**The treatment of substance addiction with a focus on the family of origin as possible cause of addiction**

**INTRODUCTION**

With the opening of South Africa’s borders in 1994, the movement of drugs has become easier and the country has since become known as the drug trafficking capital and dumping ground of the south (Meyer and Fakier, 2007). Twenty two years later, South Africa is still the largest transit zone for illicit drugs in Southern Africa (Health Systems Trust, 2016). In a survey conducted in 2010/11 among 7 800 people in nine South African provinces, it was found that 65 percent of respondents reported that someone in their household was a substance abuser (Health Systems Trust, 2016). The survey took place in both urban and rural settings in South Africa and the nation’s drug problem was compared to global trends. The reality of world-wide drug use is a well-known fact. According to The World Drug Report 2015 (UNODC, 2016) it is estimated that almost a quarter of a billion people between the ages of 15 and 64 used an illicit drug in 2013. Drug users have risen to 246 million and it is stated that 27 million people or 0.6 percent of the global population between the ages of 15 to 64 suffer from drug addiction. Although there are no official figures for drug use in South Africa, drug use prevalence is high and it is estimated that 70 to 80 percent of the world’s consumption of Mandrax (Methaqualone) occurs in South Africa (Health Systems Trust, 2016).

The demand for treatment of addiction in South Africa is high; however, there are roughly only 80 treatment centres for substance abuse and these treatment centres can treat only around 20 000 addicts per year (The Central Drug Authority, 2011). Many models of treatment- and intervention plans are used to treat addicts in these treatment centres. The treatment models that are used in South Africa include, for example: *Moral Model*: Addiction is viewed as a result of poor choices due to human weakness (Promises Treatment Centres, 2010). *Medical Model*: Mental problems are ultimately physical problems and can therefore, like physical conditions, also be classified and treated (Joseph, 2010). *Minnesota Model*: The first part of treatment focuses on abstinence, the second part on underlying emotional trauma and the third part on reaching out to other addicts (Lefever, 2008). *Behaviour Model*: The focus is on the environmental conditions that shape behaviour (Joseph, 2010). *Narrative Model*: Storytelling and metaphors are used to provide insight. Stories are retold from different point of views, while searching for new solutions and meanings (Freedman and Combs in Joseph, 2010). *Biopsychosocial Model*: Deals with the interaction of mind and body and the effects of this interaction (Colman 2001). *Cognitive Behavioural Therapy*: Substance dependence is viewed as learned behaviour that is acquired through experience (Joseph, 2010). *Neuro-linguistic Programming*: The programme combines three concepts: neurology, language and programming (Dilts, 2011). *Teen Challenge program*: Provides addicts with effective and comprehensive Christian faith-based solutions to addiction (Teen Challenge International, 2011). *Twelve Step*: Addicts need to apply twelve steps that addresses the addict’s spiritual foundation as recovery (Buddy, 2009; Lefever, 2008). *Social and Educational program*: Addresses both physical and cognitive aspects of addiction (Louw, 2004).

During treatment, most of the treatment plans focus in one way or the other on the cause(s) of addiction. Many causes of addiction are mentioned in the literature. Examples of these causes include genetic, biological, psychological and environmental factors (Tracey, 2016). In a preliminary literature review it was found that the family of origin could be one of the most significant environmental factors that can cause addiction (Engelbrecht, 2014). Some of the treatment plans in South Africa do include aspects of the family of origin; however, it seems that there is no treatment plan that specifically focuses on the family of origin as a possible cause of addiction (Louw, 2004; Engelbrecht, 2014).

Many addicts benefit from treatment by reaching abstinence (referred to in this paper as Phase 1 of a drug treatment programme). They also benefit from treatment by leading relatively well-adapted lives (referred to in this paper as Phase 2 of a drug treatment programme). However, due to own experience with regards to the treatment of addicts, the researchers questioned the level of self-actualisation reached after having completed treatment plans, as well as the existence of meaningful relationships in the life world of addicts after treatment (referred to in this paper as Phase 3 of a drug treatment programme). 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). In this regard, it has to be considered that an individual as a social being can never stand alone and isolated in the world, but stands in relationship to God/gods, objects, ideas, other people and the ‘self’ (Jacob 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).

