / PRE	3	2	3	3	4	4	4	4	3
"Cat" (Methcathinone)	2	2	3	4	3	3	1	2	4
"Tik" Methamphetamine	-	-	< 1	< 1	< 1	< 1	1	1	1
Other	2	2	3	2	1	1	0	4	-
Inhalants	-	-	-	-	-	-	2	1	2
Khat	-	-	-	-	-	-	< 1	< 1	< 1
LSD	-	-	-	-	-	-	< 1	-	-
GHB	-	-	-	-	-	-	-	< 1	-

3. Mpumalanga: Primary substance of abuse for the period January 2005 to December 2007

	Jan - Jun 2005	Jul - Dec 2005	Jan - Jun 2006	Jul - Dec 2006	Jan - Jun 2007	Jul - Dec 2007	Jan - Jun 2008	Jul - Dec 2008	Jan - Jun 2009
	%	%	%	%	%	%	%	%	%
Alcohol	56	53	55	47	44	42			
Dagga	22	23	25	34	36	40			
Dagga/Mandrax	0	<1	0	<1	<1	0			
Crack	3	3	7	5	4	7			
Cocaine	1	3							
Heroin	13	10	10	10	12	7			
Ecstasy	<1	<1	<1	<1	<1	<1			
OTC / PRE	3	3	2	2	1	2			
"Cat" (Methcathinone)	<1	<1	0	<1	0	1			
"Tik" Methamphetamine	-	<1	0	0	0	<1			
Other	1	0	0	0	0	0			

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4. Port Elizabeth: Primary substance of abuse for the period January 2005 to June 2009

	Jan - Jun 2005	Jul - Dec 2005	Jan - Jun 2006	Jul - Dec 2006	Jan - Jun 2007	Jul - Dec 2007	Jan - Jun 2008	Jul - Dec 2008	Jan - Jun 2009
	%	%	%	%	%	%	%	%	%
Alcohol	47	59	46	39	48	34	42	42	54
Dagga/Mandrax	20	9	9	9	10	10	4	11	7
Dagga	12	14	16	15	17	14	13	13	12
Crack	3	3	22	4	16	25	22	13	8
Cocaine	9	9	-	20	-	-	-	-	-
Heroin	2	<1	2	3	1	7	8	7	3
Ecstasy	<1	0	2	1	0	<1	<1	0	0
OTC / PRE	5	6	3	4	5	4	8	7	11
"Cat" (Methcathinone)	0	0	0	0	<1	0	-	-	-
"Tik" Methamphetamine	<1	0	1	4	2	5	3	7	5
Other	0	0	0	0	<1	0	<1	0	<1

5. Northern Region: Primary substance of abuse for the period January 2005 to June 2009

	Jan - Jun 2005	Jul - Dec 2005	Jan - Jun 2006	Jul - Dec 2006	Jan - Jun 2007	Jul - Dec 2007	Jan - Jun 2008	Jul - Dec 2008	Jan - Jun 2009
	%	%	%	%	%	%	%	%	%
Alcohol	56	53	55	47	44	42	35	34	38
Dagga/Mandrax	0	<1	0	<1	<1	0	0	<1	1
Dagga	22	23	25	34	36	46	56	45	45
Crack	3	3	7	5	4	7	5	5	4
Cocaine	1	3	-	-	-	-	-	-	-
Heroin	13	10	10	10	12	7	8	9	8
Ecstasy	<1	<1	<1	<1	<1	<1	-	<1	1
OTC / PRE	3	3	2	2	1	2	2	2	1
Other (solvents etc.)	1	0	0	0	0	0	-	3	0
TIK	-	<1	0	0	0	<1	-	0	<1
"Cat" (Methcathinone)	<1	<1	0	<1	0	1	<1	1	<1
Inhalants	1	<1	0	<1	1	1	1	1	<1

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6. East London: Primary substance of abuse for the period January 2005 to June 2009

	Jan - Jun 2005	Jul - Dec 2005	Jan - Jun 2006	Jul - Dec 2006	Jan - Jun 2007	Jul - Dec 2007	Jan - Jun 2008	Jul - Dec 2008	Jan - Jun 2009
	%	%	%	%	%	%	%	%	%
Alcohol			64	53	64	56	53	51	59
Mandrax			5	5	3	7	2	5	4
Dagga			19	28	23	22	26	29	21
Crack					8	15	13	10	7
Cocaine			10	13					
Heroin			1	0	0	< 1	1	3	3
Ecstasy			0	0	0	< 1	1	3	3
OTC / PRE			< 1	2	< 1	0	2	0	0
Other (solvents etc.)			0	0	0	0	1	1	4
Speed / crystal methamphetamine			-	-	< 1	0	0	0	1
"Cat" (Methcathinone)			-	-	-	-	1	0	0
Inhalants			0	0	0	0	2	1	0

Source: SACENENDU. 2009. *South African Community Epidemiology Network on Drug Use.* Available: http://www.saheathinfo.org/admodule/sacendureport 15. pdf. Accessed: 21 August 2010.

APPENDIX B

CRITERIA FOR OUT-PATIENT TREATMENT

Section A: Criteria for adult clients,
Section B: Criteria for the treatment of adolescents.

Section A: Criteria for the out-patient treatment of adults

According to Perkinson (2008:49,50), an adult client qualifies for out-patient treatment if he or she meets the diagnostic criteria for psycho-active substance-use disorder, as defined in the current *Diagnostic and Statistical Manual of Mental Disorders (DSM IV-R)*, and if the client meets all six of the following criteria:

1. The client is not acutely intoxicated and is at minimal risk of suffering severe withdrawal symptoms.

2. All the client's medical conditions are stable and do not require in-patient management.

3. All of the following conditions exist:
    - The individual's anxiety, guilt and/or depression, if present, appear to be related to substance-related problems rather than to a co-existing psychiatric, emotional or behavioural condition. If the client has psychiatric, emotional or behavioural problems other than those caused by the use of a substance, then the

problems are being treated by an appropriate mental health professional.

- His mental status does not preclude the client from comprehending and understanding the program, or from participating in the treatment process.
- The client is not at risk of harming himself or herself, or others.

4. Both the following conditions exist:

- The client expresses a willingness to cooperate in the programme, and to attend all scheduled activities.
- The client may admit to having a problem with alcohol or drugs, but he/she still requires monitoring, as well as motivating strategies. The client does not need a more structured programme.

5. The client is able to remain abstinent only with support, and can do so between appointments.

6. One of the following conditions exists:

- The environment is sufficiently supportive to make out-patient treatment feasible. The family or significant others are supportive of the client's recovery.
- The client does not have the ideal support system in his or her current environment, but is willing to obtain such support.

- The family or significant others are supportive, but the client needs professional intervention to improve his/her chances of success.

Section B: Criteria for the out-patient treatment of adolescents

According to Perkinson (2008:51.52), an adolescent qualifies for out-patient treatment if he or she meets the *Diagnostic and Statistical Manual of Mental Disorders (DSM IV-R)* criteria for substance-use disorder, and also the following:

1. The client is not intoxicated and presents no risk of withdrawal.
2. The client has no bio-medical condition that would interfere with out-patient treatment
3. The client's problem behaviours, moods, feelings and attitudes are related to addiction, rather than to a mental disorder, or the client is being treated by a qualified mental health professional. The client's mental status is stable; he/she is not at risk of harming himself or herself, or others.
4. The client is willing to cooperate and attend all the scheduled out-patient activities. The client is responsive to parents, school authorities and the staff.
5. The client is willing to consider maintaining his/her abstinence and recovery goals.
6. A sufficiently supportive recovery environment exists to make out-patient treatment feasible, namely

- parents or significant others are supportive of treatment, and the program is accessible;
- the client currently does not have a supportive recovery-environment, but is willing to obtain such support.
- The family or significant others are supportive but the client requires professional intervention to improve the chances of success.

Source: Perkinson, RR. 2008. *Chemical Dependency. A Practical Guide. 3rd edition.* Los Angles: SAGE Publications.

APPENDIX C

CRITERIA FOR IN-PATIENT TREATMENT

Section A: Criteria for the in-patient treatment of adults Section B: Criteria for the in-patient treatment of adolescents

Section A: Criteria for the in-patient treatment of adults

According to Perkinson (2008:50.51), an adult needs in-patient treatment if he or she meets the *Diagnostic and Statistical Manual of the American Psychiatric Association, Fourth Edition, Text Revision (DSM-IV-TR)* diagnostic criteria for substance-use disorder, and meets at least two of the following criteria:

1. The client presents a risk of severe withdrawal, or has had past failures at entering treatment after detoxification.
2. The client has medical conditions that present imminent danger of damaging his/her health if the use of substances resumes, or concurrent medical illness needs medical monitoring.
3. One of the following conditions exists:
   - Emotional and/or behavioural problems interfere with abstinence and stability to the degree that there is a need for a structured 24-hour environment.
   - There is a moderate risk of behaviours which could endanger him/herself, or others. There are current suicidal/homicidal thoughts with no action plan, and a history of suicidal gestures or homicidal threats.

- The patient manifests stress behaviour related to losses or anticipated losses that significantly impair his/her daily living. A 24-hour facility is necessary to address the addiction.
- There is a history or presence of violent or disruptive behaviour during intoxication, with imminent danger to him/herself, or others.
- Concomitant personality disorders are of such severity that the accompanying dysfunctional behaviours require continuous boundary-setting interventions.

4. Despite the consequences, the client does not accept the severity of the problem, and needs intensive motivating strategies that are available in a 24-hour structured setting.
5. One of the following conditions exists:
    - Despite active participation at a less intensive level of care, or in a self-help fellowship, the client is experiencing an acute crisis with an intensification of addiction symptoms. Without 24-hour supervision, the client will continue to abuse substances.
    - The client cannot control his or her abuse as long as alcohol or drugs are available.
    - The treatment necessary for the patient requires this level of care.
6. One of the following conditions exists:
    - The client lives in an environment where treatment is unlikely to succeed (*e.g.*, an environment rife with interpersonal conflict that undermines the patient's effort to change, non-existent family, other environmental conditions,

significant others living with the client who manifest current substance use and are likely to undermine the client's recovery).

- Treatment accessibility prevents participation in a less intensive level of care.
- There is a danger of physical, sexual or emotional abuse in the current environment.
- The patient is engaged in an occupation where continued use constitutes a substantial imminent risk to his/her personal or public safety.

Section B: Criteria for the in-patient treatment of adolescents

According to Perkinson (2008:52, 53), to qualify for in-patient treatment, the adolescent must meet the *Diagnostic and Statistical Manual of the American Psychiatric Association, Fourth Edition, Text Revision (DSM-IV-TR)* criteria for substance-use disorder, the whole criteria for out-patient treatment, plus at least two of the following:

1. The risk of withdrawal is present.
2. Continued use places the client at imminent risk of serious damage to his/her health, or a bio-medical condition requires medical management.
3. His/her history reflects a cognitive development of at least eleven years of age, as well as significant impairment in his/her social, interpersonal, occupational or educational functioning, as evidenced by one of the following:

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- There exists a current inability to maintain behavioural stability for more than a forty eight-hour period.
- There is a mild to moderate risk to him/herself or others. Suicidal/homicidal thoughts exist with no active plan, and a history of suicidal/homicidal gestures
- His/her behaviours are sufficiently chronic and/or disruptive to require separation from the current environment.

4. The client has difficulty in acknowledging an alcohol or drug problem, and is not able to follow through with treatment in a less intense environment.
5. The client experiences an intensification of addiction symptoms, despite interventions on a less intense level of care; the client has been unable to control his/her abuse as long as alcohol or drugs are available in his or her environment; or the client, if abstinent, is in a crisis, and appears to be in imminent danger of taking alcohol or drugs.
6. One of the following conditions exists:
   - The environment is not conducive to successful treatment at a less intense level of care.
   - The parents or legal guardians are unable to provide the consistent participation necessary to support treatment on a less intense level of care.
   - Accessibility to treatment precludes participation on a less intense level of care.
   - There exists a danger of physical, sexual or emotional abuse in the client's current environment.

Source: Perkinson, RR. 2008. *Chemical Dependency. A Practical Guide. 3rd edition.* Los Angles: SAGE Publications.

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APPENDIX D

GUIDELINES FOR DETOXIFICATION

For the purposes of this study, the researcher would like to adhere to the guidelines as provided by Lefever (2008:115,116), namely

- Cannabis, ecstasy, LSD, amphetamines and even cocaine require no medical detoxification.
- Alcohol is safely detoxified on Chlordiazepoxide (Librium), starting in doses that often frighten the chemist: 25 milligrams of Librium or 10 milligrams of Diazepam (Valium) three times per day, and then reducing it to zero over four days. Phenobarbitone will need to be added in a reducing regime over the first week if the client has ever had epileptic fits, as severe alcoholics often do, when trying to give up by themselves.
- Heroin can be safely detoxified on Methadone or Lofexidine over four days, but the process is sometimes extended to eight days. Methadone addiction itself takes longer because it is a more addictive drug than heroin, and is harder to come off. Even so, two weeks' detoxification on Methadone itself in reducing the doses, should be enough.
- The really difficult detoxification is from benzodiazepine tranquillizers and sleeping tablets, and from antidepressants. Benzodiazepines have to be taken down very slowly to avoid a severe emotional backlash, and even the risk of suicide. By

reducing the total quantity taken each week by one seventh and by spreading the remainder as evenly as possible throughout the week, the full detoxification programme takes seven weeks. Anti-depressants should also be tailed off slowly, usually over a period of three or four weeks.

Source: Lefever, R. 2008. *Break Free From Addiction Using the Twelve Step Programme.* London: Carlton Publishing Group.

APPENDIX E

GUIDELINES FOR CONDUCTING A BIO-PSYCHO-SOCIAL INTERVIEW

1. General information

Characteristics of the informant: Indicate if you trust the information that the client is giving you.

Chief complaint: Write down, in the client's own words, the chief problem that brought the client for treatment.

History of the present problem: Everything that pertains to the chief complaint. The following information need to be included: age of onset, duration of use, patterns of use, consequences of use, previous treatment, blackouts, tolerance, withdrawal symptoms.

2. Past history

Developmental milestones: Indicate problems with birth, walking, talking, toilet training, reading, writing. Cover both developmental and intellectual problems.

Raised with : Primary caregivers, siblings. Also indicate what it was like to live with them.

Ethnic/cultural influences: Race, geographic location, socio-economic status.

Home of origin: Where did the client grow up and how did he/she feel in the house that he/she grew up in.

Primary school / Secondary school / Tertiary institution / Military: How did the client experience his/her primary/secondary/tertiary school years?

Occupational history: Ask the client to provide a brief description of his/her work history. Include the longest job held and any consequences of drug and alcohol use.

Employment satisfaction: Is the client happily employed?

Financial orientation: What is the client's current financial situation?

Gambling: Any relevant information.

Sexual orientation: How old was the client when he/she first had sex? Indicate homosexual or lesbian relationships.

Sexual /physical abuse: Has the client ever been sexually/physically abused?

Current sexual history: Does the client have any current sexual problems. Also indicate HIV/AIDS.

Relationship history: Briefly describe the client's relationship and friendship patterns.

Social support for treatment: Does the client's family/friends support the treatment?

Spiritual orientation: Does the client believe in God? Indicate any religious activities.

Legal: Does the client have any legal problems?

Strengths: Ask the client to describe his/her strengths or good qualities.

Weaknesses: Ask the client to indicate his/her weaknesses or qualities that he/she is not good at.

Leisure: Indicate any activities, and how it affects the client's chemical use.

Depression / Anxiety disorders / Personality disorders / Psychotic disorders / Other disorders: Describe them, from the client's point of view.

3. Medical history

Illnesses: Indicate even the small illnesses like measles, mumps, *etc*.

Hospitalization: Write down the reasons for hospitalization.

Allergies: Any?

Medication: Write down the name, dosage and who prescribed the medication. Also indicate how the client has been using the medication.

4. Family history

Father: Age, health, what is he like, how did he act when the client grew up? Mention any history of abuse/psychological problems.

Mother: Age, health, what is she like, how did she act when the client grew up? Mention any history of abuse/psychological problems.

Description of the client: Describe how the client is dressed. Does the client appear neat, sloppy, seductive, formal?

Sensorium: Indicate if the client is fully conscious and able to use his/her senses normally. Is the client alert, lethargic or drowsy?

Orientation: Is the client orientated to persons, a place, time, location, the date?

Motor behaviour: How is the client moving: normally, restlessly, continuously, or slowly?

Speech: Indicate his/her manner of speech, any language problems, overly talkative, minimal response.

Range of affect: Indicate if the client's range of feelings seems normal, constricted, blunted, flat.

Mood: Indicate the predominant feeling in the client's life.

Thought processes: Is the client's thoughts logical and coherent, blocked, circumstantial, tangential, incoherent, distracted, evasive, or persevered?

Abstract thinking: Ask the client what the following means to him/her? "People who live in glass houses shouldn't throw stones". Indicate if the answer is concrete or abstract.

Suicidal / homicidal ideation: Describe any thoughts, acts, plans and attempts.

Delusions: A delusion is a false belief that is fixed. Describe any delusions that the client may have experienced.

Obsessions: Obsessions are persistent ideas, thoughts, impulses or images. Describe any obsessions that the client may have had.

Compulsions: Compulsions are repetitive, purposeful and intentional behaviours that are performed in response to an obsession, according to certain rules, or in a stereotyped fashion. Describe any compulsions that the client may have.

Intelligence: Indicate above-average, average, low average or borderline functioning.

Concentration: Describe the client's concentration during the interview: normal, mild, moderate, or severely impaired.

Memory: Immediate memory - ask the client to repeat any set of five numbers (7, 9, 3, 2, 10) that you have said. Now say another set of three numbers and ask the client to say the numbers backward. Recent memory – tell the client you are going to name three objects (red ball, an open window, a police car) and then you are going to ask

him/her to repeat the objects in five minutes' time. Remote memory – the client should be able to tell you what he/she had for dinner last night, or for breakfast that morning. The client should also know his/her past history.

Impulse control: Estimate if the client is able to control his/her impulses.

Judgement: Estimate the client's ability to make good judgments. Ask, for example, "If you were at the movies and were the first person to see smoke and fire, what would you do?"

Insight: Does the client know that he/she has a problem with drugs or alcohol? Does the client understand the nature of the problem?

Motivation for treatment: Is the client committed to treatment? Estimate the level of acceptance or resistance.

5. **Summary and impressions**

Begin with the client's childhood, and summarize all that you have heard and observed. Include all of the problems that you have observed, and give your impressions of all the relevant aspects.

6. **Diagnosis**

Diagnose the problem using the *Diagnostic and Statistical Manual of Mental Disorders, DSM-1V-TR.*

7. **Disposition and treatment plan**

List and describe all the problems that need treatment and how you plan to treat each problem.

Source: Perkinson, RR. 2008. *Chemical Dependency. A Practical guide. 3rd edition.* Los Angles: SAGE Publications.

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APPENDIX F

STRESS MANGEMENT SKILLS

Managing stress is all about taking charge of your thoughts, your emotions, your schedule, and the way you deal with problems.

1. Identifying the sources of stress in your life

Stress management starts with identifying the sources of stress in your life.

1.1 Start a stress journal

A stress journal can help you identify the regular stressors in your life and the way you deal with them. As you keep a daily log you will begin to see patterns. You need to indicate the following aspects in your journal:

- what caused your stress (make a guess if you are not sure);
- how you felt, both physically and emotionally;
- how you acted in response;
- what did you do to make yourself feel better?

1.2 Look at how you are currently coping with stress

Unhealthy ways of dealing with stress are:

- smoking;
- drinking, or using drugs;

- over- or under-eating;
- zoning out for hours in front of the television or the computer;
- withdrawing from friends, family and activities;
- sleeping too much;
- procrastinating;
- filling every minute of the day dealing with your problems;
- taking out your stress on others.

There are many healthy ways to deal with stress. Due to the fact that everyone has a unique response to stress, there is no "one size fits all". You therefore need to experiment with different techniques and strategies.

2. Dealing with stressful situations: the four A's

Change the situation:

- **A**void the stressor
- **A**lter the stressor

Change your reaction:

- **A**dapt to the stressor
- **A**ccept the stressor

2.1 Avoid unnecessary stress

Not all stress can be avoided, and it is also not healthy to avoid a situation that needs to be addressed. There may, however, be a number of stressors in your life that you can eliminate, for example:

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- *learn to say no* – do not take on more than you can handle;
- *avoid people who stress you out* – limit the time you spend with a person who constantly stresses you out, or end the relationship;
- *take control of your environment* – if the evening news makes you anxious, turn the television off; if the traffic makes you tense, drive to work earlier, *etc.*;
- *avoid hot-button topics* – if you get upset over religion or politics, cross them off your conversation list; if you repeatedly argue about the same subject with the same people, stop bringing it up, or excuse yourself when it is the topic of discussion;
- *pare down your 'to-do' list* – analyze your schedule, responsibilities and daily tasks. If you've got too much on your plate, distinguish between the 'shoulds' and the 'musts'. Drop tasks that are not truly necessary to the bottom of the list, or eliminate them entirely.

