Article

THE TREATMENT OF SUBSTANCE ADDICTION WITH FOCUS ON THE FAMILY OF ORIGIN AS POSSIBLE CAUSE OF ADDICTION

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ABSTRACT

Although substance addiction is treated by means of different treatment programmes in South Africa, it seems that the level of self-actualisation and changes in the addict's relationships are problematic. A preliminary literature review indicated that the family of origin could be one of the causes of addiction. The aim of the research was firstly to develop a treatment plan that focuses on the family of origin as a cause of addiction, and secondly to evaluate the treatment plan in order to determine the level of self-actualisation and the changes in the addict's relationships with the "self" and others, after treatment. The family systems and relations theories served as the theoretical framework for the study. The treatment plan that focuses on the family of origin as a cause of addiction was implemented by therapists during an empirical investigation to determine the effectiveness of the treatment programme. The findings of the research indicated that both therapists and addicts had a positive experience of the treatment plan with improvements in self-actualisation, as well as changes in meaningful relationships occurring.

Keywords: substance abuse; treatment programme; family of origin; self-actualisation; Family Systems Theory; Relations Theory

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INTRODUCTION

According to The World Drug Report 2015, it is estimated that almost a quarter of a billion people between the ages of 15 and 64 used an illicit drug in 2013 (UNODC 2016). Drug users have risen to 246 million, and it is stated that 27 million people or 0.6 per cent of the global population between the ages of 15 and 64 suffer from drug addiction. In a survey conducted by the Central Drug Authority (CDA) in 2010/2011 among 7 800 people in rural and urban areas in nine South African provinces, 65 per cent of the respondents reported that someone in their household was a substance abuser (CDA 2014). According to the survey, the use of cannabis, cocaine and *tik* in South Africa is twice as high as the use of the same substances worldwide. With regard to alcohol usage, it is estimated that two million people in South Africa could be classified as problem drinkers, 37 per cent of adults are binge drinkers, and 7 000 deaths occur per annum due to driving under the influence. The socio-economic cost of alcohol abuse is an estimated R130 billion per year (PMG 2011). South Africa also has the highest reported cases of fetal alcohol syndrome (FAS) in the world (DSD 2017). Around 50 per 1 000 South African children entering school were shown to suffer from FAS (CDA 2014).

Addiction is treatable and does not have to be a life sentence (NIDA 2014). While the statistics clearly indicate that the demand for treatment of addiction in South Africa is high, the CDA stated that in 2011 there were roughly only 80 treatment centres in the country. At the time, these centres were able to treat 20 000 people per year, but the demand was nine to 15 times higher (PMG 2011). The annual report of the CDA 2013/2014 indicated that only one in every 18 people who requested treatment got access to such treatment (CDA 2014). Learning evidence-based approaches to provide effective services to clients is an important aim of social work practice (Erlank 2013). However, social workers only have limited knowledge and training with regard to the treatment of substance abuse (Engelbrecht 2012). Social workers should therefore be encouraged to gain knowledge on the implementation of evidence-based approaches to render effective services to clients suffering from substance abuse.

Literature comprises various examples of causes of addiction that include genetic, biological, psychological and environmental factors (Tracey 2016). In a preliminary literature review, researchers found that the family of origin could be one of the most significant environmental factors that can cause addiction (Engelbrecht 2012). Owing to their own experience with regard to the treatment of substance abuse, the researchers questioned the level of self-actualisation reached, as well as the existence of meaningful relationships in the life world of clients that are treated with treatment plans that do not include the family of origin as a significant environmental factor. Self-actualisation can be described as the ultimate goal of personality development (Gouws 2015) and refers to an individual's deliberate effort to realise all the latent possibilities of the self. Self-actualisation therefore refers to a "fully-functioning" individual (Rogers 1961). An individual as a social being can also never stand alone and isolated in the world, but

stands in relationship to God/Gods, objects, ideas, other people and the "self" (Jacobs and Lessing 2000). Inadequate involvement could affect the individual's cognitive structure, emotional life and value system and result in, for example, anxiety, frustration and failure (Jacobs 1982).

The question underlying the research that informed this article therefore was: If the intra-psychic process within the family of origin of an individual with a history of substance addiction is treated with a treatment plan, will changes occur in the self-actualisation and in the relationships of that individual, after treatment? The first aim of the research was to develop a treatment plan that focused on the family of origin as a cause of addiction, and the second aim was to determine the effectiveness of the treatment plan. The effectiveness of the treatment plan was evaluated by determining changes in the levels of self-actualisation and the relationships of individuals who have a history of substance addiction, after treatment.