In this research a literature review and a case study were conducted to investigate methods to assist addicts to reach a certain level of self-actualisation and meaningful relationships after treatment.

The question underlying the research that informed this article therefore is: If the family of origin is treated as a cause of addiction by means of a treatment plan, will changes occur in addicts’ levels of self-actualisation and in their relationships with others and with the ‘self’, after treatment? The aim of the research is therefore to develop a treatment plan that addresses the family of origin as a cause of addiction and evaluate the treatment plan to determine the level of self-actualisation and the changes in the client’s relationships with the ‘self’ and others, after treatment.

The remainder of the article explains the theoretical framework, the research design and the results of the study. The article 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 comprising of 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, as well as in child headed households (Gouws, 2015).

According to Tessina (2003), the provision of an environment that provides physical and psychological wellbeing is the main purpose of the family of origin. However, some parents are not able to create a safe and nurturing environment. Children that grow up in these ‘unsafe’ environments often experience feelings of confusion and unhappiness (Whitfield, 2006), and a lack of self-motivation and structure (Tessina, 2003). Self-destructive behaviour, such as addiction, is often a result of the hurt experienced during childhood (Forward, 1989). Young people who depend on alcohol and hard drugs to cope with daily life fail to learn and retain responsible decision-making skills and coping mechanisms. These addicts may display adjustment problems, such as anxiety, depression and antisocial behaviour (Berk, 2010). Childhood trauma may also prohibit adults from functioning properly in relationships with others (Meyer, 2003). Black (2001) is of the opinion that recovery from addiction begins when drug rehabilitation clients start speaking the truth about the families they grew up in. Based on the above, it appears that a dysfunctional family system could lead to self-destructive behaviour, such as addiction. One can therefore argue that the family of origin could be the cause of addiction. Many individuals go through life and never deal with the hurt they experienced in their childhood years. If addicts can gain insight into their own family of origin system and address that pain, healing might take place faster and more effectively. This, in turn, could lead to improved self-actualisation and meaningful relationships.

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

**Family Systems Theory (Bowen)**

The Bowen Family Systems Theoryis 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 (Herr, 2000). 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 each other’s thoughts, feelings and actions. Within the system, each member strives to meet the needs and expectations of the others (The Bowen Theory, undated). 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 toKarson (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 addressed. With regard to this research (reference) the addict is viewed as the identified patient, and for the addict to heal from his addiction, aspects in the addict’s family of origin need to be addressed during therapy.

**Relations Theory**

The point of departure of the Relations Theory is that individuals, as centre of their life-worlds, stand in a relation to different components (God, others, objects, ideas and the ‘self’) of their worlds. Through the interactive processes of involvement and experience, and 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, Kruger, Lessing and Venter, 2002). Changes in the intra-psychic process 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. With regards to this research, the treatment plan will focus on the addict’s intra-psychic process (involvement, experience and attribution of meaning). If the treatment plan is effective, changes in the addict’s level of self-actualisation and relationships will occur.

**A treatment plan that addresses the family of origin as a cause of addiction**

As mentioned in the introduction, there are different treatment plans used in South Africa for the treatment of substance addiction. Almost all these different plans focus on helping addicts to reach abstinence during Phase 1 of the treatment plan and how to function effectively within their life-world during Phase 2 of the treatment plan. The focus in this article is on the inclusion of a third phase to treatment plans, namely the treatment of the family of origin as a cause of addiction and the subsequent change in the intra-psychic processes of the recovering addict.