2.2 Alter the situation

If you cannot avoid stressful situations try to alter them, for example:

- *express your feelings instead of bottling them up* – if something or someone is bothering you, communicate your concerns in an open and respectful way;
- *be willing to compromise* – when you ask someone to change their behaviour, be willing to do the same. If you both are

willing to change, at least you have a good chance of finding a happy middle-ground;

- *be more assertive* – do not take a backseat in your own life - deal with problems head-on, doing your best to anticipate and prevent them;
- *manage your time better* – poor time-management can cause a lot of stress. When you are stretched too thin and running behind, it is hard to stay calm and focused. If you plan ahead and make sure you do not over-extend yourself, you can alter the amount of stress you are under.

2.3 Adapt to the stressor

If you cannot change the stressor, change yourself, for example:

- *reframe the problems* – try to view stressful situations from a more positive perspective; rather than fuming about a traffic jam, look at it as an opportunity to pause and regroup;
- *look at the big picture* – take perspective of the stressful situation. Ask yourself how important it will be in the long run. Will it matter in a month's time? In a year? Is it really worth getting upset about? If the answer is 'no', focus your energy and time elsewhere
- *adjust your standards* – perfection is a major source of avoidable stress. Stop setting yourself up for failure by demanding perfection. Set reasonable standards for yourself and others and learn to be okay with "good enough";

- *focus on the positive* – when stress is getting you down, take a moment to reflect on all the things you appreciate in your life, including your own positive qualities and gifts.

2.4 Accept the things you cannot change

Some sources of stress are unavoidable. You cannot prevent or change stressors, such as the death of a loved one, a serious illness, or a national recession. In such cases the best way to cope with stress is to accept things as they are. Acceptance may be difficult, but in the long run it is easier than railing against a situation you cannot change, for example:

- *do not try to control the uncontrollable* – many things in life are beyond control – particularly the behaviour of other people. Rather than stressing over them, focus on the things you can control, such as the way you choose to react;
- *look for the upside* – as the saying goes, "What does not kill us makes us stronger". When facing major challenges, try to look at them as opportunities for personal growth. If your own poor choices contributed to a stressful situation, reflect on them and learn from your mistakes;
- *share your feelings* – talk to a trusted friend, or make an appointment with your therapist. Experiencing what you are going through can be very cathartic, even if there is nothing you can do to alter the stressful situation;
- *learn to forgive* – accept the fact that we live in an imperfect world, and that people make mistakes. Let go of anger and resentment.

3. Make time for fun and relaxation

Beyond a take-charge approach and a positive attitude, you can reduce stress in your life by nurturing yourself. If you regularly make time for fun and relaxation, you will be in a better position to handle life's stressors when they inevitably come your way.

3.1 Healthy ways to relax and recharge

- go for a walk;
- spend time in nature;
- call a good friend;
- do a good workout;
- write in your journal;
- take a long bath;
- light scented candles;
- savor a warm cup of coffee or tea;
- play with a pet;
- work in your garden;
- go for a massage;
- curl up with a good book;
- listen to relaxing music;
- watch a comedy.

3.2 Nurturing yourself is a necessity, not a luxury

- *set aside relaxation time* – include rest and relaxation in your daily schedule;

- *connect with others* – spend time with positive people who enhance your life;
- *do something you enjoy every day* – every day make time for leisure activities you enjoy;
- *keep your sense of humor* – this includes the ability to laugh at yourself.

Source: National Victim Assistance Academy U.S Department of Justice. 2009. *Stress Management. How to Reduce, Prevent and Cope with Stress.* Available: www.helpguide.org/…/stress_management_relief_coping.htm.
Accessed: 24 March 2010.

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APPENDIX G

RECOMMENDATIONS FOR GOOD SLEEP HYGIENE

- Establish a regular bedtime and wake-up time and continue this on weekends. Make your sleeping environment comfortable, quiet, dark, cool and well-ventilated.
- Use your bed for sleep and sex only, not for watching TV or eating.
- Place your clock out of sight to avoid anxiety about the time. Use an alarm clock to ensure a scheduled wake-up time.
- Take time to relax before bedtime. Engage in a quiet activity: read, write in your journal, practice focused breathing and progressive muscle relaxation.
- Take a warm bath or shower 30 to 60 minutes before bedtime.
- Avoid beverages with caffeine for at least 6 hours before bedtime. Caffeine is a strong stimulant, and its effect lasts for hours.
- A light protein snack before bedtime may be helpful.
- Limit fluids just before bedtime.
- Avoid alcohol in the evening. Alcohol is a poor sleep aid.
- Avoid naps in the daytime.
- Exercise regularly. It is best to exercise early in the day, before dinner.
- Stop smoking. This eliminates the stimulating effects of nicotine.

- If you do not fall asleep after 30 minutes, get up and do something relaxing with low impact lighting, such as listening to music or reading a magazine, or something totally boring, such as reading a book about something that does not interest you. Return to bed when you feel sleepy.
- Consider synthetic Melatonin 1 mg about 30 minutes before bedtime. Look for the USP marking on the label. Contact your physician if you are considering this option.

Source: The University of Cincinnati: 2010. Insomnia: How to Get a Better Night's Sleep. *Available: http://www.netwellness.org/healthtopics/substanceabuse/insomnia.cfm. Accessed: 2 May 2010.*

APPENDIX H

CONFLICT MANAGEMENT SKILLS

1. The different ways of approaching conflict

The first step in learning a healthy conflict style is to acknowledge your current conflict style. The different styles of approaching conflict are as follows:

(a) Relationship at whatever cost

These are individuals who cannot say "no", because they are saying "yes" to a relationship. They usually complain that they cannot say "no".

(b) Withdrawn

These individuals are either avoidant (cannot hear "yes") or non-responsive (cannot say "yes").

(c) Goal at whatever cost

These individuals are usually controllers (outright or manipulative) and they cannot hear "no".

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(d) Goal and relationship

These individuals are able to achieve their goals and to maintain the relationship.

2. Negotiation – getting what I want

Getting what you want starts with the belief that conflict is constructive. The client also needs to let go of the fears that they will either lose the relationship or the goal in the negotiation process. The first part of negotiation is to lay out preferences on the table. The second part is to brainstorm ways to achieve both goals. Sometimes compromise may be necessary which means that neither achieves all that he/she wants and that partial goals are achieved, but the relationship is at least maintained.

3. Winning without losing

A commitment to win-win means that the person refuses to 'win' without making sure that the other person is also 'winning'. That is in contrast to the person who demands to get his/her goal even if the other person loses, resulting in a win-lose situation. It is also in contrast to the person who sacrifices what he/she wants in order to maintain the relationship, resulting in a lose-win situation. The person who withdraws from the conflict is in a lose-lose situation, resulting in a situation where both parties lose.

4. Traps and pitfalls

One of the most common traps in a conflict situation is to start fighting *against* the person, instead of fighting for the goal. Accusations like “always” and “never” are also bound to fail. Teach the client that it is a far stronger argument to stay with the facts and to own your own feelings. Another pitfall is to tap into old hurts. People may leave certain things unsaid for some time, but in a disagreement the hurts and the frustrations come to the fore. To avoid falling into traps and pitfalls, the following important principles for conflict management need to be kept in mind:

- focus on the issue, not the person;
- stay with the present issue, not past ones;
- own your own feelings;
- use “I” statements;
- avoid “always”, “never”;
- refuse to counter-attack;
- ask for time-out;
- arrange a time to discuss an issue;
- place yourself in the other person’s shoes.

5. Taking offence, giving offence

Conflict has two sides. Someone has given offence, and someone has taken offence. Frequently the person who gives offence does so in ignorance, but giving offence intentionally may come from an old hurt, a choice to hurt the other person before he/she hurts you, or a reaction to a present attack.

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Taking offence is often more under our own control than giving offence. People have certain expectations and beliefs, and taking offence is often the result of others not measuring up to these expectations and beliefs. Taking-offence is therefore the individual's own responsibility. Clients need to take responsibility for their own actions, own their own feelings and release the person from their imposed expectation.

6. Triangulation

When people are offended they frequently tell a third person. When a third party is pulled into the conflict and takes up the offence of the offended person or takes responsibility for trying to solve the problem, it is referred to as *triangulation.* This is a natural human interaction, and it can be either constructive or destructive. In a constructive way people sometimes have a need to vent their feelings. However, when a person tells somebody else of another person's offence against them, it is tempting for this person to side with the one telling the story. While this may feel satisfying in the short term, it is not constructive to relationships on either side. The third party does not know the history of the relationship, and also does not know what will bring healing to the two people. The client needs to understand that this is a boundary issue. Clients need to learn to own their own feelings. When they have to talk to a third person, they need to be honest about who said what, what they think, and what their perceptions are.

7. Mediation

Sometimes conflicts become so difficult or destructive that a third party is invited to help negotiate. This often happens when one person has more power that the other. Mediation is often a good option when strong emotions are involved, or when one or both parties know they need help to hear the other person, or to articulate what they have to say.

Source: Alexander, I. 2009. *You Can't Play the Game If you Don't Know the Rules. How Relationships Work.* Oxford: Lion Hudson.

APPENDIX I

THE ASSESMENT AND TREATMENT OF DEPRESSION

1. How to assess depression

To be able to assess depression, the addiction counsellor could make use of the Hamilton score, the mental status examination, the history of the present problem, and the past history of the client (Perkinson 2008:181). Based on the information obtained from using these tools, the addiction counsellor will be able to determine the presence, as well as the severity of depression, and either include the treatment of depression in the treatment plan, or refer the client to a psychiatrist or psychologist.

2. The treatment of depression

Depression, even the most severe cases, is a highly treatable disorder.

2.1 Pharmacotherapy

According to Blume (2005:221), the first step in treating depression is pharmacotherapy. Anti-depressant medication is prescribed in treating depression. Anti-depressants work to normalize naturally occurring brain chemicals called neuro-transmitters, notably serotonin and norepinephrine, while other anti-depressants work on the neurotransmitter dopamine (NIMH 2009a:1). Blume (2005:221)

names three groups of anti-depressant medications commonly used in treating depression, namely monoamine oxidase (MAO) inhibitors, tricyclic anti-depressants, and selective serotonin reuptake inhibitors (SSRIs). Perkinson (2008:181) includes lithium as a fourth group of anti-depressants commonly used for the treatment of depression. He further states (2008:181,182) that doctors might have to try a variety of anti-depressant medications or a combination of medications before finding the right one. For all classes of anti-depressant medication, the patients have to take regular doses for at least three to four weeks before they are likely to experience the full therapeutic effect. Clients should continue taking the medication for the time specified by their doctor, even if they are feeling better, in order to prevent a relapse in the depression. Medication should be stopped only under a doctor's supervision. Although anti-depressant medications are not habit-forming or addictive, abruptly ending an anti-depressant can cause withdrawal symptoms or lead to a relapse (NIMH 2009:1).

(a) Monoamine oxidase (MAO)

MAO inhibitors is the least used drug today, but may be effective in treating severely depressed clients for whom other anti-depressant drugs have not been effective. The use of this class of anti-depressant drugs is often thought of as a last resort because of the risk attached to them. Individuals who use these medicines may not consume certain kinds of drinks or foods, because they can produce deadly interactions with the medication (Blume 2005:221). Clients taking MAOIs must therefore adhere to the significant food and medical restrictions to avoid serious interactions. Certain foods

containing high levels of the chemical tyramine, which is found in many cheeses, wines and pickles, and some medications including decongestants, needs to be avoided. MAOIs interact with tyramine in such a way that it may cause a sharp increase in blood pressure, which could lead to a stroke. The client taking MAOIs should be given a complete list of prohibited foods, medicines and substances (NIMH 2009:1).

(b) Tricyclic medicines

Like MAOIs, Tricyclic is one of the older classes of anti-depressants. The name is derived from the medication's chemical structure (NIMH 2009:1). Tricyclic medicines are generally taken at night, due to the fact that they may cause drowsiness (Blume 2005:221).

(c) Selective serotonin re-uptake inhibitors (SSRIs)

The latest and most popular kinds of anti-depressant medications are called selective serotonin re-uptake inhibitors (SSRIs). SSRIs include fluoxetine (Prozac), citalopram (Celexa), sertraline (Zoloft), and several others. Serotonin and norepinephrine re-uptake inhibitors (SNRIs) are similar to SSRIs, and include venlafaxine (Effexor) and duloxetine (Cymbalta) (NIMH 2009a:1). SSRIs are generally the medicine of choice for depression, but it has a high risk of sexual side-effects (Blume 2005:222).

(d) Lithium

According to Perkinson (2008:181), lithium, carbamazepine and volproic acid are the current treatments for bipolar affective disorder.

2.1 Psychotherapy

Medication should never be the only treatment for depression. Blume (2005:222) states that there are several kinds of psychotherapy that have been empirically validated, including interpersonal psychotherapy, cognitive therapy, cognitive behavioural therapy, and problem-solving therapy. According to him,(2005:222) the most commonly used of these therapies is cognitive therapy, or cognitive behavioural therapy. Perkinson (2008:182) states that the two major psychological treatments for depression are behavioural therapy and cognitive therapy, while, according to the NIMH (2009:1), cognitive behavioural therapy (CBT) and interpersonal therapy (IPT) have been shown to be effective in treating depression. A brief discussion of behavioural therapy and cognitive therapy with regard to treating depression, as described by Perkinson (2008:182-188), will follow:

(i) Behavioural therapy

Studies have shown that depressed people do not do fun things. Behavioural therapy for depression therefore centres on teaching the client new skills, and increasing the positive reinforces in the client's environment. Typically this will involve aspects like an exercise program, the increase of social interactions with treatment peers, the involvement in games, hobbies, sports, *etc.* Depressed clients will also need to be encouraged to set goals, practice relaxation and

stress reducing skills, talk in both individual and group sessions, and do something differently to taking medication. As clients try these new behaviours, they will naturally begin to feel better. When this happens the therapist needs to reinforce this by showing the client it is the new behaviour that is influencing how he or she feels. The therapist could chart the new behaviours and the responses of the client.

(ii) Cognitive therapy

Cognitive therapy concentrates on how a client thinks. Many depressed feelings come from negative self-talk that tends to in-accurate thinking. It is therefore the negative self-talk of the client that needs to be corrected. The therapist could ask the client to:

1. Write down each situation that makes him or her feel uncomfortable. The client needs to be specific about the situation, stating exactly what happened that triggered the uncomfortable feelings.
2. Make a list of each uncomfortable feeling that he or she had following the situation, *e.g.,* fear, sadness, anger, *etc.*
3. Rate each feeling on a scale of one (least intense), to one hundred (most intense).
4. The client adds up the scores of all the negative feelings that he or she felt.
5. Help the client to determine what he or she was thinking between the situation and the negative feelings.

6. Help the client to go back and develop accurate thoughts. Again go over what happened, and help the client to decide what he or she should have been thinking.
7. Once the client has a list of accurate thoughts, re-rate each feeling based on an accurate evaluation of the situation.

Sources:

Blume, AW. 2005. *Treating Drug Problems.* New Jersey: John Wiley & Sons.

The National Institute of Mental Health (NIMH). 2009. *How depression is detected and treated.* Available: http://www.nimh.nih.gov/health/publications/depression/how-is-depression -detected-and -treated.html. Accessed on 5 April 2010.

Perkinson, PR. 2008. *Chemical Dependency. A Practical Guide.* 3rd edition. Los Angeles: SAGE Publications.

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APPENDIX J

THE ASSESSMENT AND TREATMENT OF PERSONALITY DISORDERS

1. How to assess personality disorders

According to Khantzian and Treece (in: Perkinson 2008:196) there exists a higher incidence of Antisocial Personality Disorder among substance abusers, than in the rest of the population. Blume (2005:65), however, states that due to the fact that drug use often includes illegal activities, Antisocial Personality Disorder is likely to be over-diagnosed among drug users. He further states (2005:65) that if an individual with a drug problem is consistently breaking rules, defying authority, manipulating people, and seemingly acting without a heart or without a conscience towards others, the therapist needs to consider the possibility of Antisocial Personality Disorder co-occurring with drug use.

The Mayo Foundation for Medical Education and Research (2008:2) provides the following guidelines for the diagnosis of personality disorders:

Step 1

The therapist needs to ask the client a number of questions about his/her mood, thoughts, behaviour and urges, for example:

- When did you first notice the symptoms?
- How is your daily life affected by your symptoms?
- What other treatment, if any, have you had?
- What have you tried on your own to feel better or to control your symptoms?
- What makes you feel worse?
- Have family or friends commented on your mood or behaviour?
- Have any relatives had a mental illness?
- What do you hope to gain from treatment?
- What medications or over-the-counter herbs and supplements do you take?

Step 2

Before a diagnosis can be made a series of medical and psychological tests need to be done. The aim of the tests is to help rule out other problems that may be causing the symptoms, to pinpoint a diagnosis and to also consider any related complications.

These examinations and tests generally include:

- A physical examination: measuring the client's height and weight, checking his/her vital signs, such as heart-rate, blood-pressure and temperature, listening to the heart and lungs, and examining the abdomen.
- Laboratory tests: a complete blood count (CBC), screening for alcohol and drugs, and a check of the functioning of the thyroid.

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- A psychological evaluation: a doctor or psychologist has to discuss with the client his or her thoughts, feelings, relationships and behaviour patterns. The client could also be asked about his/her symptoms, including when the symptoms started, how severe the symptoms are, how they affect the client's daily life and whether the client has had similar episodes in the past. Any thoughts concerning suicide, self-injury or harming others, also need to be discussed.

Step 3

The medical practitioner or psychologist now needs to pinpoint which personality disorder/s the client has. It can sometimes be difficult to determine which particular personality disorder or personality disorders the client has, due to the fact that some personality disorders share similar symptoms. A diagnosis is also often based largely on how the client describes his/her symptoms and behaviour, along with how the examiner interprets those symptoms and observes the client's behaviour. Because of this, it can take some time and effort to get an accurate diagnosis.

To be diagnosed with a particular personality disorder, the criteria for that disorder, as listed in the *Diagnostic and Statistical Manual of Mental Disorders (DSM IV-R)*, have to be met. Each personality disorder has its own set of diagnostic criteria. The doctor or psychologist needs to review the client's signs and symptoms to see if the client meets the necessary diagnostic criteria for a particular personality disorder. Some people may not meet all of the criteria but may still have a personality disorder, and need professional help

to overcome or manage it. It is also not unusual for a client to have more than one personality disorder at the same time.

2. The treatment of personality disorders

According to Levin (2005:1), personality disorders are of the most challenging mental disorders to treat. Cognitive behavioural therapy seems to be effective in treating many kinds of personality disorders (Blume 2005:224). The treatment often focuses on increasing the client's coping and interpersonal relationships skills (Levin 2005:1).

(a) Anti-social Personality Disorder

Perkinson (2008:198) states that a person's moral development occurs in three stages:

- it is right, as long as I can get away with it (no rules);
- it is right, if it is within the law (rules outside of self); and
- it is right, because I believe it is right (rules internalized).

Clients suffering from Antisocial Personality Disorder are stuck in the first stage of moral development. According to Perkinson (2008:197,198), it is therefore important to teach clients suffering from Antisocial Personality Disorder the consequences of their behaviour, as well as how to think in a new way. These clients need to start accepting the responsibility for their own actions, instead of blaming others. It is the role of the therapist to assist the clients to see how their own choices lead directly to painful consequences. These clients love to argue a point so that they can blame somebody

else, and the therapist needs to constantly direct them to see the truth. Each time the client does something wrong, the therapist could go over the trigger, thoughts, feelings, actions and consequences with the client. This will enable the client to recognize certain patterns in his or her behaviour. These clients also have little self-discipline and poor self-control. It is important for the therapist to teach them to stop, think and plan before they act. They also need to be encouraged to follow the tasks through until they are completed.

(b) Borderline Personality Disorder

Clients suffering from Borderline Personality Disorder have problems in regulating their emotions (Olson & Levounis 2008:40). These clients may under- or overreact emotionally to certain situations by expressing rage, or out-of-control behaviour, or by avoiding any emotional expression or intimacy. Acts of self-harm, including self-mutilating behaviour such as cutting, burning and picking often occur (Blume 2005:66). Other impulsive behaviour, such as excessive spending, binge-eating and risky sexual activities, may also came to the fore (Olson & Levounis 2008:41). Borderline Personality Disorder clients also often engage in black-and-white thinking, and behave in an all-or-nothing fashion (Blume 2005:66).

Perkinson (2008:200-202) provides the following guidelines in the treatment of clients suffering from Borderline personality Disorder:

Due to the fact that these clients overreact to emotional events such as relationship problems, separation, criticism and frustration, they

need long-term psychotherapy and often psychopharmacology, to stabilize their psychiatric symptoms. Treatment has to include the learning of impulse-control, the setting of limits, and skills for dealing with feelings. Borderline Personality Disorder clients need specific plans when they experience strong feelings, for example to exercise, to talk to someone, to turn to a Higher Power, to attend a meeting, *etc*.

