RESILIENCE IN FAMILIES WHERE A PARENT MISUSES ALCOHOL

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Abstract

Surveys have shown that alcohol misuse is the biggest substance misuse problem in the world today, affecting millions of people. With the disease being part of a family, all members of the family experience the distress of parental alcohol misuse. While the challenges that these families have to face are many, they seem to have the ability to “bounce back”, in other words, have resilience.

There has been limited research to date on family relations and alcohol misuse in South Africa, especially in terms of the parental member as the alcohol misuser. The proposed research aimed to explore and describe the factors that facilitate adjustment and adaptation in families where a member misuses alcohol.

The Resiliency Model of Family Stress, Adjustment and Adaptation was used to analyze the factors that enable a family to adapt to the alcohol misuse, as outlined in the broader study at the University of Stellenbosch. An exploratory descriptive research design was employed in the proposed study.

For the purposes of this study, the researcher combined qualitative and quantitative research methods in order to use their complementary strengths to enrich the data obtained from the proposed study. Sixty three families were surveyed using a biographical questionnaire and seven pencil-and-paper questionnaires. These families were accessed via drug and alcohol rehabilitation facilities throughout South Africa.

The data from the biographical questionnaire was analyzed using descriptive statistics, while the qualitative data was analyzed using content analysis. The quantitative data was analyzed using correlation and regression analysis.

The findings of the proposed research allow for better management of the alcohol misuser’s condition through the understanding of what resiliency areas the family may improve upon. Furthermore, the study can be used as a stepping stone for future research of resilience in families living with a parental member who misuses alcohol, and ultimately contributes to the broader context of family resilience research in South Africa.

Key words: alcohol misuse, alcohol abuse, alcohol dependence, family, resilience, adjustment, adaptability.
CHAPTER 1

INTRODUCTION AND PROBLEM STATEMENT

1.1 Introduction

This chapter provides an introduction to the paradigm within which this study was conducted. The need for this study is then discussed, after which the aim of the study is presented. The chapter concludes with a summary of the subsequent chapters in the study.

1.2 The pathogenic versus positive psychology paradigm

Originally, the traditional focus in the health and social sciences has been within a pathogenic paradigm (Carruthers & Hood, 2005; Strümpfer, 1993; 2005). This paradigm is described by Strümpfer as the striving to understand one’s functioning within a “problem-orientated framework” (2005, p. 22). In his earlier work, Strümpfer described the purpose of the pathogenic orientation as “finding out why people fall ill and, in the specific, why they develop particular disease entities” (1993, p. 160). Keyes and Haidt (2003) argued that this traditional view overly emphasized the negativity of human nature, and questioned whether such pessimism was justified.

The discipline of positive psychology, as conceived by Martin Seligman (1998), emerged formally as a psychological approach in 1979 in an attempt to understand better how to make meaning out of life and how to function optimally as a human being (Linley & Joseph, 2004). Since then, there has been a shift in psychology from investigating a person’s pathology and disease to examining his or her health and strengths for development. Seligman stated that “psychology is not just the study of weakness and damage, it is also the study of strength and virtue” (1998, p. 2). What was lacking within the pathogenic paradigm was knowledge about the positive qualities that people employ to live life with purpose, despite the difficulties they confront in life (Sheldon & King, 2001). Fundamental to this transition was a call for a more balanced view of people’s lives.

A key theorist involved in altering the traditional pathogenic paradigm was Antonovsky (1979; 1987). This author proposed an explanation for people’s ability to achieve wellness, which contributed to no longer exclusively classifying people as either healthy or diseased, but rather on a continuum between the two. According to Seligman and Csikszentmihalyi, the aim of positive psychology is “to begin to catalyze and change in the focus of psychology from preoccupation only with repairing the worst things in life, to also building positive qualities” (2000, p. 5). Where psychology previously dwelt within a problem-orientated framework, this shift in paradigms recognizes the individual’s assets and positive qualities, and holds a greater appreciation for human potential. Furthermore, this positive orientation identifies the characteristics of healthy, strong and successful families, thereby emphasizing resilience (Saunders, 2003).
Keyes and Haidt (2003) broadened the aim of positive psychology and their definition to include life stressors. These authors stated that the aim of positive psychology is to “better understand how individuals can negotiate, resolve, and grow in the face of life’s stressors and challenges” (Keyes & Haidt, 2003, p. 6). The distinctive feature of positive psychology is its focus on what comprises and promotes a satisfying life which ultimately leads to well-being and contentment (Compton, 2004). Seligman and Csikszentmihalyi (2000) delineated three aspects of positive psychology, namely the study of positive emotion, the study of positive traits and abilities, and the study of positive institutions such as strong families. The current study has contributed towards the domain of positive psychology in incorporating these three aspects.

The benefit of positive psychology is that, while it focuses on the positive, it brings balance to the field of psychology (Keyes & Haidt, 2003). It does so by being realistic and not claiming that human nature is all positive, but simultaneously takes note of the fact that people do have the capacity to thrive when confronted with challenges (Keyes & Haidt, 2003). A concept which finds its home in the positive psychology paradigm is that of resilience. While family resilience is the focus of this study, a discussion of individual resilience follows first.

1.2.1 Individual resilience

There are a number of working definitions in describing the notion of resilience. The concept of individual resilience “implies a track record of successful adaptation in the individual who has been exposed to biological risk factors or stressful life events” (Werner & Smith, 1983, p. 4). Norman Garmezy, considered the founder of the study of resilience, described resilience as “manifest competence despite exposure to significant stressors” (Glantz & Johnson, 1999, p. 5). Walsh defined resilience as “the ability to withstand and rebound from adversity” (2002, p. 130). Resilience, as defined by Masten, Garmezy, Tellegen, Pelligrini, Larken and Larsen, is “a process of, or capacity for, or the outcome of successful adaptation in challenging and threatening circumstances” (1988, p. 459). Resilient individuals regain balance and keep going despite adversity and misfortune and find meaning amidst confusion and tumult (Wagnild & Young, 1993). Resilient individuals experience the same difficulties and stressors as everyone else; they are not immune or hardened to stress, but they have learned how to deal with life’s inevitable difficulties (Wagnild & Young, 1993). Resiliency can therefore be understood in terms of values, attitudes and behavioural dimensions that the individual must have to overcome adverse conditions.
1.2.2 Family resilience

Although resilience previously focused on the individual, a number of researchers have highlighted the importance of resilience as a systemic quality within the family (Hawley, 2000; Hawley & De Haan, 1996; Walsh, 1996; 2002; 2003a). Definitions for family resilience emphasize the potential a family has to emerge stronger over time after facing stressful and challenging conditions. Hawley and De Haan described family resilience as “the path a family follows as it adapts and prospers in the face of stress, both in the present and over time” (1996, p. 293). McCubbin, McCubbin, Thompson, Han and Allen defined family resilience as “the property of the family system that enables it to maintain its established patterns of functioning after being challenged and confronted by risk factors” (1997, p. 2). Viewing families from a family resilience perspective engages families who are struggling with respect and compassion, and affirms their reparative potential (Walsh, 2002).