# The knowledge obtained from the literature review (reference), as well as the Family Systems Theory and the Relations Theory was used to compile a treatment plan that treats different aspects within the addict’s family of origin. The treatment plan (Phase 3) was reviewed by therapists working in the field of addiction. The treatment plan (Phase 3) focuses on the intra-psychic process, namely involvement, experience and meaning attribution, during treatment. The literature review further indicated that addicts need to grieve losses of their childhood and forgive certain members of their family of origin. Only thereafter, an improvement in the addict’s relationships and self-actualisation can take place. The treatment plan (Phase 3) is divided into six sessions and includes the following:

# *Involvement:* A geneagram is drawn up to investigate the nature of the relationships between the different family members (Joseph, 2010). This provides insight for addicts into how the different relationships in their family of origin influenced their thoughts, feelings and actions. Individuals get involved in their life-world through the self, and by getting involved certain identities are formed (Jacobs and Lessing, 2000). In a healthy family system important contributions are made during certain times in the child’s development. A dysfunctional family system does not make any or only some important contributions. Addicts gain insight into the characteristics of a healthy family system and compare the characteristics of their own family of origin with these characteristics. This will enable addicts to recognise and gain insight into the dysfunctions of their own family of origin.

# *Experience:* When individuals get involved, they attribute meaning to their involvement, and experience success, failure, frustration, and so on. The experience could be positive or negative. Their experience determines the quality of their involvement, as well as their meaning attribution (Jacobs, 1982). Literature indicates that addicts often experience anger (Black, 2001; Dayton, 2007; Lerner, 2004; Whitfield, 2006), guilt (Black, 2001; Grohol, 2007; Whitfield, 2006), shame (Beattie, 1989; Black, 2001) and ‘frozen’ emotions (Beattie, 1989; Dayton, 2007; Triposi, undated). During the implementation of the treatment plan (Phase 3) addicts receive knowledge, insight and treatment regarding the experience of these emotions with regard to their family of origin.

# *Meaning attribution:* Meaning attribution refers to an individual’s personal understanding of his life-world (Roets, Kruger, Lessing and Venter, 2002). 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). Each family system has its own set of rules and beliefs. According to Forward (1989) the beliefs within a family system determine the attitudes, judgement and perceptions of the members of the system. By means of the beliefs in the system the members attribute meaning in their life-worlds. Even as adults, these thought patterns may still exist and are difficult to break (Impact Alaska Counselling Services, undated). The aim of the treatment plan is to provide addicts with examples of possible beliefs and rules within dysfunctional family systems. The addicts then needs to point out if any of these beliefs or rules existed or still exist in their family of origin, as well as other beliefs and rules that were not included in the examples. During this process, addicts will be able to gain insight into their own attitudes, judgements and perceptions.

# *Childhood losses:* 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 set up a major block,for example, “Do not feel”, or “Do not talk about it” (Whitfield, 2006). During the implementation of the treatment plan (Phase 3) addicts identify their childhood losses, gain knowledge regarding the different stages of grief and deal with their own grief.

# *Forgiveness:* Receiving forgiveness for one’s past mistakes and forgiving others for their mistakes are two of the most important factors in emotional healing (Meyer, 2013). Addicts first need to gain insight into what happened in their past. They 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 addicts have gone through this entire process will they reach the point where they are able to forgive. The treatment plan (Phase 3) includes misconceptions of forgiveness, as well as the different stages of forgiveness.

As mentioned in the introduction, the aim of the research is to evaluate Phase 3 of the treatment plan however, to be able to review Phase 3, Phase 1 and 2 also need recognition in the formation of a holistic treatment plan.

**RESEARCH DESIGN AND METHODOLOGY**

The effectiveness of the treatment plan in Phase 3 was evaluated by investigating changes in addicts’ relationships and the level of self-actualisation reached after treatment.A sequentially mixed method design was used to investigate the above. Traynor (undated) describes a mixed method design as a qualitative mini-study and a quantitative mini-study in one overarching design. 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. Data was collected in two sequential phases.

The quantitative descriptive (survey) design was used in the first stage of the research. . Two treatment questionnaires – one for therapists and one for clients – were designed. The decision to use questionnaires during this stage was based on the fact that the time of completion for the implementation of the treatment plan 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 treatment plan. The selection of the questions for the two questionnaires was guided by the literature review and the aims of the study.

The case study method was used during the second stage. 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). Interviews were conducted with therapists who took part in the study regarding their views on the implementation of the treatment plan.