This article contains the theoretical framework, the research design and the results of the study, and ends with the most significant conclusions and recommendations.

THEORETICAL FRAMEWORK

To establish common ground for the rest of the article, the concept of "family of origin" is clarified.

Family of Origin

According to Colman (2001, 268), the primary social group that comprises the parents, their offspring, and in some societies, other relatives sharing the same household (the extended family), is known as the family of origin. In other words, the family of origin is the family one grew up in. Households where a mother, father and children live together are not the norm, and diverse family structures form part of South African society. Children are being raised, for example, by grandparents, single parents, foster parents, gay and lesbian parents, parents from different ethnic and cultural backgrounds, and also in child-headed households (Gouws 2015).

The theoretical framework underpinning this research is the Family Systems Theory and the Relations Theory.

Family Systems Theory (Bowen)

The Bowen Family Systems Theory is a theory of human behaviour that views the family as an emotional unit and uses systems thinking to describe the complex interactions in the unit (Joseph 2010). Bowen suggests that people cannot be understood in isolation and that every family is a unique social system (Joseph 2010) where the members are emotionally connected. The different members are affecting and influencing one another's thoughts, feelings and actions. Within the system, each member strives to

meet the needs and expectations of the others (The Bowen Theory n.d.). If changes occur in any one part of the system it will have an effect on all the other parts of the system (Joseph 2010). The system could function either in a healthy or in a dysfunctional manner. According to Karson (2006) the Systems Theory is best known to many clinicians by means of the concept of the identified patient. 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 and the behaviour of the client is seen as a symptom of the underlying problem in the family system. During therapy, the therapist attempts to provide the client with insight into different aspects of the family system. For the client to be able to heal, problems that occurred within the family of origin need to be solved.

Relations Theory

The point of departure of the Relations Theory is that individuals, as centre of their life-worlds, stand in relation to different components (God, others, objects, ideas and the "self") of their worlds. Through the interactive processes of involvement and experience, the attribution of meaning, and by means of self-talk, individuals develop different identities. They constantly evaluate these acquired identities with regard to the related relations, and in this evaluation individuals acquire self-concepts for each identity. If the behaviour is socially acceptable, it will contribute to sufficient self-actualisation and healthy relations. If the personality composition results in unacceptable behaviour, it will lead to insufficient self-actualisation and unsatisfying relations (Jacobs and Lessing 2000). Problematic behaviour (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 means of the intra-psychic process. For the client to heal, therapy needs to focus on the intra-psychic process (Roets et al. 2002). Changes in the intra-psychic process will lead to changes in the intra-psychic structure, which in turn will lead to changes in the individual's relationships and the level of self-actualisation reached.

DEVELOPMENT OF A TREATMENT PLAN FOR SUBSTANCE ADDICTION

During the rest of the article a distinction is made between therapists and participants. Therapists refer to psychologists, social workers and a counsellor who implemented the treatment plan, while participants refer to individuals with a history of substance addiction. The research design consists of two parts, namely the development of the treatment plan and the empirical investigation to evaluate the effectiveness of the treatment plan. To enable the researcher to develop a treatment plan, a literature review was undertaken on the relations theory, the family systems theory and the family of origin as a possible cause of addiction. The treatment plan was divided into seven

sessions. Table 1 includes the outcomes, objectives, activities, techniques and theoretical components of the seven sessions of the treatment plan.