The definition of resilience has been extended by McCubbin, McCubbin, Thompson, Han and Allen (1997) to the family system, stating that there are two factors which are also important. These are elasticity, which refers to that characteristic of the family system that enables it to maintain its established patterns of functioning after being challenged and confronted by risk factors; and buoyancy, which is the family’s ability to recover quickly from misfortune, trauma or transitional events causing or calling for changes in the family’s pattern of functioning. The process of resilience subsequently involves the ability to withstand disruptive life challenges and rebound from them. It involves dynamic processes fostering positive adaptation where strengths and resources allow individuals and families to respond successfully to crises and persistent challenges, and to recover and grow from those experiences (Cowen, Cowen & Shultz, 1996). Resilience therefore does not exclude tensions and afflictions of life, but rather embraces them with the resources of competence and adaptability, resulting in a positive effect.

Various researchers have noted that a family resilience perspective has a considerable amount to offer the field of family psychology (De Haan, Hawley & Deal, 2002; Hawley & De Haan, 1996; Patterson, 2002a; Walsh, 2002; 2003a). This perspective offers more respect to families and recognizes their resources and competence (Patterson, 2002a; Walsh, 2002). Moreover, learning about how families not only cope but thrive in the face of adversity, can inform the development and implementation of family interventions (Hawley, 2000; Hawley & De Haan, 1996; Walsh, 2003a). Additionally, this perspective recognizes the unique context of each family (Hawley, 2000).

Walsh (1996; 2002; 2003a) detailed the advantages that a family resilience framework has to offer. Firstly, a family resilience framework focuses on family strengths rather than deficits that are created through facing challenges. Secondly, family functioning is examined in the context of its unique values, structure, psychosocial demands, resources and stressors. Thirdly, resilience
processes may vary depending on specific challenges and resources, implying that resilience is not a static concept. The family’s life cycle is simultaneously considered. Basically, at the foundation of the family resilience perspective, the family is viewed with the potential to repair itself and grow through adversity and stress (Walsh, 1996; 2002; 2003a).

1.3 A resiliency perspective and the changing nature of the family this century

The concept of resilience has an integral place in the field of family psychology as the 21st century has been forecast as an era wrought with family transformation and stress (McCubbin, McCubbin, Thompson, Han & Allen, 1997). Key family trends have emerged as society has faced challenges and upheavals over recent decades (Walsh, 2000; 2003b). These trends include changing gender roles, cultural diversity and socioeconomic disparity, varying and expanded family life cycles, and varied family forms.

The focus of the current research is on the resilience in families where a member misuses alcohol. Marlatt, Baer, Donovan and Kivlahan (1988) defined addictive behaviour as a repetitive habit pattern that increases the risk of disease and/or associated personal and social problems. Surveys have shown that alcoholism, a form of addictive behaviour, is the biggest substance misuse problem in the world today, affecting millions of people (Searll, 1989). For example, it is estimated that there are ten million alcoholics in the United States alone. There are thought to be over 300 000 alcoholics in South Africa, and over half a billion rand in production is lost annually as a result of alcohol misuse (Searll, 1989). Alcohol misuse and alcoholism are the most costly of addiction problems in terms of frequency of usage and potential for harm (Marlatt et al., 1988). These statistics reveal a wide area in which research is required in order to investigate the resiliency factors that play a role in these families. Alcohol misuse has potentially devastating effects on the family unit (Searll, 1989). Challenges these families face include feelings of guilt and shame, which are experienced to one degree or another by all co-dependents. An example of how co-dependents may be affected by alcohol misuse is that the adolescent often feels it is his or her fault that a parent becomes upset and he or she struggles with the fact that he or she is not loveable (Daley & Raskin, 1991). Some other challenges the family may face include financial setbacks, and lack of nurturing and essential emotional support from the caregiver, among others.
1.4 **Research aim and objective**

The proposed study aims to identify, explore and describe the resiliency factors that enable families to adjust and adapt as a result of having a parental member in the family who misuses alcohol.

1.5 **Chapter overview**

Chapter one provides an introduction to the current research and discusses the context within which this study was conducted. It includes an exploration of positive psychology and family resilience, as well as the motivation for the present study.

Chapter two examines the construct formulation of resilience. This chapter provides a distinction between individual and family resilience, and describes the fruition of family resilience research from individual resilience. A detailed explanation is then given of the conceptual framework that underpins the current research project, namely the Resiliency Model of Family Stress, Adjustment and Adaptation.

Chapter three focuses specifically on families in which a parental member misuses alcohol. This chapter explores various definitions of alcohol misuse, and the DSM-IV-TR diagnoses of various alcohol-related pathologies. Global as well as South African patterns and trends of alcohol use are investigated, as well as strategies to address alcohol misuse in the South African context. The various roles children in alcohol misusing families take on are briefly described, and finally, the numerous causes and consequences of alcohol misuse are explored.

Chapter four outlines the research design and methodology implemented in the current research. The sampling procedure, research procedure, measures used to gather the data and data analysis are all discussed. Chapter four is then concluded with a review of the ethical considerations pertaining to this specific study.

Chapter five presents the results of the research. A discussion correlating the results to the available literature cited in chapters two and three is also given.

Chapter six provides the conclusions to the study. These are based on the research results presented in chapter five. Recommendations for future research in the field of resilience are thereafter made based on the results of the research, and the limitations of the study are outlined.
1.6 Conclusion

This chapter provided an introduction to the paradigm within which the current study was conducted. The need for the study was then discussed, after which the aim was presented. The chapter was concluded with an outline of the forthcoming chapters in this treatise. The following chapter is devoted to an in-depth discussion of family resilience.
CHAPTER 2
FAMILY RESILIENCE

2.1 Introduction

The concept of resilience is less than twenty-five years old, yet it has a substantial history in developmental psychopathology (Garmezy, Masten & Tellegen, 1984; Garmezy, 1985). In the past, individual resilience research has been plentiful; however the concept of family resilience has only recently begun to evolve as a central area of research. This chapter begins by examining the multitude of resilience definitions supplied in literature, and a distinction is made between individual and family resilience. This is followed by a description of how family resilience evolved from individual resilience research. The latter part of this chapter focuses on the various models that contributed to the roots of the Resiliency Model of Family Stress, Adjustment and Adaptation, which forms the conceptual framework for the research project. Finally, a detailed explanation is given of the phases of the Resiliency Model of Family Stress, Adjustment and Adaptation.

2.2 Defining resilience

Various terms have been used synonymously with resiliency throughout resilience research. Resilience has been defined by Luther, Cicchetti and Becker (2000) as a dynamic process where individuals exhibit positive behavioural adaptation when they encounter significant adversity or trauma. Resilience is a two-dimensional construct concerning the exposure to adversity and the positive adjustment outcomes of that adversity (Luther & Cicchetti, 2000). The term “invulnerable children” was used by Anthony and Garmezy in 1974 to describe children who “seemed to develop normally in spite of prolonged exposure to serious psychosocial hazards and adversities” (Rutter & Quinton, 1984, p. 191). For decades it has been well documented that children who experience one or more chronic, profound stressors, such as death of a close family member, illness and hospitalization, chronic poverty and neglect, chronic family tensions and discord, parental divorce, alcoholic parents, or parental mental illness, were destined to experience adverse psychological and physical effects (Garmezy & Rutter, 1985; Masten & Garmezy, 1985; Rutter, 1985). The concept of "resilience" originated from an intriguing incongruity; many children who experience chronic, profound stressors, for reasons not fully understood, not only surmount adversity, but "exhibit behavioral adaptation and manifest competence" (Garmezy, 1981, p. 197). The term “resilience” therefore describes this more fluid process (Luthar, Cicchetti & Becker, 2000).