Invitations to take part in the study were sent per e-mail to members of the Lowveld Psychological Association and SANCA’s offices 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, as well as a work book that could be used during the implementation of the treatment plan.

Ethical clearance and consent forms were obtained from therapists and clients. Data that was collected for the research was cleared of any identifying information to ensure confidentiality and protect the privacy of the participants.

After the training, eleven therapists indicated per e-mail that they would be able to implement the treatment plan at their work place. The other nine therapists reported that they would not be able to implement the treatment plan due to other work obligations. After a period of 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 suffering from addiction in the previous six months.

At the completion of treatment plan (Phase 3), data was collected to determine the effectiveness of the treatment plan (Phase 3). 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 was to determine the effectiveness of the treatment programme. The selection of the two therapists for the interviews was based on the differences in profession, work place, experience in the field of substance abuse and their willingness to take part in the research.

The number of observations in the empirical investigation of this study was limited, and therefore the constructs in both questionnaires could not be tested for reliability. The indications identified from the results of the completed questionnaires 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’ and reported as research findings in the quantitative component of the research.

Constructs were selected based on the literature review and opinions of experts in the field. Discussions of the constructs were included in the training. Only information relevant to the purpose of the study was disclosed. The selection of therapists was based on their qualifications and work experience. Therapists indicated per e-mail that they were interested in participating in the study, while clients were selected by each therapist individually. The treatment plan was implemented by each therapist at his own workplace. The therapists received instructions regarding the implementation of both questionnaires from the researchers. The researchers never had any contact with the addicts. The request for, as well as the implementation of the completion of the questionnaire for addicts were therefore done individually by each therapist with the addict they were treating during the implementation of the treatment plan. Nine completed questionnaires from therapists and five completed questionnaires from addicts were received. Data was obtained from the completed questionnaires. The selection of the respondents was based on their willingness to participate.

Due to the limited number of participants, no statistically significant tests could be conducted. The researchers were also not able to make comparisons between clients due to the big 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, relationships, and so on.

**DISCUSSION OF THE FINDINGS**

The first part of the discussion includes the results of stage one and the second part the results of stage two of the empirical investigation.

**STAGE ONE RESULTS**

Data was obtained from two treatment questionnaires; one for therapists and one for addicts. The discussions of the findings therefore entail views of therapists and views of addicts. Nine therapists and five addicts completed the questionnaires. The discussion includes information of participants, benefits of the treatment plan (Phase 3), self-actualisation reached, as well as changes in relationships with ‘others’ and the ‘self’.

**Information of participants**

One counsellor, five social workers, one clinical psychologist and two educational psychologists took part 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 same therapist could be employed at two institutions at the same time, for example, at a hospital and in private practice). 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. 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. 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.

All nine therapists:

* believed that training was necessary before the implementation of the treatment plan;
* were able to implement the treatment plan at their workplace;
* will use the treatment plan in future

Eight of the therapists

* will use the treatment plan when they deal with aspects other than substance abuse.

One male addict and four female addicts completed the questionnaire. One addict was between the age of twenty-two and twenty-seven, one between the age of thirty-four and thirty-nine and four addicts were older than forty years of age. Two addicts indicated substances use, while three addicts indicated no substance use during treatment. The results on how long they were free from substance use were as follows: One addict reported between seven to twelve months, one between thirteen to eighteen months and one more that twenty-five months. Two addicts did not answer the question. One addict indicated that he/she attended a rehabilitation centre before treatment, while three addicts had not attended a rehabilitation centre before. One addict did not answer the question whether he/she had previously attended a rehabilitation centre. Three addicts indicated the presence of co-occurring disorders, while one addict indicated no co-occurring disorders. One addict did not answer the question about co-occurring disorders.

**Benefits of the treatment plan**

All the therapists who took part in the study indicated that they would use the treatment plan (Phase 3) in future.

On completion of treatment 100% of addicts reported that they:

* were able to name their guilt feelings;
* experienced a release from their guilt feelings;
* were able to identify the presence of obsessive compulsion in their lives; and
* gained insight into the importance of boundaries, as well as that their skill to set boundaries had improved.