Table 1: A treatment plan for substance addiction

Outcomes and objectives	Activities and techniques	Theoretical component
Session1: To gain insight into the functioning of a healthy family system and to become aware of the dysfunctions of their own family of origin.	Psycho-education and exercises on characteristics of healthy family systems and characteristics of their own family of origin (Ferguson 2010; Hurlock 1978).	Individuals can only be understood as part of a system (GenoPro n.d.). Meaning is attributed when individuals get involved (Roets et al. 2002).
Session 2: To gain insight into the processes of, as well as their own involvement in, their family of origin.	Drawing of a family genogram (Joseph 2010; Kilpatrick and Thomas 2009; Papero 1990). Participants are also requested to write letters to their different family members throughout the process (Dayton 2007).	Family members are connected and affect one another's thoughts, feelings and actions (Joseph 2010), and by getting involved, certain identities are formed (Jacobs and Lessing 2000).
Session 3: Participants suffering from addiction often experience guilt (Black 2001; Grohol 2007; Whitfield 2006) and shame (Beattie 1989; Black 2001). To gain insight, to become aware and to work through these emotions in a safe environment.	Psycho-education and exercises on guilt, the value of guilt, the difference between healthy and unhealthy guilt and the release of guilt feelings (Black 2001). Psycho-education and exercises on shame, the difference between guilt and shame, how shame is turned into "safer" emotions, obsessive compulsive behaviour, and the setting boundaries (Beattie 1989; Whitfield 2006).	Experience determines the quality of involvement and meaning attribution. The intensity of the experience determines the clearness and the stability of the meaning that is being formed (Jacobs 1982).

Session 4: Beliefs and rules within a family system determine the attitudes, judgements and perceptions (Forward 1989). To become aware of beliefs and rules within their family of origin. Individuals suffering from addiction often experience anger (Black 2001; Dayton 2007; Lerner 2004; Whitfield 2006). To gain insight, to become aware and to work through anger in a safe environment.	Psycho-education on beliefs and rules in a family system, how distorted beliefs are often carried unchallenged into adult lives, as well as how these could influence thinking and behaviour (Black 2001; Forward 1989). Psycho-education and exercises on the importance of "healthy" anger, reactions to anger, passive aggressive anger and healthy methods of dealing with anger (Black 2001; Dayton 2007).	Members of a family system affect one another's thoughts, feelings and actions (Joseph 2010). Meaning attribution implies that the individuals recognise, know and understand. Meaning attribution could be denotative (logical) or connotative (uniquely personal). A connotative experience could cloud a person's understanding (Roets et al. 2002).
Session 5: To understand beliefs and rules, to become aware of self-talk and to challenge and strive to change negative self-talk. Individuals suffering from addiction often suffer from frozen emotions (Beattie 1989; Dayton 2007; Tripodi n.d.). To gain insight, to become aware and to work through frozen emotions in a safe environment.	Exercises on beliefs, unspoken rules, awareness of negative messages and the changing of own negative self-talk (Black 2001; Forward 1989). Psycho-education on frozen emotions and exercises in dealing with frozen emotions through relaxation techniques, awareness of recurring events from their childhood and to learn how to follow the childhood event to an emotional conclusion (Beattie 1989; Dayton 2007; Tripodi n.d.).	Individuals are constantly evaluating their relations through self-talk (Raath and Jacobs 1993). Self-talk is influenced by an individual's own subjective value system. Negative self-talk often initiates an unrealistic negative self-concept (Roets et al. 2002).
Session 6: Negative messages, for example, "Do not feel", or "Do not talk", could set up a major block for grief (Whitfield 2006). The aim of the session is to gain insight, to become aware and to work through grief in a safe environment.	Psycho-education on grief, the difference between self-pity and grief, and the different stages of grief (Dayton 2007; Whitfield 2006). Exercises on the identification and naming of grief (Whitfield 2006).	Self-talk influences the way individuals give meaning to, become involved and experience their life-world (Jacobs and Lessing 2000).

Session 7: Forgiving others and the self are two of the most important factors in healing (Meyer 2003). To gain insight, to become aware and to work through unforgiveness in a safe environment.	Psycho-education on the misconceptions of forgiveness and the stages of forgiveness (Dayton 2007; Leman 2007). Exercises on forgiveness, discussion of letters written through the process, empty-chair method to deal with the content of the letters and to celebrate the healing process (Dayton 2007).	Participants need to gain insight, as well as understand and remember their past. They then have to examine their involvement, experience and meaning-attribution in their family of origin (Engelbrecht 2012).

METHOD

The second part of the research design consists of the empirical investigation. During the empirical investigation the effectiveness of the treatment plan was evaluated. The researchers argued that the satisfaction of therapists and participants regarding the treatment plan could indicate the effectiveness of the treatment plan. After the literature review of the Relations Theory, the researchers concluded that the effectiveness of the treatment plan could also be determined by investigating changes in the participants' relationships, as well as changes in the level of self-actualisation reached on completion of the treatment plan.