When it comes to relationships, it is very important that the therapist has to consider the fact that Borderline Personality Disorder clients at first adopt an engaging, clinging, overly dependent style of relating. When these clients sense a threat to a specific relationship, real or imagined, they shift to angry manipulation. They may even become self-destructive to regain control. In the therapist-client relationship it is important that the clients should not always talk to the therapist when they are upset, due to the fact that this fosters dependency. The clients need to learn to develop other coping skills. They need to be able to see another person's good and bad qualities at the same time. When a client is, for example, extremely angry with someone, help the client to see the person's positive characteristics. Help him/her to see him/herself and others more realistically. The therapist could also assist the client to become aware of his/her unconscious thoughts and motivations.

Borderline Personality Disorder clients do not feel safe and do not trust others, because whenever they have trusted others in the past, bad things inevitably occurred. The therapist constantly needs to ask

the client, "What do you need to feel safe right now?" The therapist then needs to support the client to find a safe situation, and when the client has calmed down, to try to help him or her see the emotionally charged situation more clearly. Many of these clients also have a history of childhood physical or sexual abuse (Perkinson 2008:200).

(c) Narcissistic Personality Disorder

Long (2009:1) defines *Narcissistic Personality Disorder* as a condition that is characterized by an inflated sense of self-importance, a need for admiration, and a lack of empathy for others. Clients with this disorder usually appear arrogant, self-assured and confident. They also expect others to notice them as superior. These clients try to sustain an image of perfection and personal invincibility (Levin 2005:1). However, behind the mask of ultra-confidence lies a fragile self-esteem, vulnerable to the slightest criticism (Mayo 2009:1). The grandiose image that they create is a way to protect themselves from fearing that others will find out that they have weaknesses and imperfections, just like everybody else (Levin 2005:1). Although they may not show it outwardly, criticism may haunt them, and may leave them feeling humiliated, degraded, hollow and empty. These clients may counter-attack with disdain or rage. Their social lives are often impaired, due to the problems derived from entitlement, the need for admiration and the relative disregard for the sensitivities of others. Though their excessive ambition and confidence may lead to high achievement, their performance may be disrupted due to their intolerance of criticism or defeat (Long 2009:1).

There is no specific medication for treating these clients; however, if symptoms of depression, anxiety or other conditions are present, medication such as anti-depressants or anti-anxiety medication may be helpful (MFMER 2009:2). In therapy the therapist needs to be aware of the importance of helping to sustain the client's self-image, of refraining from confronting the need for self-aggrandizement, and of helping the client to use his or her narcissistic characteristics to develop a self-image based upon a genuine positive self-esteem, rather than out of fear for inadequacy (Levin 2005:2). The therapist could also assist the client to learn to relate better to others so that the client's relationships could be more intimate, enjoyable and rewarding. The client would benefit from understanding the causes of his/her emotions, and what drives them to compete with, and to distrust others (MFMER 2009:3). Time also needs to be spent on developing empathy for others (Perkinson 2008:204).

Sources:

Blume, AW. 2005. *Treating Drug Problems.* New Jersey: John Wiley & Sons.

Levin, C. 2005. *Narcissistic Personality Disorder Treatment.* Mentalhelpnet. Available: http://www.mentalhelpnet/poc/viewdoc. Accessed: 19 April 2010.

Long, PW. 2009. *Narcissistic Personality Disorder Treatment.* Internet Mental Health. Available: http://www.mentalhealth.com. Accessed: 19 April 2010.

Mayo Foundation for Mental Education and Research (MFMER). 2009. *Narcissistic Personality Disorder.* Available: http://mayoclinic.com/health/narcissistic-personality-disorder. Accessed: 19/4/2010.

Olson, P & Levounis. 2008. *Sober Siblings. How to Help Your Alcoholic Brother or Sister – and not Lose Yourself.* Philadelphia: Da Capo Press.

Perkinson, PR. 2008. *Chemical Dependency. A Practical Guide.* 3rd edition. Los Angeles: SAGE Publications.

APPENDIX K

THE ASSESSMENT AND TREATMENT OF ANXIETY DISORDERS

1. How to asses anxiety disorders

A general practitioner or psychiatrist needs to conduct a careful diagnostic evaluation to determine whether the symptoms are caused by an anxiety problem or a physical problem. If an anxiety disorder is diagnosed, the type of disorder or combination of disorders that is present, needs to be identified, as well as any co-existing conditions (NIMH 2010:2).

2. The treatment of anxiety disorders

Anxiety disorders can be treated very effectively by means of cognitive behavioural therapy (CBT) (Blume 2005:223). Current clinical practice often combines cognitive-behavioural therapy with medication (Bourne 2001:6, Brady 2001:1, NIMH 2010:2). With the correct treatment, many people suffering from anxiety disorders could lead a normal, fulfilling life.

2.1 Pharmacotherapy

Medication does not cure anxiety disorders, but it keeps the symptoms under control while the client receives psychotherapy. The principal medication used for anxiety disorders are anti-depressants, anti-anxiety drugs and beta-blockers (NIMH 2010:2).

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(a) Anti-depressants

Although anti-depressants were developed to treat depression, it is also very effective in the treatment of anxiety disorders. Anti-depressants start to alter the individual's brain chemistry after the first dose; however, it usually takes about four to six weeks before the symptoms start to fade. Selective serotonin re-uptake inhibitors (SSRIs), tricyclics and monoamine oxidase inhibitors (MAOIs) are prescribed for the treatment of anxiety disorders (NIMH 2010:2,3).

The table below provides a summary of the different anti-depressants that may be prescribed (NIMH 2010:2,3):

Anxiety disorder	**Anti-depressant**	**Anti-depressants**
Panic Disorder	SSRIs Tricyclics MAOIs	fluoxetine (Prozac), sertraline (Zoloft), escitalopram (Lexapro), paroxetine (Paxil), citalopram (Celexa) imipramine (Tofranil) phenelzine (Nardil), tranylcypromine (Parnate), isocarbaxazid (Marplan)
Obsessive Compulsive Disorder (OCD)	SSRIs Tricyclics	fluoxetine (Prozac), sertraline (Zoloft), escitalopram (Lexapro), paroxetine (Paxil, citalopram (Celexa) clomipramine (Anafranil)
Post-Traumatic Stress Disorder (PTSD)	SSRIs	fluoxetine (Prozac), sertraline (Zoloft), escitalopram (Lexapro), paroxetine (Paxil), citalopram (Celexa)
Social Phobia	SSRIs	fluoxetine (Prozac), sertraline (Zoloft), escitalopram (Lexapro), paroxetine (Paxil), citalopram (Celexa)

	MAOIs	phenelzine (Nardil), tranylcypromine (Parnate), isocarbaxazid (Marplan)
Generalized Anxiety Disorder (GAD)	Tricyclics	Venlafaxine (Effexor) Imipramine (Tofranil)

(b) Anti-anxiety drugs

High-potency benzodiazepines combat anxiety and have few side-effects, other than drowsiness. Due to the fact that individuals can get used to them and may need higher doses to get the same effect, benzodiazepines are generally prescribed for short periods of time, especially for individuals who have abused drugs or alcohol, or for individuals who easily become dependent on medication. One exception to this rule is people with panic disorder, who can take benzodiazepines for up to a year without harm (NIMH 2010:3).

The table below provides a summary of the different kinds of anti-anxiety medication prescribed for anxiety disorders (NIMH 2010:3):

Anxiety disorder	Anti- Anxiety medication
Panic Disorder	Lorazepam (Ativan), alprazolam (Xanax)
Social Phobia	Clonazepam (Klonopin)
Generalized Anxiety Disorder (GAD)	Clonazepam (Klonopin), alprazolam (Xanax), buspirone (Buspar), azapirone

(c) Beta-blockers

Beta-blockers, such as propranolol (Inderal), which is used to treat heart conditions, can prevent the physical symptoms that accompany certain anxiety disorders, particular social phobia. When a feared

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situation can be predicted (such as giving a speech), a doctor may prescribe a beta-blocker to keep the physical symptoms of anxiety under control (NIMH 2010:3).

2.2 Psychotherapy

Blume (2005:223) describes the following steps in the treatment of anxiety disorders:

Step 1

The therapist needs to teach the client that anxiety cues are generated by over-interpreting normal physiological reactions. Clients with anxiety may be more vulnerable than non-anxious individuals to notice physiological changes, and tend to misinterpret those changes as a threat. The type of cues that often get misinterpreted are changes in heart-rate, muscle pains, sweating, headaches, tingling in the extremities, photo-sensitivity and hyperventilation. People with anxiety will assume that these changes are risky, and may interpret these symptoms to mean that something is physically wrong with them.

Step 2

The therapist also teaches the clients how their fear, in relation to their symptoms and the errors in their thinking, leads to aggravating their anxiety, and in some clients, to the avoidance of certain situations related to these fears. By being exposed to cues that generate physiological changes and by their fears (with avoidance)

being blocked, the clients are taught to circumvent their fears by understanding that the physiological changes are normal and nothing to fear. The most common way to conduct this exposure is by the use of *systematic desensitization* (exposure done gradually in small steps), although there are some kinds of exposure that may require *flooding* or *implosion* (almost the opposite of systematic desensitization), namely the exposure is done all at once to the most feared stimulus or cue. In addition to the exposure, clients are taught to modify and challenge their thoughts and fears. Rumination and obsessive thinking patterns can be a problem, but cognitive-modification techniques help with these as well. The retaining of the breath to normalize the respiration-rate is used to reduce the sympathetic nervous system's fight-or-flight responses, thus naturally lowering the anxiety levels.

Step 3

The clients are assigned homework to generalize the new skills that have been learnt into real-world situations.

Sources:

Blume, AW. 2005. *Treating Drug Problems.* New Jersey: John Wiley & Sons.

Bourne, EJ. 2001. *Beyond Anxiety and Phobia.* Oakland: New Harbinger Publications.

Brady, T. 2008. *Addiction and Substance Abuse.* Available: http://medscape.comviewarticle. Accessed: 21 April 2010.

The National Institute of Mental Health (NIMH). 2010. Available: *Anxiety Disorders.*http://www.nimh.nih.gov/health/ topics/anxiety-disorders/index.shtml. Accessed: 19 April 2010.

APPENDIX L

THE ASSESMENT AND TREATMENT OF PSYCHOTIC DISORDERS

1. How to asses psychotic disorders

A mental status examination as well as a careful personal history will indicate if the client is suffering from a psychotic disorder. It is, however, very important not to overlook a physical illness that might mimic or contribute to the symptoms of a psychotic disorder. If there is any doubt about a medical problem, the client should be referred to a physician, who will do a complete physical examination, and request any necessary laboratory tests (Miller 2009:2).

2. The treatment of psychotic disorders

Psychotic disorders, if properly diagnosed, can be effectively treated with medication. When the psychotic symptoms are under control, it is strongly advised that cognitive-behavioural skills be included in the treatment plan of these clients (Blume 2005:61).

2.1 Pharmacotherapy

Clients suffering from psychotic disorders need to be stabilized in order to make progress in therapy (Blume 2005:222). According to John Miller (2009:2), in the acute stage a person with a psychotic disorder is treated with medication. The medications are called anti-

psychotics, and are used to help organize the person's thinking and behaviour. Examples of such medications are Clozaril (clozapine), Haldol (haloperidol), Risperdal (risperidone), and Zyprexa (olanzapine). Hospitalization in serious cases may be necessary, namely where a person may be dangerous to himself or to others (MedlinePlus, undated:1). There may be clients who have psychotic symptoms throughout the treatment. These symptoms will probably gradually decrease in intensity over time. The hallucinations will disappear first, with the delusions gradually decreasing over the next several months. Some of the delusion material may be persistent, lasting for years, or even during the client's entire life (Perkinson 2008:210).

2.2 Psychotherapy

Perkinson (2008:209,210) provides the following guidelines:

(a) Reinforce healthy perceptions

In psychotic clients there exists a mixture of psychotic and real perceptions. The therapist needs to reinforce the healthy perceptions of these clients. The therapist should not respond to a psychotic statement other than to reassure the client and to point out reality to the client. Perkinson states (2008:209) that even in the most florid psychotic states, clients have some hold on reality, and do remember what happened.

(b) The client's environment

The environment of a client who has active hallucinations needs to be reduced to its lowest level of stimulation. A quiet room, without a radio or a television set, is advised.

(c) The client's behaviour

Many psychotic clients have an unusual or flat affect. Their range of feelings may be very limited. These clients may often only say a few words, are often not goal-orientated, and may have attention problems. Their behaviour may not fit the circumstances, and they may have little or no motivation.

The therapist can assist the client by helping him or her to identify and use their feelings. The client's motivation may improve by having him or her do many small tasks that can be separately reinforced. These clients also need training in social skills. The therapist may need to teach them how to sit, walk, talk, smile, and use eye-contact. They also need to learn communication skills, interpersonal relationship skills, and problem-solving skills.

(d) Insight-oriented therapy

If painful aspects are uncovered, the psychotic symptoms may worsen. With these clients it is best to stay with the here and the now.

Sources:

Blume, AW. 2005. *Treating Drug Problems.* New Jersey: John Wiley & Sons.

MedlinePlus. Undated. *Psychotic Disorders.* Available: http:www nim.gov/medlineplus/psychoticdisorders.html.
Accessed: 19 April 2010.

Miller, JL. 2009. *Psychotic Disorders.* Available: http://www. athealth.com /Consumer/disorders/Psychotic.html.
Accessed: 2 May 2010.

Perkinson, RR. 2008. *Chemical Dependency. A Practical Guide.* 3rd edition. Los Angles: SAGE Publications.

APPENDIX M

CONSENT FORM

I ________________________________ (name and surname) hereby agree to participate in the implementation of a treatment program for addiction, as part of a doctoral study. I understand that I am free to participate or to withdraw from the research at any stage. I give my permission that the information regarding the therapeutic sessions may be made available to the researcher.

I do understand that:

- confidentiality and privacy will be ensured at all times;
- only information relevant to the purpose of this study will be discussed, and my personal identity will not be revealed;
- the therapist may disclose confidential information in order to obtain the necessary information;
- the therapist may disclose confidential information if there is any fear of harm to me or someone else;
- when any other ethical aspects have to be considered, the therapist will explain them, and discuss them with me.

__________________ Signature

__________________ Date

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APPENDIX N

THE ETHICAL CODE OF CONDUCT

The Ethical Code of Conduct as provided by the Health Professions Act, 1974 (Act No. 56 of 1974), under the section Rules of Conduct pertaining specifically to Psychology, will be used as guideline during this study.

The researcher would like to highlight the following aspects of the Act:

1. Chapter 3: Privacy, Confidentiality and Records

1.1 Rights to confidentiality

(1) A psychologist shall safeguard the confidential information obtained in the course of practice, teaching, research or other professional duties, subject only to the exceptions set forth as limits to confidentiality.
(2) A psychologist shall only disclose confidential information to others with the written informed consent of a client.

1.2 Discussing the limits of confidentiality

(1) A psychologist is oblidged to discuss with persons and organisations with whom they establish a scientific or professional relationship (including, to the extent feasible persons who are legally incapable of giving informed consent and their legal representatives), the limitations on confidentiality, including any limitations on confidentiality that may apply to group, marital and family therapy or to organisational consulting and the foreseeable uses of the information obtained.

(2) A psychologist shall unless it is contra-indicated, discuss confidentiality at the outset of the relationship and thereafter as new circumstances warrant its discussion.
(3) A psychologist shall obtain the permission from a client for the electronic recording of interviews or electronic transmission of information prior to such recording or transmission and such psychologist shall inform such client of the risks to privacy and confidentiality intrinsic to electronic recording or transmission of information.
(4) A psychologist shall, when engaging in electronically transmitted services, ensure that confidentiality and privacy are ensured and shall inform a client of the measures undertaken to guarantee confidentiality.
(5) A psychologist shall not withhold information from a client who is entitled to such information, where it does not violate the confidentiality of others, and where the information requested is required for the exercise or protection of any rights.

1.3 Limits on intrusions on privacy

A psychologist shall include in a written report, oral report or consultations, only information relevant to the purpose for which the communication is made and shall discuss confidential information obtained in his or her work only for appropriate scientific or professional purposes and only with persons concerned with such matters.

1.4 Disclosures

(1) A psychologist may disclose confidential information -
(a) only with the permission of a client;
(b) as mandated by law;
(c) when permitted by law for a valid purpose such as to provide needed professional services to a client;
(d) to obtain appropriate professional consultations;
(e) to protect a client or others from harm; or
(f) to obtain payment for a psychological service, in which instance disclosure is

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limited to the minimum necessary to achieve that purpose.

(2) A psychologist shall not disclose confidential information unless prohibited by law.

1.5 Legally dependent clients

(1) A psychologist shall be cognisant that a child's best interests is of paramount importance in every professional matter concerning direct or indirect psychological services to children.

(2) A psychologist shall take special care when dealing with children 14 years of age and younger.

(3) A psychologist shall, at the beginning of a professional relationship, inform a child or a client who has a legal guardian or who is otherwise legally dependent, of the limits the law imposes on the right of confidentiality with respect to his or her communications with such psychologist.

1.6 Professional consultations

(1) When a psychologist renders psychological professional services as part of a team or when he or she interacts with other appropriate professionals concerning the welfare of a client, such psychologist may share confidential information about such client, provided such psychologist takes reasonable steps to assure that all persons who receive such information are informed about the confidential nature of the information and abide by the rule on professional confidentiality.

(2) When consulting with colleagues, a psychologist shall -

(a) not disclose confidential information that reasonably could lead to the identification of a client, research participant, or other person or organisation with whom he or she has a confidential relationship, unless

(i) he or she has obtained the prior consent of the person or organisation;
or

(ii) the disclosure cannot be avoided; and
(b) disclose information only to the extent necessary to achieve the purposes of the consultation.

1.7 Disguising confidential information used for didactic or other purposes

A psychologist shall not disclose in his or her writings, lectures or other public media, confidential and personally identifiable information which he or she obtained during the course of his or her work concerning a client, organisation, research participant, supervisee, student, or other recipient of his or her psychological services, unless -
(a) he or she takes reasonable steps to disguise such client, organisation, research participant, supervisee, student, or other recipient;
(b) such client, organisation, research participant, supervisee, student, or other recipient has consented in writing; or
(c) there is other ethical or legal authorisation for doing so.

1.8 Maintenance, dissemination and keeping of records

(1) A psychologist shall create, maintain, store, disseminate and retain records and data relating to his or her scientific and professional work in order to -
(a) enable efficacious provision of services by him or her or by another professional;
(b) allow for replication of research design and analysis;
(c) meet institutional requirements;
(d) ensure accuracy of billing and payments;
(e) facilitate subsequent professional intervention or inquiry; and
(f) ensure compliance with the law.
(2) A psychologist shall maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium;

(3) A psychologist shall, if confidential information concerning users of psychological services is entered into a database or system of records available to persons whose access has not been consented to by the user, use coding or other techniques to avoid the inclusion of personal identifiers.

(4) A psychologist shall make plans in advance to facilitate the appropriate transfer, and to protect the confidentiality of records and data in the event of his or her unavailability through factors such as death, incapacity or withdrawal from practice.

2. CHAPTER 6: THERAPEUTIC ACTIVITIES

2.1 Informed consent to therapy

When obtaining informed consent to therapy as required in Standard Informed Consent Forms, a psychologist shall inform a client as early as is feasible in the therapeutic relationship about appropriate information, including the nature and anticipated course of therapy, fees, involvement of third parties, and confidentiality, and when -

(a) obtaining informed consent from a client for treatment involving emerging areas in which generally recognised techniques and procedures have not been established, such psychologist shall inform his or her client of the developmental nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation

3. CHAPTER 10: RESEARCH AND PUBLICATION

3.1 Research responsibilities

Prior to conducting research (except research involving only anonymous surveys, naturalistic observations, or similar research), a psychologist shall enter with a participant into an agreement that clarifies the nature of the research and the responsibilities of each party.

3.2 Informed consent to research

(1) A psychologist shall use language that is reasonably understandable to a research participant in obtaining his or her appropriate informed consent.

(2) Informed consent referred to in sub-rule (1) shall be appropriately documented and shall-

(a) inform a participant of the nature of the research;

(b) inform a participant that he or she is free to participate or to decline to participate or to withdraw from the research;

(c) explain the foreseeable consequences of declining or withdrawing;

(d) inform a participant of significant factors that may be expected to influence his or her willingness to participate (such as risks, discomfort, adverse effects or limitations on confidentiality);

(e) explain other aspects about which a participant enquires;

(f) when conducting research with a research participant such as a student or subordinate, take special care to protect such participant from adverse consequences of declining or withdrawing from participation;

(h) in the case of a person who is legally incapable of giving informed consent nevertheless -

(i) provide an appropriate explanation;

(ii) obtain the participant's assent; and

(iii) obtain appropriate permission from a legally authorised person.

3.3 Dispensing with informed consent

Before determining that planned research (such as research involving only anonymous questionnaires, naturalistic observations, or certain kinds of archival research), does not require the informed consent of a participant, a psychologist shall consider applicable

regulations and institutional review board requirements, and shall consult with colleagues as may be appropriate.

3.4 Informed consent in research filming or recording

A psychologist shall obtain informed consent from a participant prior to filming or recording him or her in any form, unless the research involves simply naturalistic observations in public places and it is not anticipated that the recording will be used in a manner that could cause personal identification or harm to such participant.