On completion of treatment 80% of the addicts indicated that they:

* had a better understanding of themselves;
* benefited from the treatment programme;
* were able to relax during the relaxation exercises;
* understood the difference between a healthy and a dysfunctional family system;
* were able to identify guilt feelings;
* understood the difference between shame and guilt;
* were able to determine what they did to express their anger as children;
* were able to identify what caused their anger as adults;
* were able to experience some release from the anger that they experienced as adults;
* were able to deal with their frozen emotions;
* were able to identify the beliefs and rules of their family of origin;
* were able to identify messages from their childhood;
* were able to identify their losses; and
* were able to forgive.

On completion of treatment 60% of addicts indicated that they:

* were able to experience release from their childhood anger; and
* were able to grieve their childhood losses.

Whitfield (2006) is of the opinion that individuals who grew up in dysfunctional homes often possess a mixture of ‘healthy’ and ‘unhealthy’ guilt. He states (2006) 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; and she states that this is a pattern that needs to be broken. The fact that 80% of addicts were able to identify guilt feelings during 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% of addicts 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% of addicts indicated that their skills to set boundaries had improved could be an indication that shame was effectively addressed in treatment.

It is noted that only 60% of addicts 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. He 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 confirmed the beliefs of Alexander.

Dayton (2007) is of the opinion that the frozenness of childhood memories will wear off in the safety of therapy. This will allow clients to process the feelings that they were never able to process. . 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 addicts were able to deal with their frozen childhood experiences.

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. 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), people are often afraid to give in to grief, because they fear they will never emerge. The above could explain that although 80% of addicts were able to identify their childhood losses, only 60% were able to grieve their losses.

**Changes in self-actualisation**

On completion of treatment 100% of therapists agreed that self-actualization was reached by their clients. Twenty five characteristics of Vrey, Maslow and Frankl were used as a guideline to determine the level of self-actualisation reached after treatment. On completion of the treatment plan therapists agreed that the following changes occurred:

Between 89% to 100% agreed that there are improvements in the following thirteen characteristics of their client:

• Ability to set realistic goals

• Accepts him/herself more readily

• More accepting of others

• Realistic with regards to limitations and strengths

• Understanding of who he/she is

• Realistic view of life

• Spontaneity

• Ability to function more independently

• Spirituality

• Democratic values

• Ability to separate means from ends

• Sense of humour

• Ability to rise above the environment rather than merely adjusting to it

78% of therapists agreed that there are improvements in the following nine characteristics of their client:

• Accepting of the aspects of life

• Focused on problem-solving

• Detachment from others

• Less stereotype appreciation

• More intimate relationships

• Creativity

• Ability to function on own

• Need for substances

• Addiction as a coping mechanism

67%% of therapists agreed that there are improvements in two characteristics of their client:

• Improvement of physical health

• More other-orientated

33% of therapists agreed that there is an improvement in one of the twenty five characteristics of their client:

* Need for privacy

**Views on changes in the relationships with ‘others’**

Therapists indicated that between 78% and 100% of addicts gained insight into their relationships with their mothers, siblings and objects; 67% gained insight into their relationship with their father and 56% gained insight into their relationship with their siblings. It could therefore be concluded that according to therapists, clients gained insight into their relationships with others after treatment.

Therapists indicated that between 56% and 100% of addicts experienced changes in their relationships with their mothers, siblings, objects, ideas and God, while only 33% of clients experienced changes in their relationships with their fathers. Based on the above, the conclusion could be made that according to therapists, changes occurred in clients’ relationships with ‘others’ after treatment.

Between 60% and 100% of addicts 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.

Between 60% and 100% of addicts indicated changes in their relationships with their mothers, fathers, siblings, ideas and God. It should be noted that 40% of addicts reported that they were uncertain about changes in their relationships with their fathers and 20% of addicts disagreed that changes occurred in their relationships with their mothers. Based on the above, it could be concluded that according to addicts, changes occurred in their relationships with ‘others’ after treatment.