DESIGN

A sequentially mixed-method design was used to investigate the effectiveness of the treatment plan. A mixed-method design involves the collection, analysis and interpretation of quantitative and qualitative data in a single study (Cameron 2015). The sequentially mixed-method was selected because it answers a broader and more complete range of questions. It also adds insight and meaning that might otherwise be missed when a mono-method approach is used.

Quantitative Descriptive Design

The quantitative descriptive (survey) design was used in the first stage of the empirical research. Two treatment questionnaires – one for therapists and one for participants – were designed. The selection of the questions for the two questionnaires was guided by the literature review, opinions of experts in the field and the aims of the study.

Qualitative Design

During the second stage of the empirical research, one-on-one interviews were conducted with therapists who took part in the study to gain insight into their views on the treatment plan. The indications that were identified from the results of the questionnaires (stage one) were used to guide the type of questions that were used during the interviews (stage two). The researchers were able to investigate certain outcomes and trends that came to the fore during the analysis of data obtained from the questionnaires.

PARTICIPANTS AND SAMPLING

During the quantitative investigation the researchers made use of probability sampling and therapists were selected based on their qualifications, work experience and willingness to participate (Rovai, Baker, and Ponton 2013). Due to ethical considerations and especially based on therapist-client confidentiality, the researcher had no part in the selection of participants. The selection of participants was therefore done through non-probability sampling and was done by the therapists based on accessibility, a history of substance abuse and willingness to participate (Rovai, Baker, and Ponton 2013).

Invitations to take part in the study were sent by email to members of the Lowveld Psychological Association and the offices of the South African National Council on Alcoholism and Drug Dependence (SANCA) in Mpumalanga. A counsellor who works at a church learnt about the study and requested to take part. Forty-two invitations were sent and twenty-two therapists agreed to participate in the study. Twenty therapists attended a one-day training session. Each therapist received a manual and a workbook that could be used during the implementation of the treatment plan. After the training, eleven therapists indicated by email that they would be able to implement the treatment plan at their workplace. The other nine therapists reported that they would not be able to implement the treatment plan owing to other work obligations. After six months, nine therapists reported that they were able to implement the plan. The two therapists who could not implement the treatment plan did not treat any clients with a history of substance addiction in the previous six months.

During the qualitative investigation the researchers made use of purposeful sampling and participants were chosen based on the purpose of the study and on what the researchers hoped to acquire (Rovai, Baker, and Ponton 2013).

The selection of the two therapists for the second stage of the empirical investigation was based on the differences in profession, workplace, experience in the field of substance addiction and their willingness to take part in the research.

DATA COLLECTION

The treatment plan was implemented by therapists at their own workplace. Therapists received instructions regarding the implementation of both questionnaires from the

researchers. The request and the instructions for the completion of the questionnaire for participants were done by therapists. At the completion of the treatment plan, data were collected in two sequential phases. During phase one, data were collected by means of questionnaires. All nine therapists who took part in the study completed the questionnaire for therapists, while only five of the nine participants completed the questionnaire for participants. The Likert scale and the following five-point range were used by therapists and participants to indicate the rank order of agreement or disagreement during the completion of the questionnaires: (1) strongly agree, (2) agree, (3) undecided, (4) disagree, and (5) strongly disagree. Both questionnaires were sent to the statistical department of Unisa to be reviewed by experts in the field. The researchers argued that

- if therapists were satisfied with the treatment plan, they would use the treatment plan in future. A question to determine future use was included,
- if participants were able to achieve the outcomes of the exercises, they would be satisfied. Twenty questions regarding the outcomes of exercises were included in the questionnaire for respondents,
- if the treatment plan was effective, changes should have taken place on the levels of self-actualisation reached by participants after treatment. Twenty-five questions on the characteristics of self-actualisation were included in both questionnaires,
- if the treatment plan was effective, changes should have taken place in the participants' relationships with God, others, objects and ideas. Ten questions were included in the questionnaire for therapists, and thirty-one questions in the questionnaire for participants with regard to relationships with "others", and
- if the treatment plan was effective, changes should have taken place in the participants' relationships with the "self". Six questions with regard to the relationship with the "self" were included in both questionnaires.

During the second phase, one-on-one interviews were conducted with two therapists. The main aim of the empirical investigation was to determine the effectiveness of the treatment plan. The following questions were included:

- Therapists and participants all seem to have a positive experience of the treatment plan. How did you experience the treatment plan?
- The treatment plan seems to be effective. Did you perceive it to be the main contributor to the successful recovery from addiction?
- The self-actualisation scores of participants who have overcome addiction seemed a little less positive than the scores of those who have not. Does this conclusion make sense?
- The longer the time period that participants are free from substance abuse, the lower their self-actualisation and their relationships. Does this make sense?