3.5 Offering inducements for research participants

In offering psychological professional services as an inducement to obtain a participant, a psychologist shall -

(a) make clear the nature of such services, as well as their risks, obligations, and limitations; and

(b) not offer excessive or inappropriate financial or other inducements to obtain a participant, particularly when it might tend to coerce participation.

3.6 Deception in research

(1) A psychologist shall not conduct a study involving deception unless he or she has determined that the use of deceptive techniques is justified by the study's prospective scientific, educational or applied value and that equally effective alternative procedures that do not use deception are not feasible.

(2) A psychologist shall never deceive a participant about significant aspects that would affect such participant's willingness to participate, such as physical risks, discomfort or unpleasant emotional experiences.

(3) Any other deception that is an integral feature of the design and conduct of an experiment shall be explained by a psychologist to a participant as early as is feasible, preferably at the conclusion of such participant's participation, but no later than at the conclusion of the research.

3.7 Debriefing of research participants

A psychologist shall provide a prompt opportunity for a participant to obtain appropriate information about the nature, results, and conclusions of the research, and such psychologist shall attempt to correct any misconceptions that such participant may have and -

(a) if scientific or humane values justify delaying or withholding this information, such psychologist shall take reasonable measures to reduce the risk of harm; or

(b) when such psychologist becomes aware that research procedures have harmed such participant, such psychologist shall take reasonable steps to minimise the harm.

3.8 Reporting research results

A psychologist shall not fabricate data or falsify results in his or her publication and, if he or she discovers significant errors in such published data, he or she shall take reasonable steps to correct such errors in a correction, retraction, *erratum* or other appropriate means of publication.

3.9 Sharing data

After research results are published, a psychologist shall not withhold the data on which his or her conclusions are based from other competent professionals who seek to verify the substantive claims through re-analysis and who intend to use such data only for that purpose, provided that the confidentiality of a participant to such research can be protected, and unless legal rights concerning proprietary data preclude the release thereof.

3.10 Professional reviewers

A psychologist who reviews material submitted for a publication, grant, or other research proposal review, shall respect the confidentiality of and the proprietary rights in such information which is vested in those who submitted it.

APPENDIX O

THE TREATMENT PROGRAMME

SECTION A: BACKGROUND INFORMATION

THE FOLLOWING TREATMENT PROGRAMME WAS COMPILED BY THE RESEARCHER. PLEASE TAKE NOTE OF THE FACT THAT THE RESEARCHER MADE USE OF OTHER RESEARCHER'S TECHNIQUES AND EXERCISES. A BIBLIOGRAPHY WILL APPEAR AT THE END OF THE BOOKLET.

1. THE ETHICAL CODE OF CONDUCT

2. RATIONALE AND MOTIVATION FOR THE STUDY

According to the researcher, any treatment programme dealing with substance abuse and/or addiction should consist of three phases, namely:

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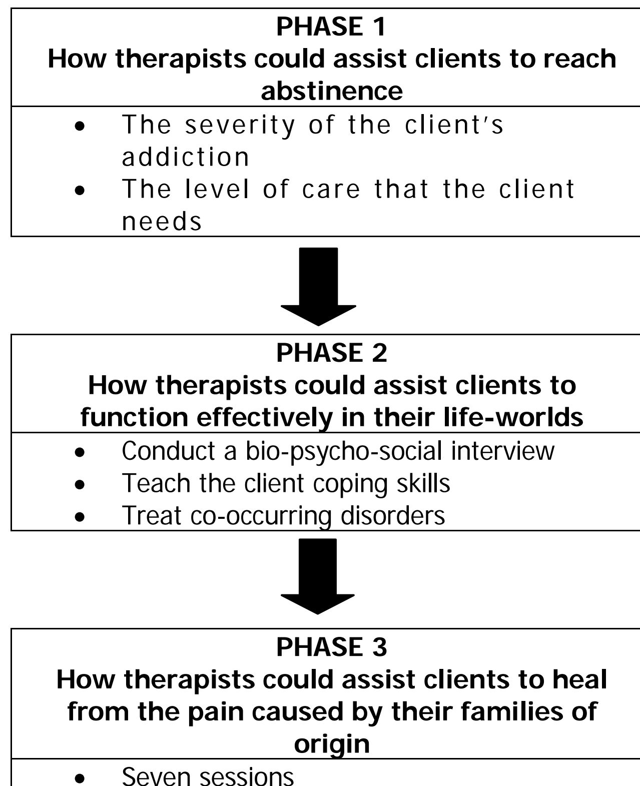

As part of her training to register as a psychologist the researcher did her internship at a rehabilitation centre in Nelspruit. During this time the researcher became aware of the following:

- the increased use of legal and illegal drugs in South Africa;
- the shortage of treatment facilities in South Africa that treat substance abuse, especially treatment facilities for adolescents with a substance abuse problem;
- the limited knowledge and training of psychologists and social workers in South Africa in respect of the treatment of clients suffering from substance abuse.

The researcher also became aware of the fact that many of the clients whom she treated in therapy were able to attain abstinence and lead relatively well-adjusted lives after treatment. She, however, questioned the level of self-actualization that was reached by these clients, as well as the changes that occurred in the different

relationships in their life-worlds. This encouraged her to do a preliminary study on the causes of addiction. As a result of this preliminary study the researcher became aware of the possible correlation that existed between addiction and the clients' families of origin. The researcher decided to investigate this aspect further and to address it together with other aspects, in a structured treatment programme that therapists could use.

3. THE RELATIONS THEORY

In this study the relations theory, which was developed by Vrey (1979), Oosthuizen and Jacobs (1982) of the University of South Africa, was used as the theoretical framework against which the out-patient treatment programme was developed.

A short discussion of relevant aspects of the theory will follow.

The point of departure of the relations theory is that an individual, as centre of his life-world, stands in a relation to different components of his life-world. The different components of the individual's life-world consist of God, other people, objects, ideas and the 'self'.

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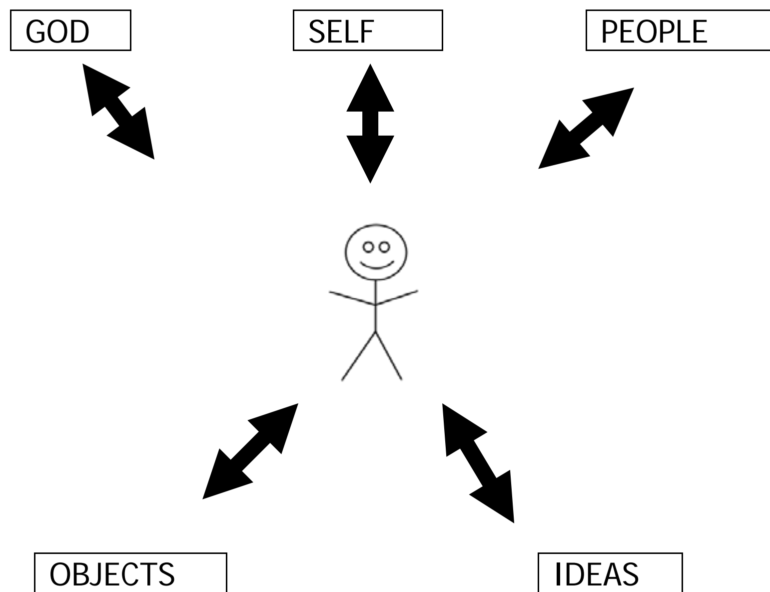
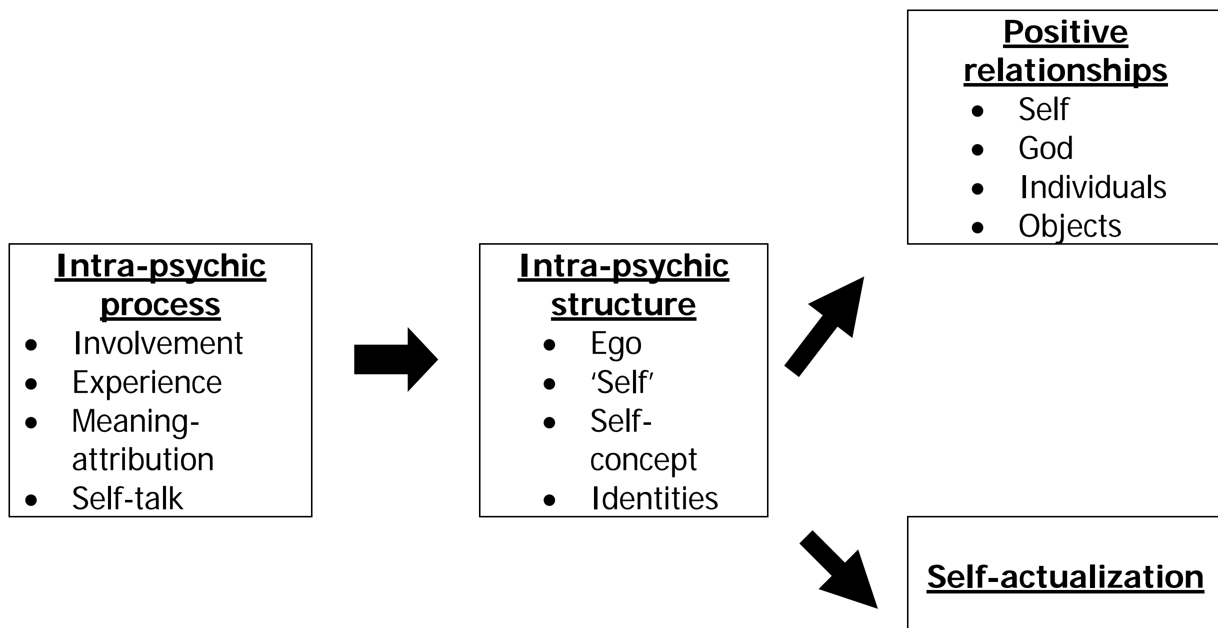


Through the interactive process of *involvement, experience*, and the *attribution of meaning,* and by means of *self-talk,* the individual develops different identities. He/she constantly evaluates these acquired identities with regard to the related relations, and in this evaluation acquires self-concepts for each identity. If his behaviour is socially acceptable, it will contribute to sufficient self-actualization and healthy relations in his/her life-world. If the personality composition results in unacceptable behaviour, it will lead to insufficient self-actualization and unsatisfying relations.



Problematic behaviour like addiction, is a symptom of what went wrong in the individual's intra-psychic structure. A low self-concept is, for example, a symptom of something that is wrong in the individual's intra-psychic structure, and little will be gained by assisting the individual to improve his self-concept. The basic cause of the problem needs to be addressed, and not the mere symptom of the problem.

The individual's intra-psychic structure is formed by the intra-psychic process, and it is therefore not the intra-psychic structure that needs to be addressed and changed in the treatment program, but the intra-psychic process. Change in the intra-psychic process will lead to change in the intra-psychic structure. For this reason the treatment program of this study will focus on the intra-psychic process of the individual. To equip the therapist to gain insight into the intra-psychic structure, the different components will be discussed in the section below.

3.1 The inter-active process

The interactive process includes involvement, experience and meaning-attribution by means of self-talk.

3.1.1 Involvement

According to Jacobs and Lessing (2000:78), the concept *involvement* refers to the actual action of getting involved. The involvement could be physical or psychological in nature, and implies perseverance, diligence and dedication. The individual gets involved in certain events in his life-world through the 'self' and through others, and by getting involved, certain identities are formed (Jacobs & Lessing 2000:78). Involvement, therefore, leads to identification with people, places or things. It is impossible to gain knowledge regarding any aspect if an individual does not get involved with that aspect (Roets, Kruger, Lessing & Venter 2002:42). An individual can also not be involved with someone or something that he does not have any interest in (Vrey 1979:37). The conclusion can be made that an individual becomes involved with a view to greater and deeper knowledge and understanding. The fact that an individual gets involved also indicates that he *wants to be* involved (Vrey 1979:37). Involvement thus refers to the act of giving attention to a person or matter because a person wants to do so. Involvement could be seen as the psychic vitality or life-force whereby significant goals are aspired to and realized (Roets, *et al.* 2002:42). Involvement leads to the achievement of goals and to fulfillment within a person's life-world. It is not passive, but involves action.

3.1.2 Experience (affective)

When an individual gets involved, he attributes meaning to his involvement, and experiences situations involving success, failure, frustration, *etc.* (Jacobs 1982:12). His experience could be positive or negative. The experience will also determine if the

individual will be attracted to the specific aspect, situation or relation, or not. The conclusion one can come to is that an individual's experience of a relation will determine the quality of that relation, due to the fact that it is affective in nature. The above emphasizes the unique nature of the individual's relations. Experience determines the quality of involvement and meaning-attribution. Jacobs (1982:12) states that experience is always limited to the affective consciousness of the individual, and will always accompany an activity or condition of involvement and meaning-attribution. The intensity of the experience determines the clearness and the stability of the meaning that is being formed.

Experience also gives an indication of how an individual is experiencing his identity in a specific situation (Jacobs & Lessing 2000:78). In other words, experience refers to, for example, how the father is experiencing his fatherhood, or how the employee is experiencing his new job. Experience does not come about in a vacuum but is related to a person's situation. An individual's experience indicates how he will evaluate a specific situation.

3.1.3 Attribution of meaning (cognitive)

According to Jacobs and Lessing (2000:79), *attribution of meaning* implies that the individual recognizes, knows, and understands. These cognitive abilities give the individual the ability to discover the meanings of his different identities. Through meaning-attribution the individual is able to orientate himself in his life-world, and can be regarded as an individual's personal understanding of his life-world (Roets, *et al.* 2002:42). By means of this orientation the individual is able to stand in certain relationships to objects and people that are important to him, as well as to himself (Jacobs 1982b:71). According to the *Victor Frankl Institute: Official Website on Logo therapy and Existential Analysis* (undated:2), human beings are called upon to bring forth the best possible in themselves

and in the world by perceiving and realizing the meaning of the moment in each and every situation. Meaning can be both denotative and connotative. *Denotative* meanings have a logical dimension and make common understanding possible. *Connotative* meanings are uniquely personal in nature. An experience can be so intense that the denotative meaning is concealed by the connotative (illogical) meaning-attribution, and this then clouds the person's understanding (Roets, *et al.* 2002:42).

3.1.4 Intra-psychic dialogue/Self-talk

Intra-psychic dialogue refers to the way a person talks to himself about himself. It need not be a discussion or talk in the usual sense of the word; it need not be spoken, and the person may not even be aware that he is talking to himself. It can also happen in the subconscious mind (Raath & Jacobs 1993:29).

According to Jacobs and Lessing (2000:84), an individual is constantly busy evaluating his relations with objects and happenings in his life-world. This evaluation is brought about by means of self-talk. Self-talk occurs in all dimensions of a person's life, and can range, for instance, from how he experiences his physical ability to how he feels about his relationship with his family (Raath & Jacobs 1993:30). Raath and Jacobs (1993:30) also state that the individual's self-talk depends on the norms and values of his society, and is therefore influenced by his own subjective value system (Jacobs & Lessing 2000:84).

By means of self-talk the individual reasons with himself (Raath & Jacobs 1993:31). The intra-psychic dialogue usually vacillates between positive and negative extremes. Negative intra-psychic dialogue often initiates an unrealistic negative self-concept due to the fact that the individual puts himself down. He tells himself he is "stupid", even though he is of average intelligence (Roets, *et al.* 2002: 23,24). The fact that he is unrealistic in his reasoning about himself does not concern him at all. The way in which he experiences the things in his life-world, the way in which he gives meaning to them and becomes involved

in them, will be influenced more and more by this unrealistic self-talk (Raath & Jacobs 1993:31). The individual is continuously busy with self-talk that will sometimes be positive and at other times negative, depending on how he feels about himself (Raath & Jacobs 1993:29). If the self-talk is constantly negative, the individual will become less and less acceptable of himself (Raath & Jacobs 1993: 31).

The conclusion can therefore be made that the intra-psychic dialogue is the catalyst that moves the pendulum of the self-concept between positive and negative poles. The power of self-talk sets the self-concept into motion. This movement of the self-concept is dynamic, and it happens subconsciously (Raath & Jacobs 1993:31).

3.2 Conclusion

Although a distinction was made between the different components in the discussion of the relations theory, one needs to remember that these components can never be separated from one another. A person, as a physical-psychological-spiritual being, is at all times an entity that cannot be separated into different parts. The aim of distinguishing between the different components is to provide a clearer image of an individual in his uniqueness.

When implementing the relations theory in the treatment programme, the therapists need to remember that the main aim is to assist the client in the establishment of positive, reliable, and efficient relationships with the self, God, other people, objects, and ideas in his life-world. The therapist should also assist the client to reach a stage where he will be able to solve his own problems, function independently, and be in a position where he does not need any form of addiction to be able to cope with life in general. To be able to reach the above, the client should have reached a certain degree of self-actualization. The therapist should strive to assist the client to reach at least a certain degree of self-actualization by the end of the treatment programme.

4. FAMILY OF ORIGIN

The focus of the implementation of the relations theory in a treatment programme is to bring change in the relationships in the client's life-world. For long-term change and emotional healing to occur, the researcher is of the opinion that one needs to go back to the client's family of origin. Work in respect of the family of origin is a significant part of recovery for any type of addiction. The researcher fully agrees with Melody Beattie (1989:80) in her book *Beyond Co-dependency* where she makes the following two statements:

> *"We go back....and back....and back...until we discover the exuberant, unencumbered, delightful and lovable child that was and still is, in us. And once we find it, we love and cherish it and never let it go".*
>
> *"Yesterday's smoldering coals – the unresolved feelings and unexamined messages – create today's fires".*

The above is true, firstly, because there is no such a thing as 'perfect parents', and, secondly, it is the only way to deal with hurts from the past that are still influencing our current problematic behaviour. The reason is that the beginning, formative years have such a huge determining influence on the way we experience and understand aspects in our adult lives.

What we deny from yesterday, will be blind to us today. Unfinished business may be buried, but it is alive and breathing, and it may have control over our lives. The reason that it is worth the time, pain and effort to work through these wounds from the past, is simply so that they do not interfere with us living comfortably in the present; so we do not unconsciously repeat emotional, psychological and behavioural patterns that get us nowhere, patterns that are driven by unresolved emotional issues, having their origins in

times gone by; so that we can get on with our lives or, maybe for the first time, start living!

5. THE TREATMENT PROGRAMME

The treatment programme that was compiled for this study was divided into seven sessions:

Session	Content
Session 1	: Taking off the bandages : (involvement)
Session 2	: Looking at the wound : (involvement)
Session 3	: Opening the wound : What about my emotions? : (experience)
Session 4	: Opening the wound : Family beliefs and emotions : (meaning-attribution and experience)
Session 5	: Opening the wound : messages from the past, and my emotions : (meaning attribution, self-talk, experience)
Session 6	: Cleaning the wound : (improved relationships, and at least a certain degree of self-actualization)
Session 7	: Healing the wound : (improved relationships, and at least a certain degree of self-actualization)

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SECTION B: THE IMPLEMENTATION OF PHASE THREE OF THE TREATMENT PROGRAMME

SESSION 1: TAKING OFF THE BANDAGES

1.1 RELAXATION

The therapist is welcome to use any relaxation technique he or she is familiar with. The researcher, however, would like to recommend the relaxation exercises described below:

(a) Deep breathing

The key to deep breathing is to breathe deeply from the abdomen, getting as much fresh air as possible into your lungs. When you take deep breaths from the abdomen, rather than shallow breaths from your upper chest, you inhale more oxygen. The more oxygen you get, the less tense, short-of-breath, and anxious you feel.

- Sit comfortably with your back straight. Put one hand on your chest and the other on your stomach.
- Breathe in through your nose. The hand on your stomach should rise. The hand on your chest should move very little.
- Exhale through your mouth, pushing out as much air as you can, while contracting your abdominal muscles. The hand on your stomach should move in as you exhale, but your other hand should move very little.
- Continue to breathe in through your nose and out through your mouth. Try to inhale so that your lower abdomen rises and falls. Count slowly as you exhale.

(b) Progressive muscle-relaxation for stress-relief

Relaxation sequence: Right foot, left foot, right calf, left calf, right thigh, left thigh, hips and buttocks, stomach, chest, back, right arm and hand, left arm and hand, neck and shoulders, face.

- Take a few minutes to relax, breathing in and out in slow, deep breaths.
- When you are relaxed and ready to start, shift your attention to your right foot. Take a moment to focus on the way it feels.
- Slowly tense the muscles in your right foot, squeezing as tightly as you can. Hold for a count of 10.
- Relax your right foot. Focus on the tension flowing away and the way your foot feels as it becomes limp and loose.
- Stay in this relaxed state for a moment, breathing deeply and slowly.
- When you are ready, shift your attention to your left foot. Follow the same sequence of muscle tension and release.
- Move slowly up through your body — legs, abdomen, back, neck, face — contracting and relaxing the muscle groups as you go.

1.2 STARTING THE HEALING PROCESS

While the client is in a relaxed state the therapist gives the following instruction:

"I am going to read something to you. I want you to listen while your eyes are closed. While you are listening, I want you to be aware of any thoughts or emotions that you are experiencing".