The term resilience was complemented by further definitions within the family field as resilience research evolved into research within the family. These definitions will be expanded upon when
discussing family resilience. The following section is a discussion of the origins of resilience research and how family resilience research began.

2.3 Individual resilience

It is of paramount importance to survey the research on resilient individuals when attempting to appreciate family resilience. This is where family resilience research began. Resilience research is rooted within the traditional pathogenic paradigm, where research aimed to understand the maladaptive behaviour of schizophrenic patients (Masten, Best & Garmezy, 1990). Although the focus of these investigations was not on the patients who managed to adapt fairly well, researchers began to notice that the premorbid history of the patients who adapted well was characterized by competence in various areas of life (Luthar, Cicchetti & Becker, 2000). Simultaneously, resilience emerged as a major theoretical and research topic from the studies of children of schizophrenic mothers in the 1980s (Luthar, Cicchetti & Becker, 2000; Masten, Best & Garmezy, 1990). Research showed that many of these children adapted well, leading to the flourishing of research on childhood resilience (Luthar, Cicchetti & Becker, 2000). Research began to focus on individual traits and dispositions concerning what helped specifically children and adolescents overcome difficult upbringings and resulted in them leading fruitful lives (McCubbin, McCubbin, Thompson, Han & Allen, 1997; Walsh, 2000). Earlier research was conducted by key researchers in the field of resilience research, which focused specifically on identifying individual traits. Rutter (1995) noted that the likelihood of adept coping was increased by self-esteem and self-efficacy. It was discovered that possessing the characteristic of hardiness aided one’s health despite the presence of high levels of stress (Kobasa, 1985; Kobasa, Maddi & Kahn, 1982). A key contributor to research in this line of stress and coping was Antonovsky (1979), who focused on what traits enabled individuals experiencing severe stress to cope and remain healthy.

A study that was pivotal in expanding resilience research, from its singular focus on psychopathology as well as its focus on various other difficult conditions such as poverty (Garmezy, 1991), traumatic life events (Helmreich, 1992), and violence (Garbarino, 1997), was a longitudinal study conducted by Werner and Smith (1982, 1992; Werner, 1993) on the Hawaiian island of Kauai. This study traced the developmental journeys of a group of multiracial children who had been exposed to peri-natal stress, chronic poverty, and an adverse family environment. The paradigm of resilience research now began to shift to a more positive orientation, as is evident in the aim of the Kauai study. The researchers focused on identifying protective factors and processes that facilitated children exposed to high-risk factors in order to become well-adjusted adults (Luthar, Cicchetti & Becker, 2000; Werner, 1993). In the Kauai study, confidence in one’s ability to rise above difficult circumstances as a key factor in developing competence was identified (Werner,
Various earlier studies also identified additional protective factors, such as moral and spiritual sources of courage (Dugan & Coles, 1989), and a sense of hope and optimism (Murphy, 1987; Taylor, 1989). The Kauai study, however, marked a significant shift in focus for research in this area. While previous research aimed to identify personal qualities of resilient children, researchers now began to realize that resilience could be aided and supported from external factors (Masten & Garmezy, 1985; Luthar, Cicchetti & Becker, 2000).

The importance of a systemic view of resilience was increasingly highlighted by research on resilient individuals (Walsh, 1996). This systemic view brought attention to external factors contributing to resilience. Throughout research on vulnerable children, it has been increasingly noted that their resilience is connected to protective factors in both the family and social context (McCubbin, McCubbin, Thompson, Han & Allen, 1997; Walsh, 2000). In the Kauai study, all of the resilient children had “at least one person in their lives who accepted them unconditionally, regardless of temperamental idiosyncrasies, physical attractiveness, or intelligence” (Werner, 1993, p. 512). Additional child-focused research isolated important factors within the family system that foster childhood resilience (McCubbin, McCubbin, Thompson, Han & Allen, 1997). Other factors that have been identified as fostering childhood resilience include: structured parenting (Hetherington, 1989); parental supervision and vigilance (Baldwin, Baldwin & Cole, 1990); consistent discipline (Wyman, Cowen, Work & Parker, 1991); parents holding an optimistic view of their children’s future (Wyman, et al., 1991); nurturing relationships with primary caregivers (Wyman, Cowen, Work, Raoof, Gribble, Parker & Wannon, 1992); and a stable and safe home environment (Richters & Martinez, 1993; Wyman et al., 1992).

The family unit became a focus of enquiry as a source of resilience as the relational context of resilience began to increase throughout research. The focus now shifts to the relational concept of family resilience now that there is greater understanding of the foundation on which family resilience is built.

2.4 Family resilience

Over the last two decades there has been a shift in the focus of the field of family psychology, from the traditional pathogenic approach to family strengths (Hawley & De Haan, 1996; Nichols & Schwartz, 2000). Focusing on family strengths and resources shifts the perspective of seeing distressed families as damaged, to seeing these families as facing challenges yet possessing the potential to grow stronger as a result of the difficulties they may be facing (Walsh, 2002).

Hawley (2000) described resilience for a family as “a pathway a family follows over time in response to a significant stressor or series of stressors” (p. 106). In crisis situations resilience can be seen as
the positive behavioral patterns and functional competence individuals and
the family unit demonstrate under stressful or adverse circumstances, which
determine the family’s ability to recover by maintaining its integrity as a
unit while insuring, and where necessary restoring, the well-being of family
members and the family unit as a whole (McCubbin, McCubbin &
Thompson 2001, p. 5).

The family members can furthermore be seen as an interacting and integral part of a larger social
ecology where hardships faced by the family call for changes in the family system, including roles,
goals, values, rules, priorities, boundaries and overall patterns of functioning (McCubbin &
McCubbin, 2005). Walsh (2002) emphasized that family resilience involves being able to emerge
from difficulties, defining family resilience as “the ability to withstand and rebound from adversity”
(Walsh, 2002, p. 130).

Family resilience is described by The Family Resiliency Network as “the family’s capacity to
cultivate strengths to positively meet the challenges of life” (Silliman, 1994, p. 2). The term is
further elucidated by Luthar, Cichetti and Becker (2000) who stated that family resilience is being
able to make positive adaptations despite confronting adversity. It is apparent from examining the
commonalities of these descriptions that resilience does not exclude tensions and afflictions of life,
but rather embraces them with the resources of competence and adaptability, resulting in a positive
effect.