- The treatment plan seems to be more effective for those persons who did not attend a rehabilitation institution. Is this true?
- With co-occurring disorders the treatment plan is slightly less effective. Is this presumption true?

DATA ANALYSIS

The two questionnaires (phase one) provided a basis for the collection of data during the interviews (phase two) and the effectiveness of the treatment plan was determined by collecting and analysing the two types of data. The researchers were able to determine the effectiveness of the treatment plan from the data obtained from the quantitative phase, while the qualitative phase was used to gain better understanding and insight. The study therefore relied more on the quantitative than the qualitative investigation.

Due to the sensitive nature of the field of study, which limited the availability of therapists and respondents, only a limited number of therapists and participants participated in the research. No statistically significant tests could therefore be conducted. Indications of possible trends and tendencies can only be considered speculative, and deductions made from the results should be treated as indications, guidelines and possibilities. The results are treated as "possible" indications and are reported as research findings of the quantitative component of the research. During the quantitative investigation the researchers made use of structured interviews. Preformulated questions based on the research findings of the quantitative component were used and thematically analysed (using the statistical software SAS JMP 12.0). The Statistical Programme for the Social Sciences (SPSS) was used for the aforementioned analyses. A list of themes about the major concepts of the study was identified (Rovai, Baker, and Ponton 2013). The second phase of the research was qualitative. This phase served as a follow-up to the quantitative phase. The questions for the interviews were based on the results of the quantitative phase of the study. The semi-structured interviews enabled the researcher to ask probing questions to gain insight into the quantitative results. The researchers used Guba and Lincoln's constant comparative method of analysis to analyse the data.

Owing to the restricted number of observations the constructs in both questionnaires could not be tested for reliability. The indications identified from the results of the completed questionnaires that were used to guide the types of questions that were used in the interview schedule, and the answers to the interview questions were treated as "possible indications". The researchers were also not able to make comparisons between clients owing to the major differences that existed between them. The researcher also did not have benchmark information regarding the treatment of clients before the implementation of the treatment plan, such as co-occurring disorders, severity of addiction, coping skills, and relationships.

ETHICAL ASPECTS

Different ethical considerations applied to therapists and participants. The ethical code of conduct by the Health Professions Act (South Africa 1974) was included in the one-day training of therapists and used as a guideline during the implementation of the treatment plan.

Therapists and participants were informed of the experimental nature of the treatment plan, voluntary participation, as well as that the purpose of the completion of the questionnaires was to determine the effectiveness of the treatment plan. Ethical clearance and consent forms were obtained from therapists and participants. Data collected for the research were cleared of any identifying information to ensure confidentiality and to protect the privacy of the participants.

TRUSTWORTHINESS OF DATA

It should be borne in mind that the number of observations in the empirical investigation was very restricted – due to the restrictions which the field of study placed on the availability of therapists and participants, as well as the fact that the implementation of the treatment plan was time-consuming. The constructs in both questionnaires could therefore not be tested for reliability. The indications identified from the results of the completed questionnaires were used to guide the type of questions that were used in the interview schedule, they were treated as "possible indications", and were reported as findings of the quantitative component of the research. The procedures regarding the following were followed to ensure high levels of validity: (a) content validity, (b) construct validity, (c) honesty of participants, (d) participants approached, (e) objectivity of the researcher, and (f) sampling.

FINDINGS

The first part of the discussion on the findings of this research includes the results of the quantitative descriptive design (stage one), while the second part includes the results of the qualitative design (stage two) of the empirical investigation.

Quantitative Descriptive Design (Stage One)

Data were obtained from two treatment questionnaires; one for therapists and one for participants. The discussions of the findings therefore entail the views of the therapists and the views of the participants. Nine therapists and five participants completed the questionnaires. The discussion includes information of therapists and participants, satisfaction with the treatment plan, self-actualisation reached, as well as changes in relationships with "others" and the "self".

Information about Therapists

The following data were obtained from the questionnaire for therapists:

Profession: One counsellor, five social workers, one clinical psychologist and two educational psychologists.