The therapist reads the section below aloud:

> *"The family that we are born into, is the most important part of our 'social network', when we grow up. As children our families form the norm of everything*

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we experience and we do not have anything to compare our family with. We made decisions as a child about who we are and how we are supposed to interact with others, based on how our family system taught us to see the world. Through our relationships with our family members we lay the foundations for attitudes:

- *towards people;*
- *things like money and work;*
- *life in general; and*
- *patterns of adjustment.*

We also learn to think of ourselves as the members of our family think of us, treat us, and speak to us and of us to other people.

In the womb we are physically joined to our mother with the umbilical cord through which we receive nourishment. It is also the beginning of the awareness of our mother's emotions. In a sense we are one being with our mother. There is no separation, what she hears we hear, what she eats we receive, what she feels we experience. When we are in our mother's womb there is total involvement between our mother and ourselves.

Then we begin to crawl, to walk and to run away from our mother. Through this we begin to learn that "I" am a person in my own right. "I" can make decisions separately from my mother and "I" can choose not to come when my parents call. We also learn that even though "I" am separate, "I" am still loved; "I" am a separate person, that "I" need other people and that "I" have a choice to turn away, return and still be loved.

We also begin to experiment with sounds, and somewhere around the end of the first year these sounds turn into words, and after another year of practice the words begin to become sentences. While we are learning the power of words, we also learn to use words to get what we want and to make people respond. Around two we discover the power of the word "no" and begin to experiment with this word to create boundaries. We learn that we are our own separate, little person and even though we are separate our parents still continue to love us. Our parents therefore allow us to become involved with our 'self,' to see our 'self' as a separate entity and to form healthy boundaries.

In our early formative years we rely on our parents to calm us down when we are upset. We also look towards them to teach us how to calm ourselves down through the example that they set. We also look to our parents to learn whether or not we should be scared and how scared we may need to be. In other words, we look at

our parents to determine what emotion needs to be experienced in a specific situation. As children we are therefore completely dependent on our parents as external regulators because our internal regulators will not be fully developed until more or less around the age of twelve years. Our emotional wiring, or limbic system, is in place from birth, but our thinking wiring or prefrontal cortex, is not in place until we are around twelve years old. Even then we are only beginning to learn how to use it. Due to this aspect we cannot use our thinking to make sense of our emotional responses early in life. Before the age of twelve, we learn how to regulate our emotions by observing role-models in our environment. Our parents hold us emotionally until we restore our own calm, until our nervous system settles. Through a successful attachment, we gradually build these skills into our self system and make them portable. We make this behaviour our own. When these skills are mastered during childhood, they feel as if they come naturally, as if we always had them.

As small children we are very vulnerable to any emotional and psychological damage within the home. If the home is chaotic, and if no one is telling us it is okay, or cuddles and reassures us that life will soon return to normal, we will become scared. When the chaos is caused by aspects like abuse, neglect or addiction, our bodies and minds react to being frightened, hurt or overwhelmed with more intense emotion than we can process and integrate. If we repeatedly find ourselves in these circumstances we learn that adults are very frightening and unreliable. We learn to hide what we are feeling. We do not learn the skills of repair and negotiation. We either feel forced to take all the blame or we want to kick, scream and throw it off.

Emotions occur in our bodies as well as in our minds. When we are scared our bodies react on a physical level. Our palms sweat, our hearts beat faster, we tense up and our blood leaves our heads and goes straight to our muscles. It could also happen that our cortex, which is our thinking brain freezes up, but our emotional brain keeps operating. If the stressor is momentary, being thrown into this mind/body conundrum is no big deal. We can take some deep breaths, relax and return to normal. However, if the stress is chronic, it can have a very negative impact. We can get stuck in this prepare-for-stress mode. Our nervous system becomes keyed for over-reaction or under-reaction. We may move from one to ten, or ten to one. We may live on the extremes rather than in four, five or six. We feel that we are always over-reacting on under-reacting, but never know why.

We must also take note of the fact that our bodies do not really distinguish between physical danger and emotional stress. If we grew up in a family that causes chronic stress, our body chemicals boil up inside and can cause physical and

emotional problems. We may find ourselves in a confusing and painful bind, we want to flee from and attack those very people who represent home and heart. We want to escape, but to escape is more or less impossible and it is like fighting a losing battle. So we do what we can: we freeze or we shut down our inner responses by numbing or fleeing on the inside. We stop being involved in relationships, but more importantly, we stop being involved with our 'self'. Through this strategy we may 'get through' a painful situation, perhaps for a period of many years, but we suffer within when we lose access to what is really going on inside. In adulthood we may be great colleagues in the workplace, but when it comes to intimacy, in those relationships that mirror our past, we may tune out the way we did when we grew up. These unresolved aspects live inside our bodies as a state of frozen feelings, needs or urges. Even though we are not consciously aware of what those intentions are, we may still be affected by them on a conscious level. Years later we may still live as if the stressor is still present, as if a repeated rupture to our sense of self and our world lurks just around the corner, because our bodies and minds tell us it does. We become hyper vigilant, waiting for the other shoe to drop. The taboos against genuine feeling that were in place in our childhood stay a reality and we become emotionally illiterate. We will not put our feelings into words, much less talk it over. Our limbic system is our mind/body system that governs our moods, emotional tones, appetite and sleep cycles, to name just a few of its functions. Repeated painful experiences, over which we have no sense of control and from which we feel we cannot escape, can over time deregulate our limbic system. We may find ourselves depressed, anxious or irritable, unable to regulate our moods, emotions, appetites and behaviours."

The therapist gives the following instruction:

"I want you to open your eyes whenever you are ready. What happened while you listened to the information? Did any specific thoughts or emotions come to the fore?"

Exercise 1

Write down any thoughts or emotions that the client experienced during the reading. Explain to the client that in the following sessions you are going to work through these thoughts and emotions, and you will then discuss them in detail. Explain that the aim of this session is to make the client aware of these thoughts and emotions. If the client did not experience any thoughts or emotions, it could be an indication of either denial or of

frozen emotions. Re-assure the client that this often happens, and will be discussed in detail in one of the sessions to follow.

1.3 THE CONTRIBUTIONS OF A HEALTHY FAMILY SYSTEM

Discuss the section below with the client:

"The family system in which we grow up is supposed to make certain contributions in our lives during our childhood years. I am going to read a list of these contributions and I want you to listen very carefully. I also want you to ask yourself if your family members made these contributions to you during your childhood years:

- *Feelings of security from being a member of a stable group.*
- *People you could rely on to meet your needs – physical and psychological.*
- *Sources of affection, regardless of what you have done.*
- *Models of approved patterns of behaviour for learning to be social.*
- *Guidance in the development of socially approved patterns of behaviour.*
- *People you could turn to for help in solving the problems you faced.*
- *Guidance and help in learning skills – motor, verbal and social.*
- *Stimulation of your abilities to achieve success at school and in your social life.*
- *Aid in setting aspirations suited to your interests and abilities.*
- *Sources of companionship until you were old enough to find companions outside the home, or if outside companionship was not available".*

Exercise 2

The client needs to indicate if his or her family of origin made any of these contributions.

1.4 THE DIFFERENCES BETWEEN A HEALTHY FAMILY SYSTEM AND A DYSFUNCTIONAL FAMILY SYSTEM

The following information needs to be provided to the client during a very brief discussion. All the information below does not have to be discussed in detail, due to the

fact that each aspect will be discussed in the following sessions. The researcher provided the information for the benefit of the therapist. At this stage of the session the client has already received a lot of information. At the end of the session he/she only needs to be aware of the fact that:

- many adults are not aware that they grew up in dysfunctional family systems;
- every family system has its own set of beliefs and rules;
- due to loyalty to the family system individuals sometimes sacrifice the 'self';
- emotions are often not experienced in healthy ways in a dysfunctional family system.

1.4.1 Introduction

Many clients who grew up in a dysfunctional environment are not aware of the fact that the family system he or she grew up in was dysfunctional. The aim of this part of the session is to provide the client with information regarding healthy and also dysfunctional family systems, in order to assist him/her to obtain insight into his or her own family system. It is recommended that this part of the session be done in dialogue form. The therapist could, for example, explain 'family beliefs', and then ask the client to share any comments, or to ask questions regarding this concept. Re-assure the client that the aim of this session is to provide background information, and that these different aspects are going to be addressed in detail in the following sessions.

1.4.2 Family beliefs

Your family system has certain beliefs, and it is through these beliefs that you attribute meaning to relationships, objects and aspects in your life-world. These beliefs also lead to

it that you experienced certain emotions regarding certain relationships, objects and aspects. A healthy family system will have beliefs like:

- a child's feelings are important;
- children are entitled to disagree;
- it is wrong to deliberately hurt your child;
- children should feel free to make mistakes.

A dysfunctional family system, on the other hand, may have beliefs like:

- a child is a second-class citizen;
- children should respect their parents, no matter what;
- there are only two ways to do things, my way and the wrong way;
- I am your father; I have all the answers.

The beliefs from your family system determine your attitudes, judgments and perceptions. These beliefs are incredibly powerful and they

- determine how you separate good from bad;
- determine how you distinguish right from wrong;
- indicate how you define relationships, moral values, education, sexuality, career choices, ethics and finances;
- mould your behaviour;
- provide a solid basis for your development and subsequent independence.

There are two types of beliefs within a family system: spoken beliefs and unspoken beliefs. *Spoken beliefs* are expressed or communicated directly. They are out there. You can hear them. These overly expressed ideas have the advantage of giving you something tangible to wrestle with when you become an adult. Although these beliefs may have become a part of you, the fact that they are stated make them easy to examine

and perhaps to discard, in favour of beliefs that are more relevant to your life. *Unspoken beliefs,* on the other hand, can dictate many basic assumptions about life. They exist below the level of awareness. They are beliefs were implied by the way your father treated your mother, or by the way either of them treated you.

1.4.3 Parental rules

Over a certain period in time parental beliefs develop into parental rules. Rules can therefore be seen as the manifestations of beliefs. These rules are the enforcers within the family system, the simple "do's and don'ts". As with beliefs, there are also spoken and unspoken rules within the family system. *Spoken* rules may be arbitrary, but they are clear, as in the following:

- spend every Christmas at home;
- do not backchat your parents.

Due to the fact that they are out in the open, adults can challenge them. *Unspoken* rules, on the other hand, are unseen and they exist below the level of awareness. These rules often demand blind obedience from the different family members. Examples of such rules are:

- do not be more successful than your father;
- do not be happier than your mother;
- do not lead your own life;
- do not ever stop needing me;
- do not abandon me.

These unspoken rules often have a hold over us in our adult lives.

1.4.4 Blind obedience to family beliefs

It has often been found that family members in a dysfunctional system blindly obey family beliefs or rules, because to disobey is to be a traitor to one's family. Blind obedience to these beliefs or rules often leads to self-defeating behaviour. It is not a matter of free choice, or it is rarely the result of a conscious decision. Blind obedience forges our behaviour patterns early in life and prevents us from escaping certain dysfunctional patterns. There is usually a huge gap between our parents' expectations and demands, and what we really want for ourselves. Unfortunately our unconscious pressure to obey almost always overshadows our conscious needs and desires.

1.4.5 Experience

In most well-functioning families one's emotions are expressed clearly, with each person being given the opportunity to share his or her feelings. Family members can freely ask for attention, and in return give others attention. In a dysfunctional family system, on the other hand, emotions are often not shared and when they are expressed, it is often done in a judgmental manner with blame being placed on one another.

It is often found that children, or even adult children, in dysfunctional family systems are not allowed to express themselves as individuals. Healthy families encourage individuality, personal responsibility, and independence. The development of a sense of adequacy and self-respect is also encouraged. Dysfunctional family systems discourage individual expression. These families promote fusion, a blurring of personal boundaries, a welding together of family members. On an unconscious level, it is hard for family members to know where one ends and the other begins. In an effort to be close they suffocate one

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another's individuality. In an enmeshed family you pay for intermittent feelings of approval and safety with your selfhood. Every decision you make becomes interwoven with the rest of your family. Your feelings, behaviours and decisions are no longer your own. You are not yourself; you are an appendage of your family system.

HOMEWORK

Ask the client to go back and to think about the information he or she has received. Explain to him or her that in the next session you are going to look at all the different relationships in the family he or she has grown up in.

Also encourage the client to practice the relaxation exercises that he or she has learned during the session.

SESSION 2: LOOKING AT THE WOUND

2.1 CREATE A SAFE PLACE

The therapist repeats the same relaxation exercises used in session 1.

2.2 TAKE THE RISK!

We can only heal if we decide that we want to become involved by facing those aspects that we have denied for so long. The aim of the exercise is to remember and to be able to say what happened in the past, and also what is happening now. Give the client the reassurance that the purpose of the session is not to blame or disrespect the individuals that form or have formed part of his or her life-world. Nor is the purpose to stay entrenched in yesterday's 'muck'. The goal is to make peace with the past, after the client

has remembered what happened. The goal is, therefore, to become free of the destruction or self-defeating influences of the past.

Exersise 1

The client needs to draw a geneagram of his/her life-world. Also include people who have already passed away.

2.2.1 Significant people

Provide the client with an A4 piece of paper for every person in his/her life-world. The client needs to write down the following for each member of his/her family of origin:

- The name and surname of the person.
- The age of the person.
- Where the person is currently staying.
- If the person is deceased, when and how did the person die?
- Are his/her parents still married? If they are divorced, when were they divorced? Did the parents re-marry? If a parent did re-marry, the new spouse should also be included in the geneagram.
- Describe the character of the person / what is or was he or she like?
- How do you feel about or around the person? As a child? At the moment?
- How did the person treat you, or is still treating you?
- What did other people say about that person?
- What comes to mind when you think about the person?
- Write down the good things that you remember about the person, first when you grew up, and at this moment in time
- Write the bad things that you remember about the person, first when you grew up and at this moment in time

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- What was your relationship like with that person? When you grew up, and what is it like now?
- Are there any significant aspects or events concerning this person that you find yourself repeatedly thinking or talking about?
- Mention any addiction, other psychological or medical aspects.

2.2.2 <u>**The 'self'**</u>

The client needs to answer relevant questions about the 'self' so that the therapist may be able to determine the relationship with the 'self'. The client needs to write down the following about the 'self':

- Name, surname and age.
- Where are you staying?
- Any nicknames or other names, and where they came from.
- Describe your own character.
- Discuss your good qualities and your strengths.
- Enumerate your weaknesses.
- How did your family members see you?
- How did your family expect you to behave?
- What other expectations did your family members have of you?
- How did your family members treat you?
- What did your family members say to you?
- How did you get attention when you were a child?
- How do you draw attention today?

2.3 <u>**Indications of unfinished business**</u>

The therapist needs to be aware of any indications of unfinished business. Indications of unfinished business are:

- not having any recollection of certain times in your life;
- repeatedly thinking or talking about certain events in the past;
- repeatedly dreaming about something specific.

2.4 Get involved!!

At this point in the healing process it is important to start taking action. From the researcher's experience, writing a letter is one of the best ways to take action. However, clients who grew up in dysfunctional families and who never had the opportunity to confront their parents openly or to talk freely about their emotions or felt that they did not have any rights, often find it difficult to write a letter. Explain to the client that the letters will **not** be posted to the person the letter is addressed to, but that the aim of the exercise is to provide the client with an opportunity to ask questions that he or she never was able to ask, or to express his/her feelings or opinions that he/she was not allowed to do when he or she grew up. Also explain that the fact that it is written, makes it concrete and not abstract; it makes it a reality, a truth, something tangible, something that you can deal with.

The client needs to write letters to:

- the person who caused the abuse, neglect, violence, *etc.;*
- the silent parent (the parent who witnessed everything, but kept quiet);
- his/her siblings.

Write a letter to the person who caused the abuse, neglect, violence, *etc.* Let it all out. Get as outraged as you want to. Use phrases like: "How dare you..."; "How could you....?"

Write a letter to the silent parent. This is the parent who witnessed everything, but kept quiet. From the researcher's experience, clients are often amazed at how furious they are with this parent, but they never allowed themselves to admit it. On a conscious level they may even have felt that this parent was not the person responsible for the chaos in the family, and they often see the parent as a victim. This is, however not necessarily true, due to the fact that the adult was in a position to take the responsibility, and to act. The silent parent was in a position to stop the abuse, neglect, *etc.*, but chose not to.

Write letters to your siblings. Express how you experienced your childhood years. Address any unresolved aspects or emotions in the letter. Give your siblings the right to experience their childhood years differently to what you have, but ask them to give you the right and freedom to experience the formative years the way you are remembering them at that moment.

HOMEWORK

The letters are to be finished at home while the client is busy with the therapeutical process. Ask the client to bring the letters to session 7, even if he or she has not finished writing them. However, encourage the client to try and finish the letters, so that healing and closure regarding certain aspects can be reached.

SESSION 3: What about my emotions? (Experience)

3.1 FEEDBACK

Give the client the opportunity to provide feedback, or to ask questions.

3.2 EXPERIENCE

The therapist needs to be aware of the fact that many adults who grew up in dysfunctional homes never allowed themselves the opportunity to experience certain emotions. It may be the first time that the client allows himself or herself to experience any emotion/s. It is important that the therapist discusses each emotion in detail.

3.2.1 Guilt

Guilt is the uncomfortable or painful feeling that results from doing something that violates or breaks personal standards or values, or from hurting another person, or from breaking an agreement or a law. Guilt concerns our behaviour. It concerns feeling bad about something that we have done, or about something that we were supposed to have done, but did not do. Like most emotions, guilt can be useful, in the sense that it guides us in our relationships with ourselves and with others. Guilt tells us that our conscience is functioning. People who never experience guilt or remorse after transgressions are classically said to have an anti-social disorder. Guilt that is useful and constructive is called 'healthy' guilt. When guilt is detrimental to our serenity, our peace of mind, or our functioning – including mental, emotional and spiritual growth – we call it 'unhealthy' guilt.

Individuals who grew up in dysfunctional homes often experience a mixture of healthy and unhealthy guilt. Children in dysfunctional homes feel guilty, not only because they

think they are the cause of problems or because they cannot remedy the problem, but also because they have conflicting feelings about anger and love. Love consists of mutual respect, trust and sharing. A parent's inability to love and accept love is both frustrating and confusing to their children. Unhealthy guilt is usually not handled or worked through, and lingers on. Our 'responsibility' towards our family overcomes our responsibility towards ourselves. There may also exist a form of 'survivor' guilt, where the person feels guilty and unworthy because of leaving and abandoning the others in the dysfunctional system.

Guilt can be relieved by recognizing its presence and by working it through in a therapeutical session.

Exercise 1

If the client is experiencing any guilt, ask him/her to tell you about the things he feels guilty about. It is important that the client distinguishes between healthy and unhealthy guilt. Remind the client that healthy guilt is a feeling of regret or remorse because of your own behaviour. If the client is experiencing problems with 'healthy' guilt, discuss different solutions, for example, "You may apologize to the person whom you may have harmed or deceived".

Explain to the client that unhealthy guilt is a feeling of remorse that comes from believing you are responsible for someone else's behaviour and actions. Adults who have grown up in a dysfunctional home, often have a distorted perception of where their power lies and as a result, live with much 'unhealthy' guilt. Because this is usually a lifelong habit, it is important to go back and delineate historically what you were and were not, responsible for. Rewrite the following sentence stems and fill in the blanks. Write "no" in the first blank and then continue by finishing the sentence:

…………, I was not responsible for ……………………………………….when she/he did ……………………. It was not my fault when …………………….It was not my duty or obligation to ……………………………………………………………………………………

The client has to write down the above concerning everything else he/she feels guilty about and that was not his/her fault.

Do not rush the client. Provide sufficient time so that he/she may identify everything that he/she feels guilty about.

The client needs to read everything that he/she has written out aloud to the therapist a few times, until he/she is in touch with his/her emotions and experiences release.

3.2.2 Shame

People often confuse *shame* with *guilt*. In contrast to guilt, where we feel bad from doing something wrong, we feel shame because of *being* somebody or something bad. We all experience shame at some or other stage; shame is universal to being human. If we do not work through it and let it go, it tends to accumulate and burden us more and more, until we become its victim. Our shame seems to come from what we do with the negative messages, beliefs and rules that we hear as we grow up. These messages tell us that we are somehow not okay, that our feelings, our needs and our 'selves' are not acceptable. Over and over we hear messages like, "Shame on you", "You are so bad", and "You are not good enough". It is important to realize that these messages could be in verbal or non-verbal form. We hear them so often and even from people we are dependent on, and towards whom we feel vulnerable, that we believe them. These messages become so real that we incorporate or internalize them into our very being. As if these were not enough, the wound is aggravated by negative rules that stifle and prohibit the otherwise healthy, healing and needed expression of our pains; rules like "don't feel" and "don't cry". We do

not only learn that we are 'bad', but that we are not to talk openly about any of it. Shame can hold us back, hold us down, and keep us staring at our feet.

Shame is the trademark of dysfunctional families. It comes with families with problems and secrets. It is used to protect secrets, and to keep them hidden. It is used to keep the family members in place. By being secretive the expression of questions, concerns and feelings are prevented and the family cannot communicate openly. The secret may span all kinds of 'shameful' conditions, from family violence, to sexual abuse, to alcoholism, to neglect. The secret may even be as subtle as a lost job, a lost promotion, a lost relationship. Keeping the secret safe disables all the members of the family, whether they know the secret or not. Even though the family may communicate poorly, its members are nonetheless highly connected emotionally, and by means of the denial of and loyalty to keeping the secret.