McCubbin and McCubbin (1988) defined family resilience as “characteristics, dimensions, and
properties of families which help families to be resistant to disruption in the face of change and
adaptive in the face of crisis situations” (p. 247), the focus of which is on the adaptive qualities of
families that aid them in coping as they face stress (Hawley & De Haan, 1996). The core of family
resilience involves more than coping or surviving adverse conditions. Resilience rather holds the
possibility for growth within both a personal and relational capacity which is moulded from
adversity (Boss, 2001). Emerging from difficult challenges as resilient means that the family is
stronger and more resourceful, the opportunity of which presents itself for re-evaluating priorities,
gaining new insights and deepening relationships (Walsh, 2003a).

Family resilience research builds on stress, coping and adaptation research (Walsh, 1996). The
cognitive appraisal model of stress and coping developed by Lazarus and Folkman (1984) has been
an influential model. This model described the adaptive behaviours between a person and their
environment, which aims at reducing stress levels within the environment by seeking the best
adaptation possible. Although this model was influential, it focused on the individual and not on
the family as a unit (Walsh, 1996). Walsh (2003a) called for a more systemic view where the family
system is looked at as a whole. Crises impact the family unit, and its impact may be felt amongst
family members and their relationships. Although the crisis is more systemically experienced, Walsh (2003a) explained how the family system as a whole may then be utilized as a resource in recovery. “Key family processes mediate the recovery of all members and the family unit. These processes enable the family system to rally in times of crisis, to buffer stress, reduce the risk of dysfunction, and support optimal adaptation” (Walsh, 2003a, p. 3).

Whereas previous research focused on family stress and coping, studies exploring what makes the family system resilient when facing normative changes as well as crises have been slower to emerge (McCubbin, McCubbin, Thompson, Han & Allen, 1997). As studies began to emerge, two components of family resilience were highlighted. The first, family protective factors, are the factors that shape endurance despite vulnerability, while the second, family recovery factors, are those factors that promote the family’s ability to bounce back. Research in this area over the past 25 years has yielded ten general resiliency factors. These protective and recovery factors include family problem-solving communication, equality, spirituality, flexibility, truthfulness, hope, family hardiness, family time and routines, social support, and health (McCubbin, McCubbin, Thompson, Han & Allen, 1997). The following section provides an overview of these factors.

2.4.1 General resiliency factors

2.4.1.1 Communication

Both verbal and nonverbal behaviour which impacts others around a particular person has been labelled communication (Wills, Blechman & McNamara, 1996). Communication is necessary amongst family members throughout both normative and non-normative life transitions. Communication patterns within a family help facilitate the achievement of the main family functions (Patterson, 2002a; 2002b). Two patterns of communication have been outlined (McCubbin, McCubbin, Thompson, Han & Allen, 1997; McCubbin, Thompson & McCubbin, 2001). Incendiary communication is the pattern of communication that involves negative communication styles. This communication pattern tends to make a stressful situation even worse and can increase the family’s risk (McCubbin, McCubbin, Thompson, Han & Allen, 1997; Olson, 1993; Patterson, 2002b). Affirming communication shows support and care for family members, facilitates resolution of conflict, and aids the family’s ability to recover (McCubbin, McCubbin, Thompson, Han & Allen, 1997; Olson, 1993; Patterson, 2002b). Positive communication styles bring clarity amidst a crisis by facilitating open expression and problem solving as a family (Walsh, 1998; 2003a; 2003b). This clarity, along with congruent messages, fosters effective family functioning (Epstein, Ryan, Bishop, Miller & Keitner, 2003).
2.4.1.2 Equality

Another factor that contributes to the resilient family is equality. The equality of all family members denotes independence and fosters self-reliance. This in turn enables each member to have the power to make decisions often necessary in a crisis situation. The experience of equality within the family system promotes family adjustment and adaptation (McCubbin, McCubbin, Thompson, Han & Allen, 1997).

2.4.1.3 Spirituality

Rising above one’s own self-interest, appreciating life, and living with a sense of positive purpose is identified as spirituality (Silliman, 1994). Finding meaning in the pain helps the family adjust and adapt during a crisis (Patterson, 2002b). Often explanations and logic do not provide family members with comfort, but rather finding meaning through a sense of spirituality gives family members a sense of strength, as well as aiding resilience (McCubbin, McCubbin, Thompson, Han & Allen, 1997; Werner & Smith, 1992; Yates & Masten, 2004). Families can look to their spirituality as a source of strength, comfort and guidance during times of crisis and difficulty (Walsh, 1998; 1999). Gaining meaningfulness from spiritual engagement contributed largely to long-term resilience (Werner & Smith, 1992).

2.4.1.4 Flexibility

Playing an important protective and recovery role in helping the family maintain stability is flexibility. Walsh (2003a; 2003b) considered flexibility to be a vital component in the process of resilience. Olson (1993) used the term adaptability, defined as “the ability of a marital or family system to change its power structure, role relationships, and relationship rules in response to situational and developmental stress” (p. 21). When a family is flexible they are able to adjust their patterns of functioning to help them cope in times of difficulty (McCubbin, McCubbin, Thompson, Han & Allen, 1997). While too much change can contribute towards family instability, it is necessary to find a balance between change and stability if flexibility is to aid the resilience of a family (Patterson, 2002a; 2002b).

2.4.1.5 Truthfulness

Truthfulness amongst family members and from other environments is essential in helping a family adapt. Truthfulness enables the family to gain information from which they can assess a situation, and from which they can guide their steps thereafter (McCubbin, McCubbin, Thompson, Han & Allen, 1997).
2.4.1.6 Hope

Another protective and recovery factor that aids the family in the adaptation process is hope. Crises are often paired with a sense of helplessness. It is important that the family is able to cling to a sense of hope amid this helplessness. The concept of “learned optimism” has been used to explain how people begin to believe that their efforts can work (Seligman, 1990). Having hope means that the family has “wishes or desires that are accompanied by a confident expectation of their fulfilment” (McCubbin, McCubbin, Thompson, Han & Allen, 1997, p. 14). Having a sense of meaning and spirituality that rises above one’s painful circumstances allows for a sense of hope despite uncertainty (Walsh, 1998).

2.4.1.7 Family hardiness

Family hardiness is a resiliency factor that safeguards against the effects of stress on one’s health (Svavarsdottir, McCubbin & Kane, 2000). Family hardiness is defined as having a sense of control over the end result of the challenges a family experiences. The family’s adaptation is ultimately aided by the family actively pulling together as a unit to handle a problem, and reframing the crisis as a challenge (McCubbin, McCubbin, Thompson, Han & Allen, 1997). This implies that family hardiness requires taking an operational stance in adapting to stressful situations (Svavarsdottir, McCubbin & Kane, 2000).

2.4.1.8 Family time and routines

Family time and routines often helps the family in crisis to maintain a sense of stability and continuity. Spending time together and having routines helps the family system create a sense of predictability (McCubbin, McCubbin, Thompson, Han & Allen, 1997). Furthermore, family time spent together and routines are considered reliable indicators of family integration and stability (McCubbin, Thompson & McCubbin, 1996; 2001). There are many advantages in having family patterns of stability in that they “allow family units to bridge generations, establish continuity in the present and in the midst of disruptions, and to build a solid foundation of interpersonal supports needed to negotiate major transitions and transformations” (McCubbin, Thompson & McCubbin, 2001, p. 358).