Workplace: Three therapists 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 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 therapists worked at institutions that only treat substance abuse and have been employed at these institutions for between one and three years. The other four did not work at institutions that only treat substance abuse.

Experience as therapists: Five therapists had been practising between one and five years, two between six and 10 years, one had been practising between 16 and 20 years, and one for over 20 years.

Experience in working with clients suffering from substance addiction: In one 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 had never treated a client with substance abuse problems.

Training and implementation of the treatment plan: All nine therapists believed that training was necessary before the implementation of the treatment plan. All nine therapists were able to implement the treatment plan at their workplace and will use the treatment plan in future. Eight therapists will use the treatment plan when they deal with aspects other than substance abuse.

Information about Participants

The following data were obtained from the questionnaire for participants:

Gender: One male and four female participants completed the questionnaire.

Age: One participant was between the ages of 22 and 27, one between 34 and 39 and three were older than 40 years.

Continued use of substance abuse: Two participants indicated use of substances during treatment, while three indicated no use during treatment.

Time period free from substances: One participant had been free between seven and 12 months, one participant had been free between 13 and 18 months, and one participant had been free for over 25 months. Two participants did not answer the question.

Number of participants who had attended rehabilitation: One participant had attended a rehabilitation centre, three had not attended a rehabilitation centre, and one did not answer the question.

Co-occurring disorder: Three participants indicated the presence of co-occurring disorders, one indicated that no co-occurring disorder was present, and one did not answer the question.

Satisfaction with Treatment Plan

Therapists

All therapists indicated that they would use the treatment plan in future.

Participants

Table 2 indicates the views of participants on the outcomes of the exercises after treatment.

Table 2: Participants' views on the outcomes of the exercises of the treatment plan

100% of participants	80% of participants	60% of participants
could name and release guilt feelings, identify their own obsessive compulsive behaviour, understood the importance of boundaries, and experienced improved boundary setting skills.	benefited from treatment, had a better understanding of themselves, the differences between an unhealthy and healthy family system and between shame and guilt, were able to identify guilt feelings, adult anger, parental beliefs and rules, childhood messages and childhood losses, could release adult anger, were able to relax, to forgive and to deal with frozen childhood emotions.	could identify and release childhood anger and were able to grieve childhood losses.

With the exception of the exercises on anger and grief, between 80 per cent and 100 per cent of the participants were able to achieve the outcomes of the exercises and 80 per cent of the participants indicated that they benefited from treatment.

Whitfield (2006) is of the opinion that "unhealthy" guilt in dysfunctional family systems is usually not handled or worked through, but lingers on. Black (2001) indicates that adults who grew up in dysfunctional families have the tendency to accept all the guilt; she states that this is a pattern that needs to be broken. The fact that 80 per cent of the participants were able to identify guilt feelings during the treatment confirmed the above beliefs of both Whitfield and Black. According to Whitfield (2006), guilt can be relieved by recognising its presence and by working through it in therapy. This belief of Whitfield was confirmed by the fact that 100 per cent of the participants were able to name their guilt feelings and experienced release from it during treatment. Beattie (1989) states that shame can prevent an individual from setting boundaries in his/her own life. The fact that 100 per cent of the participants indicated that their skills to set boundaries had improved, could be an indication that shame was effectively dealt with in treatment. Dayton (2007) is of the opinion that the frozenness of childhood memories will wear off in the safety of therapy. The opinion of Dayton was confirmed by the fact that 80 per cent of the participants were able to deal with their frozen childhood experiences.

It is noted that only 60 per cent of the participants were able to identify and experience release from their childhood anger. It therefore appears that it is more difficult to deal with anger from childhood. Alexander (2009) believes that anger is the most difficult emotion to own and process well. The findings of the empirical investigation with relevance to childhood anger confirmed the beliefs of Alexander. Whitfield (2006) states that children who grew up in dysfunctional families suffer numerous losses over which they are often unable to grieve in a complete way. According to Dayton (2007), people are often afraid to give in to grief, because they fear the grief will never emerge. The above could explain that although 80 per cent of the participants were able to identify their childhood losses, only 60 per cent were able to grieve their losses.

The findings suggest that the therapists and the participants were satisfied with the treatment plan.

Levels of Self-actualisation Reached after Treatment

Characteristics of Vrey, Maslow and Frankl were used in both questionnaires as a guideline to determine the level of self-actualisation reached after treatment.