Often one or more of the members in the family are 'dysfunctional' in some way or another, so the other members take on their roles. Everyone learns to mind everybody else's business. What then results is a group of family members who are enmeshed or fused in one another, or who have invaded or even overtaken the other's boundaries and personal spaces. Within these relationships there either exist no boundaries or the boundaries are very weak.

Shame can make us feel crazy, and do crazy things. It hurts to believe it is not okay to be who we are. To protect ourselves from that pain, we avoid shame by turning it into other feelings that are safer and easier to handle, like

- rage;
- indifference;
- an overwhelming need to control;
- depression;

- confusion;
- alcoholism;
- drug dependency;
- workolism; *etc.*

We may also transform shame to blame, numbness, or panic or we may deal with it by running from it.

When we experience shame we often feel as if something is missing, that we are somehow incomplete. We are unhappy, tense, empty, distressed, feel bad and/or numb. To be 'real', however, seems threatening to us. We tried to be 'real' with others, and too often were rejected or pushed away. So, we start to defend ourselves against realizing our real needs and feelings. Our 'selves', by now alienated and hidden from us, demonstrate an innate desire and energy to express itself. Secretly we want to feel its aliveness and its creativity. Held back for so long, its only way out is through a specific form of negative compulsive behaviour that has worked for us somewhere in the past. Such compulsive actions range across a wide spectrum of possible behaviours such as:

- heavy alcohol, or other drugs;
- short-term, intense relationships;
- trying to control others;
- over-eating;
- too much sex;
- overworking;
- over-spending; or
- over-attending certain groups.

All the above may produce temporary relief from tension, suffering and numbness, even though we may feel some shame about it.

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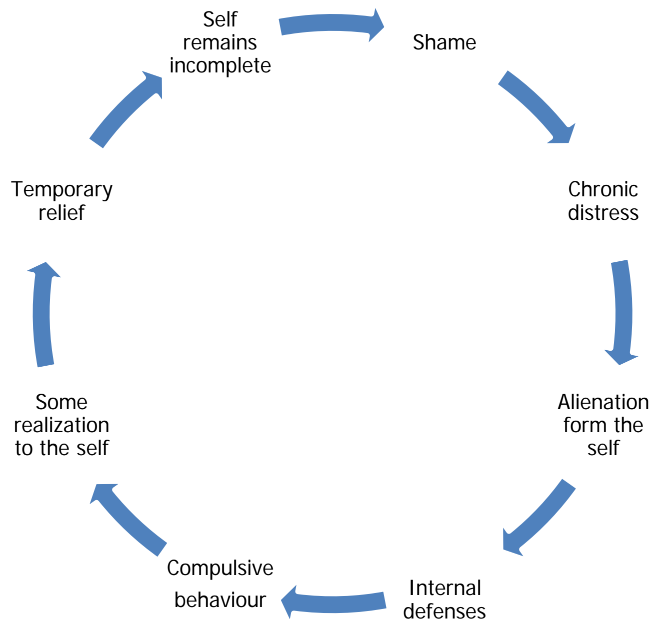
Exercise 2

Does the client suffer from any obsessive behaviour, for example any of the following:

- alcohol or drug abuse;
- overworking;
- over-exercising
- over- or under-eating;
- too much sex;
- gambling;
- controlling;
- perfectionism;
- over-spending;
- over-attending certain groups;
- always looking for a new therapist?

Explain the following shame cycle to the client:



Exercise 3

Teach the client to set healthy boundaries. First explain to the client why it is important to have good boundaries in place, according to the following:

- Setting boundaries is about learning to take care of ourselves, no matter what happens, where we go, or whom we are with.
- Boundaries develop from decisions about what we believe we deserve or do not deserve.
- Boundaries develop from the belief that what we want and need, like and dislike, is important.
- Boundaries develop from a deeper sense of our personal rights, especially the right we have to take care of ourselves and to be ourselves.

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- Boundaries develop as we learn to value, trust and listen to ourselves.

We do not have to construct a blockade to protect our territory; we also do not have to become hyper-vigilant. We need to learn to pay attention.

Teach the client the following guidelines in the strengthening of his or her boundary skills:

1. When you identify that you need to set a limit with someone, do it clearly, preferably without anger, and in as few words as possible. Avoid justifying, rationalizing or apologizing. Remember the most important person to notify of our boundary is ourselves.

2. You cannot simultaneously set a boundary and take care of another person's feelings.

3. You will probably feel ashamed and afraid when you set boundaries. Do it anyway. People may not know that they are trespassing. People also do not respect people they can 'use'; people misuse others they can 'use', and respect people they cannot 'use'. Healthy limits benefit everyone.

4. Anger, rage, complaining and whining are clues to boundaries we need to set. The things that we say we cannot stand, do not like, feel angry about, or hate may include the areas screaming for boundaries. Other clues that we may need to set a boundary are when we are feeling threatened, 'suffocated', or victimized by someone.

5. You will be tested when you set boundaries. Be prepared for it. It does not do you any good to set a boundary until you are ready to enforce it. Often the key to boundaries is not convincing other people you have limits – it is convincing yourself.

6. Be prepared to follow through your acting in congruence with your boundaries. Your boundaries need to match your behaviour. You do need to match what you say. Consequences and ultimatums are ways to enforce boundaries. Boundaries imply taking care of ourselves and not controlling others. Our boundary gives us a guideline to make a choice.

7. Some people are happy to respect our boundaries. The problem is not what they have been doing to us; it is what we have been doing to ourselves. Some people may get angry at us for setting boundaries, particularly if we are changing a system by setting a boundary where we previously had none. People especially become angry if we have been taking care of them or allowing them to use or control us, and we decide it is time to change that.

8. You need to set boundaries when you are ready, and not a minute later. You need to do it in your own time – not in someone else's. That is because it is connected to your growth.

9. A support system can be helpful as you strive to establish and enforce boundaries.

10. There is a fun side to setting boundaries. Besides learning to identify what hurts and what you do not like, you learn to identify what you like, what feels good, what you want, and what brings you pleasure. That is when you begin to enhance your quality of life. If you are not certain who you are, what you like and what you want, you have a right to that exciting discovery.

SESSION 4: FAMILY BELIEFS AND MORE EMOTIONS

4.1 FEEDBACK

Give the client the opportunity to provide feedback, or to ask questions.

4.2 MEANING-ATTRIBUTION: BELIEFS

Each family system has certain beliefs and rules and it is by means of these beliefs and rules that meaning is attributed and that certain emotions are experienced. A healthy family system will have beliefs like, "A child's feelings are important", "Children are entitled to disagree", "It is wrong to deliberately hurt your child" and "Children should feel free to make mistakes". A dysfunctional family system, on the other hand, may have beliefs like, "A child is a second-class citizen", "Children should respect their parents, no matter what", "There are only two ways to do things, my way or the wrong way", and "I am your father, I have all the answers".

The beliefs from our family system determine our attitudes, judgments and perceptions. They are incredibly powerful. They separate good from bad, and right from wrong. They define relationships, moral values, education, sexuality, career choices, ethics and finances. They mould family behaviour. They provide a solid basis for a child's development and subsequent independence. In a dysfunctional system parents resist any external reality that challenges their beliefs. Rather than change, they develop a distorted view of reality to support the beliefs they already have. Unfortunately children lack the sophistication to discriminate between *true* reality and *distorted* reality. As the children in a dysfunctional system grow up, they carry their parents' distorted beliefs unchallenged into their adult lives.

There are two types of beliefs within a family system: spoken and unspoken. *Spoken* beliefs are expressed or communicated directly. They are out there. You can hear them. These overly expressed ideas have the advantage of giving us something tangible to wrestle with when we become adults. Although these beliefs may have become a part of us, the fact that they are stated make them easy to examine and perhaps to discard in favour of beliefs that are more relevant to our lives. *Unspoken* beliefs, on the other hand, can dictate many basic assumptions about life. They exist below the level of awareness. These are beliefs implied by the way your father treated your mother, or by the way either of them treated you.

It is often found that family members in a dysfunctional system blindly obey family beliefs because to disobey is to be a traitor to one's family. Within these families the beliefs or rules are based on family-role distortions and bizarre perceptions of reality. Blind obedience to these beliefs or rules often leads to self-defeating behaviour. It is not a matter of free choice, nor is it the result of a conscious decision. Blind obedience forges our behaviour patterns early in life and prevents us from escaping certain dysfunctional patterns. There is usually a huge gap between our parents' expectations and demands, and what we really want for ourselves. Unfortunately our unconscious pressure to obey almost always overshadows our conscious needs and desires.

An exercise concerning family beliefs will follow in session 5.

4.3 EXPERIENCE: ANGER

Experiencing anger is natural to everyone, and can therefore be described as a natural human emotion. What you, however, do with anger is learned, and can be reshaped to better meet your own needs. Anger is one of the most common and important of our feelings. Like other feelings it is an indicator of something that we might need to attend to in our lives. Unresolved anger can be a secondary reaction to early relationship

wounds. We remain angry because, deep down, we still feel hurt. These early wounds occur in everyone: they are part of growing up and developing a separate sense of 'self' that is no longer merely an extension of our parents, when we were young and especially vulnerable to those we loved and needed, because they had such power over our lives. Many of these early wounds heal naturally as we become secure in our sense of our 'self' and feel increasingly capable and self-reliant, or find other ways of having our needs for love, attention and security met. Some wounds, however, do not heal so easily, particularly those that are the result of relationship trauma, abuse or neglect. These are the wounds that we need to consciously attend to in adulthood, so that they do not burden our interaction others with large amounts of pent-up anger that slip out sideways.

4.3.1 Do not feel your anger

Anger can be:

- split off (cast out of our conscious awareness);
- repressed;
- denied; or
- turned inward.

Anger hurts, and it is uncomfortable to feel. When anger sits within us and never gets worked through, or when we do not have constructive ways of processing or dealing with it, it may disappear in the following ways:

- by depression;
- physical ailments, for example back pain, headaches, excessive muscle tension;
- self-medication;
- by over-eating;
- a loss of appetite;
- by sleeping too much;

- projecting;
- other compulsive behaviour, for example over-exercising;
- nervous symptoms such as trembling, and shaking; or
- even by a feeling of excitement.

Exercise 1

Ask the client if he or she made use of any of the above methods to try and get rid of his or her anger.

4.3.2 Passive aggressive anger

When we do not want to openly own our angry feelings we may act them out sideways. When anger is disowned but leak out or is acted out in hidden, pathological or even devious ways, we refer to it as *passive-aggressive anger*. This means that the behaviour contains aggression, but the aggressive feelings are not owned or dealt with openly. Some examples of passive-aggressive anger are:

- neglect;
- ignoring;
- the silent treatment;
- stonewalling;
- constant criticism;
- chronic grouchiness;
- constantly being late;
- constant negativity; or
- even constantly taking the 'positive' or the 'high' road as a means of one-upping, or feeling superior to the other person.

This kind of anger is confusing, because we do not always see it, and the person exhibiting these behaviours may quickly deny they are angry when we confront them. They disown the feeling inside themselves and are uncomfortable with the idea of their own anger, which is why it escapes through passive-aggressive channels. Anger is often expressed by means of tense silence, through mutual blaming, or through one-sided blaming, coupled with one-sided acceptance.

Exercise 2

Ask the client if any of his family members made use of any of the above methods. Did the client, or is he or she still making use of any of these methods?

4.3.3 Anger and dysfunctional families

People who grew up in troubled families often do not realize how angry they are, or how useful it can be for them to recognize and express their anger, even if their traumas or mistreatments happened many years ago. As children grow up they do not have any other point of reference from which to test reality than their parents. So, even if they were mistreated, children and adults often do not realize that they were mistreated. They think that the way they were treated – and often how they are still being treated – is somehow appropriate or acceptable.

Many people in recovery are afraid to express their anger. This is one aspect that needs to be addressed in therapy, namely to assist the client to freely express his/her own anger. Getting in touch with and expressing your anger may set you free. Yet, in a troubled family environment, the healthy awareness and the expression of feelings is discouraged and may even be forbidden. In an environment where feelings cannot be expressed, the individual often feels as though he or she has caused the loss or trauma. He feels shame and guilt, but it is not acceptable to openly express these either. So, he or

she may then feel even angrier, and if he/she tries to express that, they are squelched again. With repeatedly stuffing or repressing their feelings, their inner selves are left feeling confused, sad, ashamed, and empty. As these painful feelings build up and accumulate; they become intolerable. With having no place to ventilate them, the individual may make one of the following choices:

(1) block them all out as best you can – become numb;
(2) hold them, until it becomes unbearable;
(3) become physically or emotionally sick;
(4) blow up;
(5) blot the pain out with food, work, exercise, sex, alcohol or drugs;
(6) express the pain and work through it with supportive people.

<u>Exercise 3</u>

The therapist and the client need to determine what the client did with his anger when he grew up.

- Did he swallow it and not become aware of it?
- Did he play the piano extra hard?
- Did he hit his brothers and sisters?
- Did he go to his room and cry?
- What did other family members do with their anger?
- Is the client afraid he will go into a rage?
- Is the client afraid he will start crying to the point of becoming hysterical?
- Does he/she fear what would happen if he/she really acknowledges his anger?

Step 1: Make a list of the things you could have been angry about as a

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Child, starting each one with, "I could have been….."

Step 2: Make a list of the things that as an adult you could be angry about, starting each one with, "I could be…."

Step 3: Now draw a large X across the words, "I could have been..." or "I could be..." in every sentence.

Step 4: Then make a new list using each remark, but begin with: "I am...", "I was….", "I am still…." depending on whether or not you are still angry.

Step 5: Read these sentences aloud to your therapist a number of times.

Step 6: Complete this sentence: "I can feel angry because ......"

Step 7: Read these sentences aloud to the therapist a number of times.

4.3.3.3 Continued anger

Some clients will find relief by simply acknowledging past pain, while others will not like the feeling at all. Remind your client that acknowledging anger is a necessary part of the recovery process. Also remind him/her that the more they share their feelings the more comfortable the recovery will be.

Anger may have the power to cleanse, but continued anger blocks healing. The purpose of these exercises are, therefore, to give the client an opportunity to express his anger in a healthy way while he is in a safe environment, but after the cleansing process it needs to stop. Maintaining your sense of outrage and resentment toward the unfairness of life

and towards those who abused or mistreated you keeps you in bondage. The anger ceases to cleanse and starts to control.

SESSION 5: MESSAGES FROM MY PAST, SELF-TALK AND EMOTIONS

5.1 FEEDBACK

Provide an opportunity for feedback or questions.

5.2 MEANING ATTRIBUTION: PARENTAL RULES

Over a certain period in time parental beliefs develop into parental rules. Rules can therefore be seen as the manifestations of beliefs. These rules are the 'forces' within the family system, the simple "do's and don'ts". As with beliefs there are also spoken and unspoken rules within the family system. *Spoken* rules may be arbitrary, but they are clear, for example, "Spend every Christmas at home", or "Do not talk back to your parents". Due to the fact that they are out in the 'open', adults can challenge them. *Unspoken* rules, on the other hand, are unseen and they exist below the level of awareness. They often demand blind obedience from the different family members. Examples of such rules are, "Do not be more successful than your father", "Do not be happier than your mother", "Do not lead your own life", "Do not ever stop needing me", "Do not abandon me". These unspoken rules often have a hold over the adult's or child's life. To change them the client first needs to understand them.

Exercise 1

What beliefs or rules, spoken or unspoken, existed within the client's family system? Below are a number of examples of beliefs or rules that may exist in dysfunctional family systems. During the exercise we focus on the dysfunctional beliefs and rules, due to the

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fact that those beliefs and rules harmed us and are still controlling our lives in a negative way. The therapist could discuss the list with the client, and the client can then indicate if any of these beliefs or rules existed within his family of origin. The client has to write these beliefs or rules down, as well as any other beliefs or rules that existed within the family system. The following are examples of beliefs or rules that could possibly exist within a dysfunctional family system:

- Do not to feel...
- Do not accept responsibility.
- It's not okay to have fun.
- It's not okay to relax.
- Do not discuss the family with outsiders.
- You should always keep the family secrets.
- Do not talk back.
- You should do well at school, at all costs.
- We have to look good in the society.
- Do not get angry.
- Do as I say, not as I do.
- You should look after your mother / father / sister/ brother.
- Do not think or talk, just follow the instructions.
- All women are...
- Women only want...
- Women are only good for...
- All men are...
- Men only want...
- Men are only good for....
- Children should be...
- Children should....

- Children ought to...
- Children are supposed to...
- Shame on you!
- We wanted a boy/girl.
- It is your responsibility to make your parents/siblings happy.
- Always make your parents proud.
- It is always your fault.
- It is not so bad.
- It did not really hurt you.
- You will not be able to survive without us.
- Do not leave us.
- You belong to me.
- Accept my authority.
- I am bending over backwards for you.
- I am sacrificing my whole life for you.
- You are so selfish.
- If I told my parents the truth about (my divorce, my abortion, my being gay, my fiancée etc.), it would kill them.
- If you stand up against me, I will punish you.
- If you stand up against me, I will not look after you.
- If you do not do as I say I will send you away to a hostel.
- Our family is perfect.
- Our family is better than any other family.
- Our feelings are more important that yours.
- You have to be loyal to the family, no matter what.
- Do not talk back.
- How did your father treat your mother?

- How did your father treat his children? Were the boys and girls treated the same way, or were they treated differently?
- How did your mother treat your father?
- How did your mother treat her children? Were the boys and girls treated the same way, or were they treated differently?
- What were your parents' attitudes in respect of their in-laws, friends, authority, money, sexuality, property, work , *etc.*?
- Any other significant behaviour?

5.3 Self-talk

If a child grew up in a dysfunctional home he/she probably had to get used to the following pronouncements, "I cannot trust anybody", "I am not worth caring about", "I will never amount to anything". It is important to explain to the client that it is self-talk that moves the pendulum of the self-concept. It is therefore the client's self-talk that determines if he will have a realistic positive self-concept, an unrealistic positive self-concept, a realistic negative self-concept or a unrealistic negative self-concept. The conclusions that the client makes about him/herself namely, for example, "I am not good enough", are based on his own negative self-talk. These negative deductions are self-defeating, and need to change.

Exercise 2

From these beliefs and rules and by means of our intra-psychic dialogue, certain messages are formed, for example:

Belief or rule	**Message**
Do not feel	My emotions are not important
Do not accept responsibility	Nobody will tell me what to do
It's not okay to relax	I can never relax
Do not discuss the family with	I have to be loyal to my family, no

outsiders	matter what
Do not talk back	I cannot have an opinion
You should do well in school, at all costs	If I am not successful, I am not accepted
We have to look good in the society	I always have to look good to outsiders, no matter what my life is really like
Do not get angry	
Do not think or talk, just follow my instructions	I cannot express my anger What I think is not important
Shame on you	
We wanted a boy/girl	I have to be ashamed of myself
It is my responsibility to make my family happy	I am not good enough I must make others happy
Always make your parents proud	
It is always your fault	I may never fail
It is not so bad	
It did not really hurt you	I am a mistake
You will not be able to survive without us	What you are feeling is wrong Do not trust your feelings
Do not leave us	I am not strong enough to be independent
I am bending over backwards for you	
I am sacrificing my whole life for you	I am responsible for my parents
If you stand up against me I will punish you	I owe my dad
If you stand up against me I will not look after you	I owe my mother
If you do not do as I say I will send you away to a hostel	If I do not conform my dad will not love me
Our feelings are more important that yours	If I do not conform I will lose my mother
	If I do not conform I will lose my family
	What you feel is not important

The client needs to draw two columns as the above example, for each member in his family of origin. In the first column the client writes down the beliefs and rules that came to the fore in exercise 1, and then column two needs to be completed by writing the messages that are the result of the belief or the rule, for example:

Father:

Belief or rule	Message

Mother:

Belief or rule	Message

Brother:

Belief or rule	Message

5.4. EXPERIENCE: FROZEN EMOTIONS

A section of the therapeutical process is acknowledging the feelings that we have experienced and releasing frozen and denied feelings. These feelings are stored in body tissue, in messages and in our behaviour. Suppressed feelings can be overwhelming and scary, but it is worthwhile taking the risk to allow the 'self' to experience the feelings. If the client keeps on recalling certain events, but cannot associate any feeling with them, the chances are that he/she has frozen these feelings inside of him or her.

Explain to the client that how we felt about an experience, rather than what we did not feel but needed to, is as important as what happened. When we feel safe, we let ourselves feel the fear, shame, rage, hurt and loneliness that we did not feel safe enough to feel then.

Exercise 3

Step 1:

The therapist may make use of any relaxation technique that he or she is familiar with.

Step 2:

With his or her eyes closed the client thinks back to his or her childhood and recalls certain events that come to mind. The therapist needs to explain to the client that we recall an event, and then follow it to an emotional conclusion. The therapist needs to ask the following questions:

- What was the feeling you had during or after the event that you are thinking about?
- Did you feel it, or freeze it?