2.4.1.9 Social support

A family draws on its supportive relationships in order to help during its time of crisis (Walsh, 1996; 2003a). There are five dimensions of social support. These include emotional support such as caring, esteem support such as affirming value, and network support where it is important to know that there is a group of people whom the family is both responsible to and from which the family
can draw on as a resource. Furthermore, there is *appraisal support* which gives family members a sense of boundary, and *altruistic support* which is giving of oneself for the gain of others (McCubbin, McCubbin, Thompson, Han & Allen, 1997). “Interpersonal relationships enhance adaptation through provision of supportive functions that are of direct or indirect assistance for the coping process” (Wills, Blechman & McNamara, 1996, p. 109).

2.4.1.10 Health

Health is the last protective and recovery factor in family resilience. Resiliency in the family unit is promoted by both the physical and emotional health of family members. Health furthermore protects the family system against vulnerability. If a family member is not healthy, the family unit is at risk of becoming more vulnerable (McCubbin, McCubbin, Thompson, Han & Allen, 1997). As an overview of international individual and family resilience research has been provided, attention is now turned to a brief overview of family resilience research in South Africa.

2.4.2 South African family resilience research

In the South African context, investigating resilience from a family perspective is relatively recent, but is gaining attention. A number of researchers have investigated resilience from a family perspective. Greeff and Human (2004) examined families in which a parent has died; Greeff and van der Merwe (2004) looked at divorced families; Greeff and Aspeling (2004) conducted a comparative study of South African and Belgian single-parent families, and Der Kinderen and Greeff (2003) looked at resiliency in families where a parent accepted a voluntary teacher’s retrenchment package. The larger, broader version of this study is currently being conducted at the University of Stellenbosch, however, research to gain an understanding of the adjustment and adaptation of families who have a member who misuses alcohol is yet to be given attention. Walsh (1996) emphasized that more research should be conducted on families that are successful in steering through the disruptions caused by major losses and transitions. This study focused on families that manage to navigate through the challenges of having a parent who misuses alcohol.

2.4.3 Conclusion – family resilience

Definitions of family resilience have been outlined, and the ten protective and recovery factors identified from research by McCubbin, McCubbin, Thompson, Han & Allen (1997) have been discussed. Furthermore, this section included a brief overview of the studies that have been conducted in the field of family resilience within a South African context. The conceptual framework of the study is now discussed in detail.
2.5 Conceptual framework

A conceptual framework in which to understand family resilience has been developed by McCubbin, Thompson and McCubbin (1996, 2001). This framework is called the Resiliency Model of Family Stress, Adjustment and Adaptation, and its roots are embedded in family stress theory. Various family stress and resiliency models have emerged over the last two decades which have formed the foundation for the Resiliency Model of Family Stress, Adjustment and Adaptation. These models are briefly discussed.

2.5.1 Evolution of the Resiliency Model of Family Stress, Adjustment and Adaptation

The roller coaster model was first proposed by Koos (1946) and provided an initial framework for tracing a family’s response to stress. Koos’ model proposed that families journey through three stages after encountering a stressful event. The length of time that it takes to progress through these stages varies. These three stages include disorganization, recovery, and reorganization. During the disorganization stage, the family initially finds themselves thrown off-balance by the crisis. It is at this time that the family unit is characterized by increased levels of conflict, efforts to find coping strategies, and general feelings of confusion, anger and resentment. Next the family enters into the recovery stage where they begin to discern new ways of adjusting to the crisis. This period is followed by the reorganization stage where the family’s primary focus is reconstructing its level of functioning. This reorganization may result in the family functioning at, above, or below its pre-crisis level of functioning. At any point during this process, the family may not find the resources to recover and may disintegrate (De Haan, Hawley & Deal, 2002). In research on the roller coaster model, five patterns of crisis response have been identified, namely roller coaster, increased functioning, decreased functioning, mixed changes, and no change (Burr & Klein, 1994). Initially, this preliminary model was considered a good foundation to identify the pathways of resilience (De Haan, Hawley & Deal, 2002). The roller coaster model was further refined by Hill (1949; 1958).

Hill’s (1949; 1958) ABCX framework focused on pre-crisis factors in families and examined the variability in families’ adaptations to stressful events. In this model, three variables interact to produce a crisis (X). The first variable is the stressor (A). A stressor is an event or transition that impacts the family in such a way that it has the potential for either family change or disruption to occur (McCubbin & Patterson, 1983). The stressor (A) interacts with the resources the family has to cope with the effects of this stressor (B). These resources help the family to prevent a crisis and interact with (C), the family’s personal interpretation of how serious the stressor is. This interpretation is a reflection of the family system’s values and previous experiences, and ultimately causes an impact if the family views the stressor as a challenge they are able to face, or as
something that is beyond their control and with which they feel they do not have the ability to cope (McCubbin & Patterson, 1983).

Where Hill’s ABCX model focused singularly on pre-crisis factors, this focus broadened to focusing on both pre- and post-crisis factors. These post-crisis factors are emphasised in the Double ABCX Model of Adjustment and Adaptation as well as its extension, the Family Adjustment and Adaptation Response Model (McCubbin & Patterson, 1983).

The Double ABCX Model of Adjustment and Adaptation incorporated additional factors that were identified in a study using the Hill ABCX model. The factors that were identified appeared to be influential in impacting the family’s post-crisis adaptation over time. The first factor is a pile-up of stressors and strains, referred to as ‘aA’ in the Double ABCX model. Family crises take time to build up as well as to be resolved. Because of this, families often do not deal with one single stressor, but rather with a build up of stressors and strains. These demands may originate from individual family members, the family system, and/or the community. There are furthermore various types of stressors and strains that add to the pile-up. These include the original stressor and its associated difficulties, normative transitions, prior strains, consequences of the family’s attempts to cope, and family and social ambiguity (McCubbin & Patterson, 1983). The second factor, referred to as ‘bB’ in the Double ABCX model, is new resources that the family develops as a result of dealing with post-crisis factors. These new resources may be individual, family, and/or community resources. A critical factor which helps the family cope is the meaning the family attributes to the total crisis situation, referred to as ‘cC’ in the Double ABCX model. The total situation includes the initial stressor along with the pile-up of stressors, old and new resources, and assessments of those things that will help rebalance the family. A family may attribute meaning from their crises by seeing their situation as an opportunity for growth or development. This can give the family hope which helps the family ultimately cope and adapt. Family adaptation, referred to as ‘xX’ in the Double ABCX model, is considered the key concept in this model. Adaptation has been described as the “outcome of family efforts to achieve a new level of balance in family functioning which was upset by a family crisis” (McCubbin & Patterson, 1983, p. 19). The goal of post-crisis adaptation is to restore balance within and amongst the individual, the family unit, and the community within which the family unit finds itself. Family adaptation is described on a continuum ranging from positive adaptation (bonadaptation) to negative adaptation (maladaptation) (McCubbin & Patterson, 1983).