**Views on changes in the relationships with the ‘self’**

100% of therapists indicated that changes occurred 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.

From the above discussion, 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-actualisation after treatment; both therapists and clients agreed that changes occurred in clients’ relationships with others after treatment; and that both therapists and clients agreed that changes had occurred in the relationship with the ‘self’, after treatment.

**STAGE TWO RESULTS**

Interviews with two therapists that took part in the study were conducted during phase two. The respondents both experienced the treatment plan positively. Respondent A regarded the plan as valuable and appreciated its structured format:

*“… 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.”*

Respondent B regarded the treatment plan (Phase 3) as thorough, and believed that it addressed the causes of addiction. He/she said the treatment plan “*contained valuable information, and provided a lot of insight to clients on their family of origin”.*

However, both of them did not consider the treatment plan as the only contributor to the successful recovery of addiction. Respondent A mentioned that the treatment plan should form part of other therapeutic processes, and Respondent B said that *“50% of the success was due to the client’s willingness to cooperate, and 50% was due to the treatment plan”.*

When asked why the self-actualisation and relationship scores of the addicts who had overcome their addiction was less positive than those of the addicts who had not overcome their addiction, respondent 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”*. Respondent B agreed with this opinion, and stated that “*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 respondents were unsure about the reason for the fact that the results obtained from the completed questionnaires indicated that the longer the time period that addicts were free from substance abuse, the lower were their self-actualisation and relationships scores. Both respondents ascribed this to the fact that the addict’s 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 the treatment plan seemed more effective in the case of those addicts who did not attend a rehabilitation institution. This is evident in respondent A’s assertion:

*“I do not agree. The persons who had attended rehabilitation before will benefit from the treatment plan.”*

The respondents differ in their view whether an addict who was suffering from a co-occurring disorder would benefit from the treatment plan. Respondent A stated that “*clients would benefit from the treatment plan, regardless of whether they have a co-occurring disorder”*, while respondent B indicated that “*an untreated co-occurring disorder would make the treatment plan less effective”.*

From the above discussion it is evident that both respondents experienced the treatment plan (Phase 3) positively, and they indicated that they would use the treatment programme in future. The researchers are aware that the two respondents differ in their training and work experience and that 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 main aim of the empirical investigation was to determine the effectiveness of the treatment programme. The researchers reasoned that if therapists and clients were satisfied with the treatment programme, if improvements occurred in self-actualisation, and if changes occurred in relationships with others, as well as relationships with the ‘self’, the researcher could conclude that the treatment programme was effective. All the therapists who took part in the study were able to successfully implement the treatment programme in their workplace. The results of the empirical investigation proved that both therapists and clients were satisfied that the treatment programme proved to be effective for the treatment of the family of origin as a cause of addiction. Based on the results of the empirical investigation the conclusion could therefore be made that the treatment programme is effective.

**CONCLUSION**

The findings of the research indicated that both therapists and addicts experienced the treatment plan positively and improvements in self-actualisation, as well as changes in relationships with ‘others’ and the ‘self’ occurred. The conclusion could therefore be made that if the family of origin is treated as a cause of addiction, improvements in the levels of self-actualisation of addicts, as well as changes in the addicts’ relationships with ‘others’ and the ‘self’ occur. The family of origin could therefore be viewed as a cause of addiction. It is therefore recommended that the treatment plan (Phase 3) could be used as part of a treatment programme by therapists in different settings to treat addiction.

Further longitudinal research into the implementation of the treatment plan (Phase 3) will not only enable therapists to implement all three stages of the treatment programme, but the number of observations would also increase. The effectiveness of the entire treatment programme could therefore be established, and statistically significant tests could be conducted to determine the effectiveness of the treatment programme.

Consequently, the researchers are of the opinion that the treatment plan (Phase 3) will benefit addicts, their family members, and therapists working in the field of addiction. 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.

In conclusion, the researchers believe that the treatment plan will not only have a positive influence on the effective treatment of addiction, but that it will also address the problem of addiction in South Africa.

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