If the client responds that he or she has frozen the feeling, the therapist needs to ask:

- Are you experiencing any emotions at the moment?

Give the client time; do not rush the situation

Step 3:

If the client experiences an emotion, make a note of it and tell him/her that you will discuss it when you have completed the exercise. If the client is not experiencing any emotion, explain to him/her that the reason is that he or she is still not feeling safe enough to allow him/herself to feel the emotion. Re-assure him/her that it is fine, that there is nothing wrong. He/she will be able to experience the emotions the moment he/she is ready and feels safe and secure. As a therapist, do not take it personally and feel that you are not a good therapist. Sometimes the hurt of the past is so intense that it takes time to get to a point where the client feels safe enough to experience the emotions.

Step 4:

Still with his or her eyes closed, let the client re-tell the event aloud to the therapist from an adult perspective. The therapist needs to determine if the client has gained any insight into the situation with the knowledge provided previously in the session.

Step 5:

Still with his/her eyes closed, ask the client if he/she would like to recall any other events during his/her childhood. Repeat steps 2 to step 5 with every event that the client wishes to recall.

Step 6:

If the client experienced any emotion or emotions during step 3, explain the emotion to him/her in order to provide insight into it.

SESSION 6: CLEANSING THE WOUND

6.1 FEEDBACK

Ask the client if he would like to discuss anything in respect of the previous session. Allow time for feedback.

6.2 GRIEF

To be able to cleanse the wound, the client needs to grieve. To grieve is a normal and necessary reaction to loss. Children who grew up in dysfunctional families suffer numerous losses over which they are often unable to grieve. The negative messages that they get when they grieve sets up a major block, for example, "Do not feel" or "Do not talk about it". When we grieve we naturally allow ourselves to feel the anger, hurt, disorientation and sadness that are part of processing pain. People are often afraid to grieve because they fear they will never emerge from the pain. When we, however,

understand that these feelings are part of the healing process and that by feeling them we can allow them to dissipate, we begin to feel better.

Emotional wounds, like wounds to the body, need to be cleansed so that they can heal. The client needs to identify his or her losses in order to experience his/her grief. He/she needs to work through these feelings to release its hold on him/her. Ignoring grief may alleviate the sad feelings for a while, but the grief will soon emerge again. Unresolved grief festers like a deep wound covered by scar tissue; a pocket of vulnerability ever ready to break through. Many people do not grieve at the time of the loss because they are expected to be 'strong', or they believe they have to take care of everyone else. These people, however, invariably fall apart, sometimes years later, often on grounds of some minor event. We experience a loss of the 'self' when we relegate emotional wounds into a kind of psychic silence. It is not until delayed grief is experienced that an individual can resume his life anew.

When we experience a loss, it stirs up the energy within us that needs to be discharged. When we do not discharge this energy, the stress builds up to a state of chronic distress. With no release this chronic distress is stored within us as discomfort or tension that may at first be difficult to recognize. We may feel it or experience it through a wide range of manifestations such as:

- chronic anxiety;
- tension;
- fear;
- nervousness;
- anger;
- resentment;
- sadness;
- emptiness;
- unfulfilment;
- confusion;
- guilt;

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- shame;
- a feeling of numbness; or
- no feeling at all.

The client may also experience:

- difficulty in sleeping;
- aches and pains;
- other somatic complaints;
- full-blown mental-emotional illness;
- physical illness; or
- Post Traumatic Stress Disorder (PTSD).

We always suffer afterwards when we do not grieve in a complete and healthy way. If we cannot mourn our losses we may

- stay stuck in anger, pain and resentment;
- lose access to important parts of our inner, feeling world;
- project unfelt, unresolved grief into any situation, placing those feelings where they do not belong;
- lose personal history along with the unmourned person or situation - a part of us dies, too;
- carry deep fears of subsequent abandonment.

Like anger, grief can throw any one of us off balance. It is, therefore, important that the client takes especially good care of himself or herself during this time. The grieving process entails shock, rage, disbelief and sadness. The client needs to get to a point where he or she feels sorry for the little boy or girl inside them who was hurt so badly.

What is the difference between self-pity and grief? People who are stuck in a situation of self-pity wait around for someone to come to their rescue. They avoid personal responsibility. Grief is active, not passive. It gets you unstuck. It allows you to heal!

6.2.1 The different stages of grief

Grief has different stages. The following stages of grief, as described by Dayton (2007:197), are relevant to this study:

Stage 1: Emotional numbness and shutting down

In this stage the client may go through a period of feeling emotionally numb. He/she is aware that something is wrong, but his feelings are shut down and out of reach. People may stay in this stage for many years.

Stage 2: Yearning and searching

There is a deep yearning for what is lost, whether a stage of life, a part of the self, or a person, followed by searching for a way to replace the loss.

Stage 3: Disruption, anger and despair

At this stage, a client may experience anger, despair, sadness and disappointment, that all come and go, and at times are overwhelming. His/her life feels disrupted. Many losses that have anger and resentment attached to them may get confusing at this point. It may be easier to feel the anger rather than the sadness beneath it. There may also be feelings like longing and relief, or rage and yearning.

Stage 4: Reorganization and integration

At this stage the client is able to articulate and experience either the natural, numbed or split-off emotion connected with the loss, and integrate it into the 'self' system. This is the stage of acceptance and letting go.

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Stage 5: Spiritual growth and a renewed commitment to life

The client experiences first-hand that he/she can heal by reaching out and letting in the love and care of willing people. The client has energy freed up that he can reinvest in life. The beauty of grief is that it frees up our energy!

Exercise 1

How do we start to deal with the grief from our past? The first step is to identify our losses by accurately naming them. The therapist needs to name examples of losses that the client could possibly have experienced during childhood so that he/she may be able to name the losses he has experienced. Examples of the losses that children from dysfunctional families often experience, are the loss of

- feeling good about the 'self';
- unconditional acceptance;
- feelings of safety;
- trust;
- joy and spontaneity;
- stability;
- support;
- nurturing, respectful parents;
- childhood;
- individuality;
- innocence; or
- love.

Identifying a loss may be difficult, especially one that has been 'stuffed', repressed or suppressed. Only an estimated 12% of our lives and our knowledge is our conscious awareness, in contrast to 88% that makes up our unconscious awareness. When the client experiences difficulty in identifying the losses from his or her childhood, experimental techniques are very useful. The use of experimental techniques allows a

focus and a spontaneity that tap into the unconscious process, which otherwise may remain hidden from our ordinary awareness.

Exercise 2

Write a letter to the child inside you. Maybe the little child inside you is scared, and angry, and feels hopeless. Write a letter where these emotions are acknowledged. Then give the child the reassurance that everything is going to be fine. If the client has any children of his/her own, explain to him/her that he/she may write the letter in the same way as he would write it to one of his children.

SESSION 7: THE WOUND STARTS TO HEAL

7.1 FEEDBACK

Give the client the opportunity to provide feedback, or to ask questions.

7.2 FORGIVENESS

Before the wounds from the childhood years can heal, the client needs to forgive. The researcher disagrees with many therapists that forgiveness needs to take place at the beginning of the healing process, but is of the opinion that the client first needs to get insight into what has happened in the past. The client then has to remember the past, and then get rid of all the negative or frozen emotions of the past. Only after the client has gone through this entire process will he/she reach the stage where he/she is ready to forgive. The researcher does, however, believe that forgiveness is a vital part of the healing process. It is only after forgiving that we will find the freedom and peace that we yearn for.

To forgive somebody is a choice that you have to make and you need to see it as an opportunity for personal growth. *Forgiveness* can be defined as giving up our claim to avenge a wrong-doing. When we forgive, we are not saying what the person did is acceptable; we are simply saying, "I am releasing myself from the responsibility of vengeance". Forgiveness also allows us to see ourselves, as well as the other person, in the way we really are. Adults who have grown up in a dysfunctional family system are often inclined to miss reality. In other words, they do not see things the way they are. They often deny reality and create an environment for themselves in which they can function, for example, a family may deny the fact that their mother is an alcoholic by creating an 'environment' where it is acceptable for the mother to drink, due to the fact that she is experiencing stress at work. The truth, however, is that if the client denies reality he/she will not be able to forgive. During the previous sessions the client had to face reality and to see things the way they really were during his childhood years. That is the reason why the therapist is of the opinion that by the time the client arrives at this stage of the recovery process, he will be able to face reality and see things the way they still are. This will enable the client to come to the point where he/she is able to forgive.

Forgiveness provides the client with the opportunity to put paid to the painful experiences of the past, and to reach the situation where he can heal emotionally. Forgiveness, therefore, brings closer, and also releases.

7.2.1 Myths about forgiveness

There are many myths about forgiveness, as will be discussed below:

Myth 1: When you forgive somebody your negative feelings will change into positive feelings

It is important to remember that forgiveness is a process rather than an event. People often believe that they have forgiven somebody, but the moment they hear that person's name they experience the old, all-consuming emotion again. The fact that they still experience certain emotions when they hear the person's name does not mean they did not forgive that person. In Mathew 18:21-22 in the Bible Jesus tells his followers to forgive people 70 X 7 times. When you do your calculations it adds to 490 times that you need to forgive the same person! Jesus' admonition to forgive 70 X 7 times, places into context how long this process can take and how difficult it can be.

Myth 2: When you forgive someone the relationship will be restored

Sometimes it does happen, but often this is not the case. The researcher has often used the example provided by Emily Barnes in her book *Heal my Heart, Lord* (1996:74-74):

> *"I know of a woman who went through a bad time in her marriage and made a series of painful mistakes. She fell apart emotionally, the marriage split up and her husband was granted custody of their two young children. Although she wrote them faithfully, they were very angry and wanted nothing to do with her. Unfortunately, her ex-husband was very bitter and inflamed these feelings of anger. Eventually he moved them to a state so distant that she could barely afford to visit (although she tried). During this time, the woman worked very hard to rebuild her life. She relied on a competent counselor and support groups. She also returned to the faith she had left behind many years earlier. On her knees she expressed her repentance to God and begged forgiveness for her part in all that had happened. She also wrote her children and asked their forgiveness for anything she had done to hurt them. After that, the problems continued. Her ex-husband was still hostile and he even used her requests for forgiveness to try to deny her visitation. Her children were still distant. They were so far away that visits were a severe financial hardship. So she went to her pastor with her pain and asked him: "I have asked God to forgive me and I really think he has. So why don't I feel forgiven and why is everything still so hard?" The wise pastor looked at her with great compassion and answered: "If you've asked the Lord for forgiveness, He has forgiven you. So maybe, what you now need is not forgiveness, but the grace to live with the consequences of your actions."*

Forgiveness is not superglue for broken relationships. It is also not an eraser for hurtful remarks or painful memories. Forgiveness also does not pardon us from having to cope with the consequences of sin in our lives and the lives of others. Forgiveness works at the soul level, sometimes deeper than the mere eye can see. That is where the healing takes place, in the soul dimension of the person that is forgiving. True forgiveness works because it changes the person that forgives, and not necessarily the person that is forgiven, or the difficult circumstances. It also does not take the consequences of our behaviour away; many times we have to live with the consequences of our actions.

Myth 3: I will feel better when I forgive the person that harmed me

Although a person may feel relief for a certain period, the moment you hear the other person's name or see the other person, the same old feelings rise up inside of you. Therefore the therapist needs to explain to the client that forgiveness is a cognitive choice and not about what you are feeling. If you have decided to forgive a person and you experience negative emotions, remind yourself that the fact that you are experiencing negative feelings does not mean that you did not forgive the person. Remind yourself that you have forgiven the person and in time, the negative feelings will also be something of the past.

Myth 4: If we forgive the person we agree or accept his/her behaviour

Forgiveness is not saying what happened was acceptable, or it is not excusing what has happened, instead it is allowing something new to grow. Forgiveness means that we do not agree with the other person's behaviour and therefore we need to forgive him.

Myth 5: Forgiveness means that you forget all that has happened to you

A healed memory is not a deleted memory. Instead, forgiving what we cannot forget creates a new way to remember. The memory can be changed from the person's past into a hope for the future".

Any person who has reached a point where he or she can truly say, "I have forgiven that person", will admit that the reward in the end is well worth it.

7.2.2 <u>The different stages of forgiveness</u>

In the magazine *Family Life Today*, four stages of forgiveness are identified (Smedes, in: Heavilin 1987:41), namely

Stage 1: Hurt

When someone causes you pain so deep and unfair you cannot forget it, you are pushed into the first stage of the crisis of forgiving.

Stage 2: Hate

You cannot shake off the memory of how much you were hurt, and you cannot wish your 'enemy' well. You sometimes want the person who has hurt you to suffer as you are suffering.

Stage 3: Healing

You see the person who hurt you in a new light. Your memory is healed.

Stage 4: Restoration

You invite the person who hurt you into your life; if he comes honestly, love can move you both toward a new healed relationship. The fourth stage depends on the person you

forgave as much as it depends on you; sometimes he does not come back, and you have to be healed alone.

Exercise 1

The client needs to bring the letters that he has written to the session. The letters can be read aloud to the therapist so that the client can feel that he/she is heard.

A chair could also be placed in the middle of the room. The client can imagine the person that the letter is addressed to sitting in the room. Then he/she can read the letter out aloud.
The client then needs to complete the following in writing for each person that he wrote a letter to. He then has to read it out aloud:

On this day .... (date), I forgive..............for ....

The therapist needs to create a little ceremony where the client decides what he wants to do with the letter, for example:

- burn it;
- tear it up into little pieces;
- jump on it; or
- bury it.

After the ceremony the therapist and the client can determine a way to celebrate the experience. Examples of celebrating are:

- make a collage of the future;
- remember the positive aspects of his her childhood.

SECTION C: THE END OF THE PROGRAMME

Therapists need to remember that the aims of the implementation of the treatment programme are to

- assist the clients to establish more positive, reliable, and efficient relationships with God, the self, other people, objects and ideas;
- assist the clients to reach at least a certain degree of self-actualization.

SECTION D: GUIDELINES ON DATA COLLECTION

Guidelines regarding the data collection process will be provided by the researcher.

THANK YOU FOR YOUR WILLINGNESS TO PARTICIPATE IN THE STUDY!

Bibliography

Alexander, J. 2009. *You can't play the game if you don't know the rules. How Relationships Work.* Oxford: Lion Hudson.

Barnes, E. 1996. *Heal my heart, Lord.* Oregon: Harvest House Publishers.

Beattie, M. 1989. *Beyond Co-dependency And Getting Better All the Time.* Genter City: Hazelden.

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Black, C. 2001. *It Will Never Happen to Me. Growing Up with Addiction as Youngsters, Adolescents, Adults.* 2nd edition. Denver: MAC Publishing.

Chapman, T. Undated. *The Power of Parental Influence.* Available: http://www.teensavers.com/what-is-a-healthy-family on 20/7/2010.

Dayton, T. 2007. *Emotional Sobriety. From Relationship Trauma to Resilience and Balance.* Florida: Health Communications.

Ferguson, P. 2010. *There Really is Such a Thing as a Healthy Family – Description For Recovering Families.* Available: http://www.Ezine Articles.com/?expert=Peggy_Ferguson on 20/7/ 2010.

Forward, S. 1989. *Toxic parents. Overcoming their hurtful legacy and reclaiming your life.* New York: Bantam Books.

Grohol, J. 2007. *Five Tips for Dealing with Guilt.* Available: http://www.psychcentral.com/blog/archives/2007/11/27/5-tips-for-dealing-with guilt on 31/7/2010.

Heavilin, MW. 1987. *Roses in December. Comfort for the Grieving Heart.* Oregon: Harvest House Publishers.

Hurlock, EB. 1978. *Child Development.* Sixth Edition. Auckland: McGraw-Hill.

Jacobs, LJ. 1981. *'n Ondersoek na die Doeltreffendheid van die Empiries-Opvoedkundige Teorie vir Pedodiagnose en Pedoterapie.* Pretoria: Universiteit van Suid-Afrika.

Jacobs, LJ. 1982. *Selfkonsep, Diagnose en Terapie.* Pretoria: H & R: Academica.

Jantz, GL. & McMurray, A. 2003. *Healing the Scars of Emotional Abuse.* Michigan: Fleming H. Revell.

Jones, LG. 2006. *Forgiveness.* Available: http://wwwpracticing ourfaith.org/prctforgiveness.html on 12/8/2010.

Leman, K. 2007. *What your Childhood Memories Say about You and What You can Do About It.* Illinois: Tyndale House Publishers.

Lerner, H. 2004. *The Dance of Anger. A Woman's Guide to Changing the Pattern of Intimate Relationships.* London: Element.

Meyer, J. 2003. *Beauty for Ashes. Receiving Emotional Healing.* New York: Warner Faith.

Raath, MC. & Jacobs, LJ. 1993. *Dynamics of the Self-concept.* Pretoria: Academica.

Roets, E., Kruger, D., Lessing, AC. & Venter. 2002. *Voorligting in Opvoedkundige Konteks. Hons. BEd met Spesialisering in Skoolvoorlgting. OSV451-3.* Pretoria: Universiteit van Suid-Afrika.

Scott, E. 2005. *Flight-Or-Fight Response.* Available: http://www.stress.about.com/od/stressmanagementglossary/g/ FightorFlight.htm on 21/7/2010.

BESTPFE.COM
List of research project topics and materials

Sekouri, C. 2010. *What is a Dysfunctional Family?* Available: http://www.improving-relationships.suite101.com/article.cfm/what is_a_dysfunctional_family on 21/7/2010.

Tessina, T. 2003. *It Ends with You; Grow Up and Out of Dysfunction.* Available: http://www.enotalone.com/article/22429. html on 21/7/2010.

Vrey, JD. 1975. *Die Rol van die Selfkonsep in Selfaktualisering.* Intreerede. 23-9-75. Pretoria: Unisa.

Vrey, JD. 1979. *Die Opvoedeling in sy Selfaktualisering.* Pretoria: Universiteit van Suid-Afrika.

Whitfield, CL. 2006. *Healing the Child Within. Expanded and Updated Edition.* Florida: Health Communications.

APPENDIX P

THE WORKBOOK

SESSION 1 **Date: _______________**

Exercise 1: Emotions, thoughts and memories

The following emotions, thoughts and/or memories have been experienced during the session:

____
____
____
____
____
____
____
____
____
____

Exercise 2: The contributions of a healthy family system

	Yes	No
Feelings of security from being a member of a stable group		
People you could rely on to meet your needs – physical and psychological		
Sources of affection, regardless of what you have done		
Models of approved patterns of behaviour for learning to be social		
Guidance in the development of socially approved patterns of behaviour		
People you could turn to for help in solving the problems you faced		
Guidance and help in learning skills – motor, verbal and social		
Stimulation of your abilities to achieve success in school and in social life		
Aid in setting aspirations suited to your interests and abilities		
Sources of companionship until you were old enough to find companions outside the home or when outside companionship was not available.		

SESSION 2

DATE: ___________________

A family geneagram

The client needs to write down the following for each member of his/her family of origin

Name, surname and age: ....
Residential address: ....
If the family member is deceased, when and how did the person die: ________
____
Are the parents still married? If they are divorced, when were they divorced? Did the parents re-marry? If a parent did re-marry, the new spouse should also be included in the geneagram:

____
Describe the character of the person (when you were a child):

____
Describe the character of the person (at the moment):
____How did you feel about or around the person? (As a child): _________________
____How do you feel about or around the person? (As an adult):

____
How did the person treat you? (As a child):
____ How is the person treating you? (as an adult):

____
What did other people say about that person?

____
What are other people currently saying about the person?

____
What comes to mind when you think about the person?

____
Write the good things that you remember about the person, first when you grew up, and at the moment:

____
Write the bad things that you remember about the person, first when you grew up and at the moment:

____
What was your relationship like with that person? When you grew up, and now?

____

Are there any significant aspects or events concerning this person that you find yourself repeatedly thinking or talking about?

____Any addiction, other psychological or medical aspects? ______________________

____

<u>SESSION 2</u>: THE 'SELF' **DATE______________________**

Name and surname: ____________________________
Age:_______
Residential address: ____
Marital status (If divorced, provide details):
____
Qualifications:
____
Profession:
____
Employer: ____
Any nicknames? Provide details:
____
Describe your character:
____
____
Strengths:
____
____
Weaknesses:
____
____
How did your family treat you when you were a child?
____
____
How are your family treating you at the moment?
____
____
How did you family expect you to behave? (as a child): __________________
____
How does your family expect you to behave at the moment? _______________
____
What expectations did your family have of you (as a child)?________________
____
What does your family expect from you as an adult?______________________
____

What did your family say to you as a child?

____

What does your family say to you today?