The Double ABCX Model was expanded into the Family Adjustment and Adaptation Response (FAAR) Model (Bristol, 1987; Patterson, 2002a). This model primarily integrates the process components of the behaviour of the family as they respond to a family crisis (McCubbin & Patterson, 1983; Patterson, 2002b). The FAAR model examines how families reach a level of
adjustment and adaptation by balancing family demands with family capabilities. These demands and capabilities can originate from individual family members, the family unit, and/or the community and consist of a number of elements. Family demands find their origin in a number of areas, including normative and non-normative stressors, ongoing family stressors, and daily minor stressors in life. Family capabilities include resources or protective factors that the family has, for example, tangible resources. These capabilities also include what the family does, for example, coping behaviours. This balancing process simultaneously interacts with family meanings (Patterson, 1988; 1993; 2002a). There are three levels of family meanings which either help or hinder the family’s adjustment and adaptation. Family meaning can be derived from (a) the family’s definition of their demands and capabilities, (b) how the family sees themselves, i.e. their identity, and (c) the family’s view of the world and how they see their family in relation to the broader social system (Patterson, 1993; Patterson & Garwick, 1994). The outcomes of the FAAR Model are similar to those of the Double ABCX Model. The family either adjusts and adapts with improved functioning (bonadaptation), or it functions more poorly as a result of their crises (Patterson, 2002a; Patterson, 2002b).

The Typology Model of Family Adjustment and Adaptation comprises two related yet distinct phases. These phases describe how families respond to life changes and stresses, namely the Adjustment Phase, and the Adaptation Phase. This model introduced new developments to the major components of the Double ABCX Model of Family Adjustment and Adaptation, namely family types and family strengths. It also focused on family types and strengths that explain why some families manage more so than others to adjust and adapt to change (McCubbin, Thompson, Pirner & McCubbin, 1988).

The first phase of the Typology Model of Family Adjustment and Adaptation, the Adjustment Phase, expands upon the family pre-crisis adjustment response, described in Hill’s ABCX family crisis model, and the Double ABCX Model of Family Adjustment and Adaptation. It expands to include family types and levels of vulnerability. Family types play an important role in explaining family behaviour whilst facing a stressor, and include the Regenerative, Resilient, Rhythmic, and Traditionalistic family types. The family’s level of vulnerability is influenced by the pile-up of demands on the family. This pile-up co-occurs with the onset of another stressor, together with the family’s Life Cycle stage and this stage’s accompanying demands (McCubbin, Thompson, Pirner & McCubbin, 1988).

A family’s typology describes how the family unit usually behaves, i.e. their established patterns of functioning. It is important to understand the various family typologies as they play a pivotal role in ensuring family harmony and balance. There are four typologies of patterns of functioning (Hawley, 2000). The regenerative typology is formed by assigning two levels to the dimensions of
family coherence and family hardiness (Hawley & De Haan, 1996; McCubbin & McCubbin, 1988). Family coherence describes the key ways that the family copes with and manages problems (Hawley, 2000). Family hardiness is defined by McCubbin, Thompson and McCubbin (2001) as the family’s “internal strengths and durability characterized by an internal sense of control of life events and life’s hardships, a sense of meaningfulness in life, involvement in activities, and a commitment to learn and to explore new and challenging experiences” (pp. 112-113). The regenerative typology describes four types of families which vary according to their levels of family coherence and family hardiness. These four types include the vulnerable, secure, durable, and regenerative family type. Regenerative families are high on both family hardiness and family coherence, which indicates that they are able to actively cope with stressors while maintaining a sense of control (McCubbin & McCubbin, 2001; McCubbin, Thompson & McCubbin, 1996).

The versatile typology is formed by assigning two levels to the dimensions of family bonding and family flexibility. Family bonding is present when family members feel emotionally connected with one another. Family flexibility is characterized by being able to accommodate changes in family structure as is necessary. The versatile typology describes four types of families which vary according to their levels of family bonding and family flexibility. These four types are fragile, bonded, pliant, and versatile. Versatile families are high on both family hardiness and family coherence dimensions, and are characterized by emotional closeness and ease in family decision-making (McCubbin & McCubbin, 2001; McCubbin, Thompson & McCubbin, 1996).

The rhythmic typology is formed by assigning two levels to the family time and routines dimension, and to the valuing of this family time and routines (Hawley & De Haan, 1996; McCubbin & McCubbin, 1988; 2001; McCubbin, Thompson & McCubbin, 1996). The family time and routines dimension is characterized by daily routines in which the family chooses to practice in order to create regularity. The valuing of family time and routines dimension examines how much the family believes in the value of the routines they practice. The rhythmic typology describes four types of families which vary according to their levels of family time and routines, and according to how much the family values these family time and routines. These four types include unpatterned, intentional, structuralized, and rhythmic family types. The rhythmic family has a sense of predictability along with the belief in the value of its routines (McCubbin & McCubbin, 2001; McCubbin, Thompson & McCubbin, 1996).

The traditionalistic model is formed by assigning two levels to the dimensions of family celebrations and family traditions. Family celebrations involve behaviours that the family engages in to highlight valued occasions. Family traditions incorporate behaviours that the family engages in that promote continuity of its values to the subsequent generations. The traditionalistic typology describes four types of families, namely situational, traditionalistic, celebratory, and ritualistic
families. Ritualistic families are high on both dimensions, which is indicative that they emphasize the importance of traditions and special celebrations (McCubbin & McCubbin, 2001; McCubbin, Thompson & McCubbin, 1996).

The second phase of the Typology Model of Family Adjustment and Adaptation, the Adaptation Phase, focused more on the family’s efforts to recover from the crisis situation. The disorganization that results from a crisis situation calls for the family to try and restore its stability to its previous, lower or higher level of functioning. The family’s attempt at reorganization marks the entrance to this phase, which involves the interaction of various other variables. These include family demands, capabilities, resources, appraisals, and coping strategies in an attempt to adapt (McCubbin, Thompson, Pirner & McCubbin, 1988).

The Resiliency Model of Family Stress, Adjustment and Adaptation finds its origin in the Typology Model of Family Adjustment and Adaptation, and focuses primarily on post-crisis situations. It explores the family’s ability to change and adapt over time (Hawley, 2000; Hawley & De Haan, 1996; McCubbin & McCubbin, 2001). This is the model that was used for the purpose of this research. A discussion of this model follows.

2.5.2 The Resiliency Model of Family Stress, Adjustment and Adaptation

The aim of the Resiliency Model of Family Stress, Adjustment and Adaptation is to understand and explain the reason why some families recover and others remain at risk, and even deteriorate under similar situations (McCubbin & McCubbin, 1993; 2001; McCubbin, Thompson & McCubbin, 1996). The Resiliency Model of Family Stress, Adjustment and Adaptation consists of two phases. These are the *adjustment phase* and the *adaptation phase* (McCubbin & McCubbin, 1993, 2001; McCubbin, McCubbin, Thompson, Han & Allen, 1997; McCubbin, et al., 1996). These phases are now discussed.