Therapists

On completion of the treatment plan the therapists indicated improvements as shown in Table 3.

Table 3: View of therapists on improved characteristics of self-actualisation

89% to 100% improvement	**78% improvement**	**67% improvement**	**33% improvement**
Setting of realistic goals, separation of means from ends, gaining independence, ability to rise above the environment, acceptance of self and others, being more realistic about limitations, strengths and view of life, gaining improved understanding of self, spontaneity, spirituality, democratic values, and sense of humour.	Accepting the aspects of life, being more focused on problem-solving, detachment from others, less stereotype appreciation, having more intimate relationships, focusing on creativity, and lesser need for substances and use of addiction as a coping mechanism.	Improvement of physical health and being more other-orientated.	Need for privacy.

On completion of the treatment plan 78 per cent to 100 per cent of the therapists agreed that there had been improvements in the level of self-actualisation reached in 22 of the 25 characteristics of self-actualisation.

Participants

On completion of the treatment plan the participants indicated improvements as shown in Table 4.

Table 4: View of participants on improved characteristics of self-actualisation

100% improvement	80% improvement	60% improvement	40% improvement
Setting of realistic goals, accepting of self, understanding of self, being realistic towards life, focusing on spirituality.	Acceptance of others, being realistic about limitations and strengths, becoming other-orientated, spontaneous, focused on problem-solving, having a need for privacy, independence, humour, creativity, rise above the environment, being able to function on his/her own.	Improved health, detachment from others, intimate relationships, separate means from ends, lesser use of addiction as a coping mechanism.	Acceptance of aspects of life, lesser need for substances.

On completion of the treatment plan 80 per cent to 100 per cent of the participants agreed that there had been improvement in 16 of the 25 characteristics of self-actualisation.

The findings suggest that the therapists and the participants agreed that changes in self-actualisation were reached on completion of the treatment.

Views on Changes in Relationships with "Others" after Treatment

For the participants to heal they need to gain insight into their relationships with God, others, objects and ideas; insight could lead to changes in relationships.

Therapists

On completion of the treatment plan the therapists indicated insight into and changes in the relationships with "others" of the participants as shown in Table 5.

Table 5: Views of therapists on changes in relationships with "others"

100% improvement	89% improvement	78% improvement	67% improvement	56% improvement	33% improvement
	Insight into relationships with mother and siblings.	Insight into relationships with objects.	Insight into relationship with father.		
Changes about ideas of life.	Changes in relationship with God.	Changes in relationships with objects.		Changes in relationships with mother, siblings.	Changes in relationship with father.

After treatment, the therapists indicated that between 78 per cent and 100 per cent of the participants gained insight into their relationships with their mothers, siblings and objects, while 67 per cent gained insight into their relationship with their father. The therapists also indicated that between 56 per cent and 100 per cent of the participants experienced changes in their relationships with their mothers, siblings, objects, ideas and God.

Participants

On completion of the treatment plan the participants indicated insight into and changes in the relationships with "others" as shown in Table 6.

Table 6: Views of respondents on changes in relationships with "others"

100% improvement	80% improvement	60% improvement
Insight into relationships with siblings.	Insight into relationships with mother and father.	Insight into relationships with objects.
Changes in relationships with God and ideas.		Changes in relationships with mother, father, siblings, objects.

Between 60 per cent and 100 per cent of the participants reported that they gained insight into their relationships with their mothers, fathers, siblings and objects. Between 60 per cent and 100 per cent of the participants indicated changes in their relationships with their mothers, fathers, siblings, ideas and God.

The findings suggest that changes in the relationships with the "others" occurred after the treatment.

Views on Changes in the Relationship with the "Self"

The researchers wanted to investigate change that occurred in the relationship with the "self" after the treatment. The findings regarding the views of the therapists and the participants are shown in Tables 7 and 8.

Therapists

Table 7: Views of therapists on changes in relationship with "self"

100% improvement	Acceptance of self and positive self-talk.
100% improvement	Awareness of own ideas, own emotions, own attitude, own thoughts.

After the treatment 100 per cent of the therapists indicated that changes occurred in the participants' acceptance of self, self-talk, awareness of own ideas, emotions, attitudes and thoughts.

Participants

Table 8: Views of participants on relationship with "self"'

100% improvement	Acceptance of self.
100% improvement	Awareness of own attitude, own thoughts.
80% improvement	Positive self-talk.
80% improvement	Awareness of own ideas, own emotions.