____

How did you get attention when you grew up? ____________________________

How are you getting attention today? ____________________________________

SESSION 3: GUILT **DATE: ____________________**

_________I was not responsible for ____

____

when she/he did ____

____

It was not my fault____

It was not my duty or obligation to ______________________________________

_________I was not responsible for ____

____

when she/he did ____

____

It was not my fault____

It was not my duty or obligation to ______________________________________

_________I was not responsible for ____

____

when she/he did ____

____

It was not my fault____

It was not my duty or obligation to ______________________________________

_________I was not responsible for ____

____

when she/he did ____

____

It was not my fault____

It was not my duty or obligation to ______________________________________

_________I was not responsible for ____

____

when she/he did ____

____

It was not my fault____

It was not my duty or obligation to ______________________________________

________I was not responsible for ____
____
when she/he did ____
____
It was not my fault____
It was not my duty or obligation to _______________________________

SESSION 3: SHAME

Date: _______________

Obsessive compulsive behaviour:

	Yes	No
Alcohol or drug abuse		
Over-working		
Over-exercising		
Over-and under-eating		
Gambling		
Over-sexing		
Controlling		
Perfectionism		
Overspending		
Over-attending certain groups		
Always looking for a new therapist		

SESSION 4: ANGER

Date: _________________

	Yes	No
Depression		
Physical ailments		
Self-medication		
Over-eating		
Loss of appetite		
Sleeping too much		
Projecting		
Other compulsive behaviours		
Nervous symptoms such as trembling, shaking		
Constantly looking for feelings of excitement		

SESSION 4: ANGER

Date: ______________

Exercise: Passive aggressive anger

Self:

	Y	N
Neglect		
Ignoring		
The silent treatment		
Stonewalling		
Constant criticism		
Chronic grouchiness		
Constant lateness		

Family members:

	Y	N
Neglect		
Ignoring		
The silent treatment		
Stonewalling		
Constant criticism		
Constant grouchiness		
Constant lateness		

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Always negative		
Always positive as a way of feeling superior to others		

Always negative		
Always positive as a way of feeling superior to others		

SESSION 4: ANGER

Exercise: What did you do with your anger?

	Yes	No
Did you swallow your anger and not become aware of it?		
Did you play the piano extra hard?		
Did you hit your brothers and sisters?		
Did you go to your room and cry?		
Are you afraid that you will start crying to the point of becoming hysterical?		
Are you afraid that you will go into a rage?		
Do you have a fear about what would happen if you acknowledge your anger today?		

What did other family members do with their anger?

____
____
____
____

SESSION 4: ANGER

Exercise

Step 1:

I could have been ____
____
I could have been ____
____ I could have been ____
____ I could have been ____
____ I could have been ____
____ I could have been ____
____ I could have been ____
____ I could have been ____

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____ I could have been ____
____

Step 2:

I could be ____
____
I could be ____
____ I could be ____
____ I could be ____
____ I could be ____
____
I could be ____
____ I could be ____
____

Step 3:

____
____
____
____
____
____
____
____

SESSION 5 Date:______________

Exercise

Belief or rule	Message	√
Do not feel	My emotions are not important	
Do not accept responsibility	Nobody will tell me what to do	
It's not okay to relax	I can never relax	
Do not discuss the family with outsiders	I have to be loyal to my family no matter what	
	I cannot have an opinion	
Do not talk back	If I am not successful I am not accepted	
You should do well in school, no matter what		
We have to look good in society	I always have to look good to outsiders, no matter what my life is really like	
Do not get angry		
Do not think or talk, just follow my directions	I cannot express my anger What I think is not important	
Shame on you		
We wanted a boy/girl	I have to be ashamed of myself	
It is my responsibility to make my family happy	I am not good enough I must make others happy	
Always make your parents proud		
It is always your fault	I can never fail	
It is not so bad	I am a mistake	
It did not really hurt you	What you are feeling is wrong	
You will not be able to survive without us	Do not trust your feelings I am not strong enough to be	
Do not leave us	independent	
I am bending over backwards for you	I am responsible for my parents I owe my father / mother	
I am sacrificing my whole life for you	I owe my father / mother	
If you stand up against me I will punish you	If I do not conform my dad will not love me	
If you stand up against me I will not look after you	If I do not conform I will lose my	
If you do not do as I say I will send you away to a hostel	mother	
Our feelings are more important	If I do not conform I will lose my	

than yours	family	

Other:

Beliefs and rules	**Messages**	**√**

<u>SESSION 6</u> Date: ___________________

Exercise

	Yes	**No**
Loss of feeling good about yourself		
Loss of unconditional acceptance		
Loss of feelings of safety		
Loss of trust		
Loss of joy and spontaneity		
Loss of stability		
Loss of support		
Loss of nurturing, respectful parents		
Loss of childhood		
Loss of individuality		
Loss of innocence		
Loss of love		
Other:		

SESSION 7 Date: ________________

Exercise

On this day ______________ (date), I forgive__________ ______________for
____

On this day ______________ (date), I forgive__________ ______________for
____

On this day ______________ (date), I forgive__________ ______________for
____

On this day ______________ (date), I forgive__________ ______________for
____

On this day ______________ (date), I forgive__________ ______________for
____

On this day ______________ (date), I forgive__________ ______________for
____

On this day ______________ (date), I forgive__________ ______________for
____

On this day ______________ (date), I forgive__________ ______________for
____

On this day ______________ (date), I forgive__________ ______________for
____

On this day ______________ (date), I forgive__________ ______________for
____

On this day ______________ (date), I forgive__________ ______________for
____

On this day ______________ (date), I forgive__________ ______________for
____

APPENDIX R

POST-TREATMENT QUESTIONNAIRE FOR CLIENTS

An evaluation of the effectiveness of the treatment programme

Dear Participant

Thank you for taking the time to complete this questionnaire. The purpose of the questionnaire and the research is to evaluate the effectiveness of the implemented treatment programme. The information supplied by you, will be applied to improve the treatment program and to identify the areas where the program is most applicable.

INSTRUCTIONS

1. All information provided by you will be treated with confidentially. Do not indicate your name on the questionnaire
2. Please answer all the questions by ticking the box corresponding to the chosen alternative.
3. Please select only one option, unless otherwise stated.
4. Please answer all the questions (if relevant).
5. Please answer all the questions as honestly, frankly and objectively as possible; there are no correct or incorrect options.
6. Answer according to your own personal opinion and experience.
7. Please hand in the completed questionnaire to the researcher.

SECTION A: BIOGRAPHICAL INFORMATION	serial number ☐☐☐ 3
Please indicate the following: **1. Your gender** 1 Male / 2 Female	☐ 4

1	Male	2	Female

2. Your age

1	16-21	
2	22-27	
3	28-33	
4	34-39	
5	40+	

5

SECTION B: YOUR ADDICTION

1. Please indicate the type of addiction your are suffering from (you may select more than one option)

1	Alcohol abuse	
2	Substance abuse	
3	Sex-addiction	
4	Work-addiction	
5	Eating disorders	
6	Gambling	
7	Exercise-addiction	
8	Other	

10

2. If the addiction is alcohol or/and substance abuse, are you still abusing?

1	Yes	2	No

11

3. If the answer was 'no' to the above question, please indicate the time period that your have been free of alcohol and/or a substance

1	Less than 6 months	
2	7-12 months	
3	13-18 months	
4	19-24 months	
5	25+ months	

12

4. If you answered 'yes' to the question on alcohol and/or substance abuse, please indicate the substance/s that you are still using. (You may select more than one option)

1	Alcohol	
2	Marijuana (Dagga)	

3	Cocaine	
4	Crack	
5	Tic (Methamphetamine)	
6	Over-the-counter drugs	
7	Prescription drugs	
8	Mandrax	
9	Ecstasy	
10	Cat	
11	Inhalants	
12	Heroin	
13	Others	

25

5. Please indicate the substance/s that you have used before. (You may choose more than one option)

1	Alcohol	
2	Marijuana (Dagga)	
3	Cocaine	
4	Crack	
5	Tic (Methamphetamine)	
6	Over-the-counter drugs	
7	Prescription drugs	
8	Mandrax	
9	Ecstasy	
10	Cat	
11	Inhalants	
12	Heroin	
13	Others	

38

6. Have you ever attended a rehabilitation centre to address your addiction?

1	Yes	2	No

39

7. If you have attended a rehabilitation centre please indicate the type of centre

1	In-patient rehabilitation centre	
2	Out-patient rehabilitation centre	
3	Other	

40

8. Please specify the type of rehabilitation centre if 'other' was selected:

____

9. Are there any other psychiatric/psychological disorders that you are suffering from?

1	Yes	2	No

10. Please indicate.(You may choose more than one option)

41

1	Mood disorders	
2	Personality disorders	
3	Psychotic disorders	
4	Anxiety disorders	
5	Other	

46

SECTION C: TREATMENT PROGRAMME

1. Did you complete the entire treatment plan?

1	Yes	2	No

47

2. In how many sessions did you complete the Treatment Plan?

1	1-4	
2	5-8	
3	9-12	
4	13-16	
5	17+	

48

3. If you did not complete it, why not?

____

4. Do you feel that you benefited from the Treatment Plan?

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1	Yes	2	No

49

5. How did you experience the Treatment Plan?

1	Positive experience	
2	Negative experience	
3	A neutral feeling	

50

6. How did you experience the letter-writing?

1	Positive experience	
2	Negative experience	
3	A neutral feeling	

51

SECTION D: SELF-ACTUALIZATION							
	On completion of the Treatment Plan, are you of the opinion that you understand yourself more completely? 1 Yes 2 No **Please indicate your agreement rating with regards to the aspects listed below. Please rate the aspect according to the agreement scale** SA (1) = strongly agree; A (2) = agree; U (3) = undecided; D (4) = disagree; SD (5) = strongly disagree						52
		SA	**A**	**U**	**D**	**SD**	
1	My physical health has improved						
2	My ability to set realistic goals has improved						
3	I am more accepting of myself						
4	I am more accepting of others						
5	I am more accepting of aspects in my everyday life (finances, working conditions, etc)						
6	I am more aware of my limitations and strengths						
7	I have a better understanding of who and what I am						
8	I am more other-orientated than before						
9	I have a more realistic life-view						
10	I am more spontaneous						
11	I am more focused on problem-solving rather than on thinking about the problem						
12	I have a greater need for privacy						
13	I experience a greater degree of detachment from others						
14	I am able to function more independently						
16	My spiritual life has improved						
17	The intimate relationships in my life have improved						
19	I experience an improvement in my ability to separate means from ends						
20	My sense of humour has improved (humour must be lively and not cruel)						
21	I am more creative						
22	My ability to rise above the environment rather than merely adjusting to it has improved						77
23	I am able to function on my own						
24	I do not need substances to cope						

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25	I do not need any other form of addiction to cope						

	SECTION C: RELATIONSHIPS					
	Please indicate your agreement with regard to whether there has been an improvement in the following aspects at the end of the treatment plan. Please rate yourself according to the agreement scale SA (1) = strongly agree; A (2) = agree; U (3) = undecided; D (4) = disagree; SD (5) = strongly disagree					
(i) Relationship with the 'self'						
		SA	A	U	D	SD
1	I am more accepting of myself					
2	My self-talk is more positive					
3	I am more aware of my own ideas					
4	I am more aware of my own emotions					
5	I am more aware of my own attitudes					
6	I am more aware of my own thoughts					
(ii) Relationship with others						
1	I was able to relax during the relaxation exercises					
2	I understand the difference between a healthy family system and a dysfunctional family system					
3	I was able to identify aspects that made me feel guilty					
4	I was able to name my guilt feelings					
5	I experienced a certain degree of release from guilt feelings					
6	I now understand the difference between guilt and shame					
7	I was able to identify obsessive compulsive behaviours in my life					
8	I gained more insight into setting healthy boundaries					

83

9	My ability to set healthy boundaries has improved					
10	I was able to determine what I did with my anger as a child					
11	I was able to identify the things that angered me as a child					
12	I found some release from the anger I experienced as a child					
13	I was able to identify things that I, as an adult, feel angry about					
14	I found some relief from the anger experienced and as an adult					
		SA	A	U	D	SD
15	I could identify the parental beliefs and rules of the family that I grew up in					
16	I could identify the messages from my childhood					
17	I could deal with my frozen emotions					
18	I was able to identify the losses from my childhood					
19	I grieved the losses from my childhood					
20	I was able to write a letter to the child within me					
21	I was able to forgive towards the end of the treatment plan					
22	I gained insight into my relationship with my mother					
23	My relationship with my mother has changed					
24	I gained insight into my relationship with my father					
25	My relationship with my father has changed					
26	I gained insight into my relationship with my siblings					
27	My relationship with my siblings has changed					
28	I gained insight into my relationships with difficult aspects in my everyday life					
29	My relationship with difficult aspects in my everyday life has changed					
30	The ideas in my life have changed					
31	My relationship with God has changed					

Thank you for your participation

APPENDIX S

POST-TREATMENT QUESTIONNAIRE FOR THERAPISTS

Evaluation of the effectiveness of the Treatment Plan

Dear Colleague

Thank you for taking the time to complete this questionnaire. The purpose of the questionnaire and research in this regard is to evaluate the effectiveness of the implemented Treatment Plan. The information supplied by you will assist in improving the treatment program and identifying areas to which the program is most suited.

INSTRUCTIONS

1. All information provided by you will be treated with confidentially.
   Do not indicate your name on this questionnaire.
2. Please answer all the questions by ticking the box corresponding
   to the chosen alternative
3. Please select only one option, unless otherwise indicated.
4. Please answer all the questions (if relevant).
5. Please answer all the questions as honestly, frankly and objectively
   as possible; there are no correct or incorrect answers.
6. Answer according to your own personal opinion and experience.

7. Please hand the completed questionnaire to the researcher.

Section A: Biographical information of the therapist

Serial number			

3

		For official use
1	**Please indicate your profession**	4

1	Counsellor	
2	Social Worker	
3	Clinical Psychologist	
4	Educational Psychologist	
5	Other	

2	**Where are you working? (You may indicate more than one place)**	13

1	Private practice	
2	Hospital	
3	Prison	
4	School	
5	Church	
6	Out-patient rehabilitation centre	
7	In-patient rehabilitation centre	
8	Welfare organization	
9	Other	

3	**How many years have you been working since you qualified?**	14

1	1-5	
2	6-10	
3	11-15	
4	16-20	
5	20+	

4	**Over a period of a year, how often do you see clients suffering from substance abuse?**	☐ 15

1	Regular-ly (daily)	2	Often (at least once a month)	3	Seldom (at least every six months)	4	Never

5	**Are you currently working at an institution that treats only addiction?**	☐ 16

1	Yes	2	No

If you answered 'no' to the above question, have you ever been employed at an institution that treats only addiction? ☐ 17

1	Yes	2	No

If you have answered 'yes' to either one of the two above questions, how many years in total have you or had you been employed at an institution or institutions that treat only addiction? ☐ 18

1	1-3	
2	4-6	
3	7-9	
4	10+	

Section B: Biographical information of the client

1	**Please indicate the following:** **The gender of the client**	☐ 19

1	Male	2	Female

2	**The age of the client**	☐ 20

1	16-21	
2	22-27	
3	28-33	
4	34-39	
5	40+	

3		

	The type of addiction (you may select more than one option):	28
4	**If the addiction is alcohol and/or substance abuse, is the client still abusing'?**	29
	If the answer was 'no' to the above question, please indicate the time period that the client has been 'clean' from alcohol and/or substance abuse:	30
	If you answered 'no' to the question on substance abuse, please indicate the substance/s that the client used at that stage (you may choose more than one option)	

The type of addiction (you may select more than one option):

1	Alcohol abuse	
2	Substance abuse	
3	Sex-addiction	
4	Work-addiction	
5	Eating disorders	
6	Gambling	
7	Exercise-addiction	
8	Other	

Is the client still abusing?

1	Yes	2	No

Time period 'clean':

1	Less than 6 months	
2	7-12 months	
3	13-18 months	
4	19-24 months	
5	25+ months	

Substance/s used:

1	Alcohol	
2	Marijuana (Dagga)	
3	Cocaine	
4	Crack	
5	Tic (Methamphetamine)	
6	Over the counter drugs	
7	Prescription drugs	
8	Mandrax	
9	Ecstasy	
10	Cat	
11	Inhalants	
12	Heroin	

13	Others	

If you answered 'yes' to the question on substance abuse, please indicate the substance/s that the client is still using. (you may select more than one option)

43

1	Alcohol	
2	Marijuana (Dagga)	
3	Cocaine	
4	Crack	
5	Tic (Methamphetamine)	
6	Over the counter drugs	
7	Prescription drugs	
8	Mandrax	
9	Ecstasy	
10	Cat	
11	Inhalants	
12	Heroin	
13	Others	

56

Has the client ever attended a rehabilitation centre to address his/her addiction?

1	Yes	2	No

57

If the client has attended a rehabilitation centre please indicate the type of centre

1	In-patient rehabilitation centre	
2	Out-patient rehabilitation centre	
3	Other	

60

If the 'other' option above was selected, please specify the type of rehabilitation centre:

Are there any other co-occurring mental disorders?

1	Yes	2	No

61

Please indicate the other co-occurring mental disorders, if you indicated that they are present (you may choose more than one option)

1	Mood disorders	
2	Personality disorders	
3	Psychotic disorders	
4	Anxiety disorders	
5	Other	

62

Section C: Training in respect of the Treatment Plan

1

Did you receive training in respect of the treatment plan before you implemented it?

1	Yes	2	No

63

If you answered 'yes' to question 1, do you believe that it is necessary for a therapist to receive training before he or she can implement the treatment plan?

1	Yes	2	No

64

If you answered 'no' to question 1, do you believe that it is necessary for a therapist to receive training before he or she can implement the treatment plan?

1	Yes	2	No

65

Section D: The Treatment Plan

1

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1. Were you able to implement the treatment plan at your place of work?

1	Yes	2	No

☐ 66

2. If you answered 'no' to the question on implementation, please indicate why you were not able to implement it.

____

3. Will you use the Treatment Plan in future?

1	Yes	2	No

☐ 67

4. If you answered 'yes' to the question on the use of the Treatment Plan, will you only use the treatment plan when you deal with substance abuse?

1	Yes	2	No

☐ 68

5. If you answered 'no' to the question on the use of the Treatment Plan, please indicate for what purpose or purposes you will use the Treatment Plan in future?

____

6. Did the client complete all the sessions in the Treatment Plan?

1	Yes	2	No

☐ 69

7. If the client did not complete all the sessions, please indicate the reason for not completing them.

____

8. In how many sessions did you complete the treatment plan?

1	1-4	
2	5-8	
3	9-12	

☐

4	13-16	
5	17+	

70

8. How did you as a therapist experience the implementation of the treatment plan?

1	Positive experience	
2	Negative experience	
3	A neutral feeling	

☐ 71

Section E: Self-actualization

On completion of the Treatment Plan, are you of the opinion that the client has reached self-actualization, or at least a degree of self-actualization?

1	Yes	2	No

☐ 72

Please indicate your agreement rating with regard to whether there has been an improvement in the following listed aspects of the self-actualization of the client at the end of the treatment plan. Please rate the client according to the agreement scale

SA (1) = strongly agree; A (2) = agree; U (3) = undecided;
D (4) = disagree; SD (5) = strongly disagree

		SA	A	U	D	SD	
1	The client's physical health has improved						☐
2	The client's ability to set realistic goals has improved						☐
3	The client is more accepting of himself/herself						☐
4	The client is more accepting of others						☐
5	The client is more accepting of aspects in his/her life-world						☐
6	The client is more aware of his limitations and strengths						☐
7	The client has a better understanding of who and what he/she is						☐

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8	The client is more other-orientated					
9	The client has a more realistic life-view					
10	The client is more spontaneous					
11	The client focuses more on problem-solving than on only thinking about the problem					
12	There is a greater need for privacy					
13	A greater degree of detachment from others is noticed					
14	The client is able to function more independently					
15	A less stereotyped appreciation of people, things, ideas is noticed					
16	An improvement in the spiritual life of the client is observed					
17	More intimate relationships are present					
18	The client developed more democratic values					
19	An improvement in the client's ability to separate means from ends has been observed					
20	The client's sense of humour has improved (humour must be lively and not cruel)					
21	The client is more creative					
22	The client demonstrates a better ability to rise above the environment rather than merely adjusting to it					
23	The client is able to function on his/her own					
24	The client does not need substances to cope					
25	The client does not need any other form of addiction to cope					

Section F: Relationships

Please indicate your agreement rating with regard to whether there has been an improvement in the following aspects of the self-actualization of the client at the end of the Treatment Plan. Please rate the client according to the following agreement scale:
SA (1) = strongly agree; A (2) = agree; U (3) = undecided; D (4) = disagree; SD (5) = strongly disagree

(i) Relationship with the 'self'

		SA	A	U	D	SD
1	The client is more accepting of himself /herself					
2	There a positive change in the client's self-talk					

3	The client is more aware of his/her own ideas						
4	The client is more aware of his/her own emotions						103
5	The client is more aware of his/her own attitudes						
6	The client is more aware of his/her own thoughts						
(ii) Relationship with others							
		SA	**A**	**U**	**D**	**SD**	
1	The client shows insight in his relationship with his/her mother						
2	There has been a change in the client's relationship with his/her mother						
3	The client shows insight in his/her relationship with his/her father						
4	A change in the relationship with his/her father has been observed						
5	The client shows insight in his/her relationship with his/her siblings						113
6	A change in the client's relationship with his/her siblings has been observed						
7	The client gained insight into his/her relationships with objects in his/her life-world						
8	There is a change in the client's relationship with objects						
9	There is a change in the client's relationship with ideas						
10	There a change in the client's relationship with God						

Thank you for your participation