2.5.2.1 The adjustment phase

The adjustment phase of the Resiliency Model of Family Stress, Adjustment and Adaptation is outlined in Figure 1. This first phase consists of different variables which interact and ultimately shape the family’s outcome.
Figure 1. The Adjustment Phase of the Resiliency Model of Family Stress, Adjustment and Adaptation (McCubbin & McCubbin, 2001, p. 34).
The various interacting variables which influence the outcome of the family is now explained. As a result of a pile-up of family strains, the family becomes Vulnerable (V). A family’s vulnerability may be high or low. This depends on the pile-up of demands on and/or within the family, and the normal stressors and demands associated with the family’s stage in the life cycle (McCubbin & McCubbin, 2001). When the family faces a stressor (S), it impacts on the family’s vulnerable state. A stressor is “a demand placed on the family that produces, or has the potential of producing changes in the family system” (McCubbin & McCubbin, 2001, p. 17). The impact that the stressor has on the family is partially determined by the severity of the stressor. Severity is determined by how much the stressor jeopardizes the family’s stability, functioning, and resources (McCubbin, 1990; McCubbin & McCubbin, 2001). In turn, the family’s Vulnerability (V) interacts with the family’s typology which is represented as Established Patterns of Functioning (T).

The result of these interactions (Stressor, Vulnerability, and Established Patterns of Functioning) leads into a circular interacting cycle of Family Resources (B), the family’s Appraisal of the Stressor (C), and the family’s Problem Solving and Coping mechanisms (PSC). Family Resources (B) are the family’s abilities to cope with the stressor, its demands, and resulting changes in the established patterns of functioning in an effort to avoid a family crisis (McCubbin & McCubbin, 2001). Key family resources that have been identified in previous research (Curran, 1983; McCubbin, Thompson, Pirner & McCubbin, 1988; Olson, McCubbin, Barnes, Larsen, Muxen & Wilson, 1983; Stinnet, 1981) are listed by McCubbin and McCubbin (2001). These include social support, economic stability, cohesiveness, flexibility, hardiness, shared spiritual beliefs, open communication, traditions, celebrations, routines, and organization. The family’s Appraisal of the Stressor (C) represents how seriously the family views the stressor. The family’s Problem Solving and Coping mechanisms (PSC) indicate the “family’s management of stress and distress through the use of its abilities and skills to manage or eliminate a stressor and related hardships” (McCubbin & McCubbin, 2001, p. 20). Stress creates the pressure for some kind of adjustment, which can result in one of two outcomes. Stress results in distress, where the stress becomes unmanageable and the family views the imbalance as negative, or eustress, where the tension is viewed as positive and challenges the family in such a way that they appreciate the resulting change (McCubbin & Patterson, 1983). Outcomes of the adjustment phase are on a continuum ranging from positive bonadjustment, which implies maintenance of family patterns, versus negative maladjustment, which accumulates into a family crisis and ultimately changes the family’s patterns of functioning (McCubbin & McCubbin, 2001; McCubbin, Thompson & McCubbin, 1996). The adaptation phase proceeds only if maladjustment results after this adjustment phase. The following is an explanation of this adaptation phase.
2.5.2.2 The adaptation phase

The adaptation phase of the Resiliency Model of Family Stress, Adjustment and Adaptation is depicted in Figure 2. This phase includes interacting elements on the path towards a continuum of adaptation.
Figure 2. The Adaptation Phase of the Resiliency Model of Family Stress, Adjustment and Adaptation (McCubbin & McCubbin, 2001, p. 44).
Adaptation ranges from positive *bonadaptation*, which implies maintenance of family patterns, versus negative *maladaptation*, which accumulates into a family crisis and ultimately changes the family’s patterns of functioning (McCubbin & McCubbin, 2001; McCubbin, Thompson & McCubbin, 1996). Throughout this process the family introduces changes aimed at restoring harmony and balance to both the family and its external environment (McCubbin & McCubbin, 2001; McCubbin, Thompson & McCubbin, 1996).

2.5.2.1.1 Family crisis

The beginning of this phase is marked by a family crisis. McCubbin and McCubbin (2001) defined a crisis as “a state of imbalance, disharmony, and disorganization in the family system” (p. 22). Although the crisis situation marks family vulnerability, the family is still faced with an opportunity for constructive changes in its patterns of functioning. Despite the fact that this opportunity is available, these vulnerable families are partially characterized by imbalance and disharmony, a situation which is unfortunately only exacerbated by the following cyclical interaction (McCubbin & McCubbin, 1996; 2001). The following explanation is a description of these elements.

The crisis the family experiences is exacerbated by two factors. The first factor is the inclusion of other stressors that the family is simultaneously facing, namely a pile-up of demands (AA) (McCubbin & McCubbin, 2001; McCubbin, Thompson & McCubbin, 1996). There are nine categories of stressors that contribute to a pile-up of demands and, in turn, the crisis situation. These include the initial stressor and its related hardships, normative changes in the family, prior family stressors that have accumulated over time, situational demands that arrive unexpectedly, efforts that the family have made to cope, ambiguity between the larger social system and the family about how families should cope during times of crisis, new patterns of functioning that the family has adopted to cope but which exert more demands, new patterns of functioning which may be incongruent with the family’s schema and paradigms, and old patterns of functioning which are established within the family but which may be incongruent with new patterns of functioning (McCubbin & McCubbin, 2001; McCubbin, Thompson & McCubbin, 1996).

The second factor that exacerbates the family’s crisis is the family’s inadequate and/or deteriorated established patterns of functioning (T) (McCubbin & McCubbin, 2001; McCubbin, Thompson & McCubbin, 1996). Established patterns of functioning were explained in the adjustment phase and carry over into the adaptation phase. Some of these patterns provide stability and harmony, and are preserved as the family’s retained and restored patterns of functioning (T).

In addition, new patterns of functioning (TT) must be implemented (McCubbin & McCubbin, 2001; McCubbin, Thompson & McCubbin, 1996). The nature of these patterns depends on what is
needed to facilitate adaptation, taking into consideration the nature of the crisis. The new patterns of functioning focus on five areas. These include different patterns that impact and change the family’s rules and boundaries; routines, relationships, and roles; coalitions within the family system; communication patterns, and transactions and interactions with the community. The purpose of new patterns of functioning is to initiate disruption within the family dynamics. This in turn helps them cope, restore balance, and achieve adaptation (McCubbin & McCubbin, 2001; McCubbin, Thompson & McCubbin, 1996).

The family’s retained and restored patterns of functioning (T) along with the new patterns of functioning (TT) interact with the family’s situational appraisal of the crisis (CC), problem solving and coping strategies (PSC), and resources (BB). This interaction ultimately leads to family adaptation (XX) (McCubbin & McCubbin, 2001; McCubbin, Thompson & McCubbin, 1996). An explanation of these processes follows.