After treatment between 80 per cent and 100 per cent of participants reported changes in acceptance of self, self-talk, awareness of own ideas, emotions, attitudes and thoughts.

The findings suggest that changes in the relationship with the "self" occurred after the treatment.

QUALITATIVE DESIGN (STAGE TWO)

The results of the interviews with the two therapists indicated that they both had a positive experience of the treatment plan. Therapist A regarded the plan as valuable and appreciated its structured format, while therapist B regarded the treatment plan as thorough, and believed that it addressed the causes of addiction. However, both therapists did not consider the treatment plan the only contributor to the successful recovery of addiction. Therapist A mentioned that the treatment plan should form part of other therapeutic processes, and therapist B said, "50 per cent of the success was

due to the client's willingness to cooperate, and 50 per cent was due to the treatment plan." When asked why the self-actualisation and relationship scores of participants who had overcome their addiction were less positive than those of participants who had not overcome their addiction, therapist A ascribed this to the fact that addicts, in the early stages of recovery, "normally undergo many positive changes as a result of the fact that they have stopped their substance abuse." Therapist B agreed with this opinion, and stated, "addicts 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 therapists were unsure about the reason for the fact that the results obtained from the completed questionnaires indicated that the longer the time period that the participants were free from substance abuse, the lower were their self-actualisation and relationships scores. Both therapists ascribed this to the fact that the participants' support systems are not able to provide the necessary support on a permanent basis. Both therapists disagreed as far as the question is concerned whether the results obtained from the questionnaires indicated that the treatment plan seemed more effective in the case of those participants who did not attend a rehabilitation institution. This is evident in therapist A's assertion: "I do not agree. The persons who had attended rehabilitation before will benefit from the treatment plan." The therapists differ in their view whether participants who were suffering from a co-occurring disorder would benefit from the treatment plan.

It could be concluded that the therapists had a positive experience of the treatment plan.

Discussion

The main aim of the empirical investigation was to determine the effectiveness of the treatment plan. The researchers reasoned that if the therapists and participants were satisfied with the treatment plan, if changes occurred in self-actualisation, relationships with others, as well as relationships with the "self", it could indicate that the treatment plan was effective. The findings of the quantitative and qualitative results both suggest that the therapists and participants were satisfied with the treatment plan. The qualitative results, however, indicated that the treatment plan could not be considered the only successful contributor to a successful recovery of addiction. With regard to the quantitative results, the therapists and participants indicated improvements in self-actualisation, and in relationships with "others" and with the "self". The qualitative design, however, indicated the stage of recovery of the participants and the importance of a support system as contributing factors on the participants' view on self-actualisation reached and changes in relationships. Based on the results of the empirical investigation the conclusion could be made that the treatment plan appears to be effective for the therapists and individuals suffering from addiction who participated in the study. Although this is a promising study, the findings cannot be generalised owing to the

fact that the number of observations during the empirical investigation was limited. A bigger sample and the implementation of control systems and standardised measuring instruments are needed before the results could be generalised.

CONCLUSION AND RECOMMENDATIONS

The Relations Theory states that changes in the intra-psychic process (involvement, experience, meaning attribution) will lead to changes in the intra-psychic structure, which will lead to changes in the individual's relationships and the level of self-actualisation reached. A treatment plan that dealt with the intra-psychic processes within the family of origin of individuals with a history of substance addiction was implemented during this research. The findings of the research suggest changes in self-actualisation, the relationships with "others" and the "self" of the participants after treatment. The conclusion could therefore be made that if the intra-psychic process within the family of origin of an individual with a history of substance addiction is treated, changes in self-actualisation and relationships with "others" and the "self" could occur.

The researchers are of the opinion that the treatment plan could benefit individuals with a history of substance addiction, their family members, and therapists working in the field of addiction. It is therefore recommended that social workers implement the treatment plan as part of the treatment for substance addiction.

Further longitudinal research into the implementation of the treatment plan will increase the number of observations, and statistically significant tests could be conducted to determine the effectiveness of the treatment plan.

Due to the escalation of substance addiction in South Africa, training on the treatment of clients suffering from substance addiction should be included in the training of all counsellors, social workers and psychologists.

In conclusion, the researchers believe that the treatment plan could not only have a positive influence on the effective treatment of substance addiction, but that it could also contribute to solving the problem of addiction in South Africa.

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