2.5.2.2.2 Cyclical interaction of processes

The family’s appraisal is comprised of five processes (McCubbin & McCubbin, 2001; McCubbin, Thompson & McCubbin, 1996). At the broadest level is the family’s schema (CCCCC). This is an important construct which contributes to helping the family shape its patterns of functioning. A family schema constitutes family convictions, values, and beliefs that have accumulated over time, and which form a solid framework that is resistant to change. This framework is used by the family to assess experiences, and is influenced by the family’s culture and ethnicity. The family schema plays a role in bringing balance, harmony, and a solid foundation to the family (McCubbin & McCubbin, 2001; McCubbin, Thompson & McCubbin, 1996). Family coherence (CCCC) is an attitude that conveys feelings of confidence that the world is understandable, manageable and meaningful (Antonovsky, 1979; 1987; Antonvosky & Sourani, 1988). Family coherence helps the family to transform potential resources into actual resources (McCubbin & McCubbin, 2001). Family paradigms (CCC) represent shared beliefs about how the family should function. Situational appraisal (CC) can be described as the family’s ability to weigh up their resources against new demands created by the crisis, on their established patterns of functioning. The family’s definition of the gravity of the stressor is at the initial level of family assessment. This is represented as the stressor appraisal (C) (McCubbin & McCubbin, 2001; McCubbin, Thompson & McCubbin, 1996).

Problem solving and coping strategies (PSC) may be directed at four aspects that facilitate adaptation (McCubbin & McCubbin, 2001; McCubbin, Thompson & McCubbin, 1996). These four aspects are coping and problem solving directed at reducing or eliminating demands; strategies aimed at acquiring extra resources not previously available to the family; strategies aimed at
managing tensions; and strategies aimed at moulding the family’s appraisal at both situational and family schema levels (McCubbin & McCubbin, 2001; McCubbin, Thompson & McCubbin, 1996). Within the Resiliency Model of Family Stress, Adjustment and Adaptation, coping behaviour is defined by McCubbin and McCubbin (2001) as “a specific effort (covert or overt) by which an individual family member or the family functioning as a whole attempts to reduce or manage a demand on the family system, and bring resources to bear to manage the situation” (p. 49).

The family’s resources (BB) include the family’s strengths and capabilities. There are three sources that the family can draw on as resources, namely individual family members, the family unit, and/or the community. McCubbin and McCubbin (2001) defined a resiliency resource as “a characteristic, trait, or competency of one of these systems (individual, family, community) that facilitates adaptation” (p. 33). Resources may be tangible, for example money, or intangible, for example family integrity. There are eight personal resources that are considered essential in the adaptation process. These resources include (1) intelligence of family members which helps them successfully fulfil demands, (2) knowledge and skills gained from education and experience which facilitate greater ease when performing tasks, (3) personality traits that aid in coping, for example a sense of humour or hardiness, (4) health in physical, spiritual and emotional spheres which fuels energy for fulfilling demands, (5) a sense of mastery, (6) self-esteem, (7) sense of coherence, and (8) ethnic identity and cultural background that helps guide family functioning (McCubbin & McCubbin, 2001; McCubbin, Thompson & McCubbin, 1996).

In addition to personal resources are family system resources. Two family resources have been identified as crucial, namely cohesion and adaptability (Olson, Sprenkle & Russell, 1979). Family cohesion is defined by Olson (1993) as “the emotional bonding that family members have toward one another” (p. 19). Other important resources have also been identified in research as valuable. Family organization helps with agreement and dependability of family roles and rules, while various aspects of communication ability, such as clear and direct messages, have been emphasized as a family resource (Satir, 1972). Communication also aids in family problem solving (Walsh, 1998; 2003a; 2003b). Families that have an affirming communication style can draw on this as a resource (McCubbin & McCubbin, 2001; McCubbin, Thompson & McCubbin, 1996). Family hardiness is another family resource and serves as a buffer against the effects of stressors (McCubbin, McCubbin, Thompson, Han & Allen, 1997; Svavarsdottir, McCubbin & Kane, 2000). Yet another family resource is having the family spend time together and having family routines. This contributes towards maintaining harmony and balance when change occurs in the family system.
These elements interact in a cyclical manner as the family attempts to manage the crisis, and ultimately results in the level of adaptation that the family experiences. The proceeding section is an explanation of family adaptation.

2.5.2.2.3 Family adaptation

The pivotal concept in understanding the family’s resiliency and its effort to handle a crisis is Family Adaptation (XX). Adaptation is a process whereby the family recognizes that changes need to be made in order to help regain stability as a result of the crisis. These changes are aimed at restoring family harmony and satisfaction. Outcomes of this phase range on a continuum from positive bonadaptation to negative maladaptation. Bonadaptation implies that the family has accepted its circumstances and is able to function congruently with new patterns of functioning. Maladaptation implies the opposite, and as a result the family is propelled back into the crisis situation (X) where the cycle is repeated (McCubbin & McCubbin, 2001; McCubbin, Thompson & McCubbin, 1996).

2.5.2.3 Conclusion – The Resiliency Model of Family Stress, Adjustment and Adaptation

The Resiliency Model of Family Stress, Adjustment and Adaptation describes how families undergo a process in order to adapt to a crisis. In a family transition, such as recovering from parental misuse of alcohol, there are many unique stressors that the family is faced with on the journey towards adaptation. The Resiliency Model of Family Stress, Adjustment and Adaptation is used as a departure point for exploring these stressors in the following chapter. Furthermore, it is used in striving to understand the factors that aid adaptation.

2.6 Conclusion

This chapter outlined the course of resilience research from the individual to the family system. Various definitions of resilience were discussed and the value of the family resilience perspective was emphasized. A detailed discussion was given explaining the evolution of the Resiliency Model of Family Stress, Adjustment and Adaptation. The two phases of this conceptual framework, the adjustment phase and the adaptation phase, were described. These two phases formed the basis for this study. The unique stressors and strengths of a family in which a parent misuses alcohol are discussed in the following chapter.
CHAPTER 3

ALCOHOL MISUSE AND THE FAMILY

3.1 Introduction

The focus of the current research is on family resilience where a parental member misuses alcohol. This chapter thus covers the concept of alcohol misuse in its various forms and begins by defining alcohol misuse. The researcher explores the current statistics available on alcohol consumption both internationally and nationally, and explores strategies in which alcohol-related harm can be reduced. There are numerous labels and classifications for alcohol misuse which are explored and discussed, along with other alcohol-related disorders. Furthermore, the causal factors as well as the consequences for alcohol misuse are explored before the chapter is concluded.

3.2 Defining alcohol misuse

Tucker, Donovan and Marlett (1999) defined addictive behaviour as a repetitive habit pattern that increases the risk of disease and/or associated personal and social problems. Alcoholism has been defined as a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking, preoccupation with alcohol, the use of alcohol despite adverse consequences, and distortions in thinking, most notably denial (Morse & Flavin, 1992). Each of these symptoms may be continuous or periodic (Morse & Flavin, 1992).

The Centers for Disease Control and Prevention (2008) highlighted the differences between alcoholism, or alcohol dependence, and alcohol abuse. In doing so, alcoholism or alcohol dependence is defined as a diagnosable disease characterized by several factors including a strong craving for alcohol, continued use despite harm or personal injury, the inability to limit drinking, physical illness when drinking stops, and the need to increase the amount drunk in order to feel the effects (CDC, 2008).

The Centres (2008) go on to define alcohol abuse as a pattern of drinking that results in harm to one’s health, interpersonal relationships or ability to work. Certain manifestations of alcohol abuse include failure to fulfil responsibilities at work, school or home; drinking in dangerous situations such as while driving; legal problems associated with alcohol use and continued drinking despite problems that are caused or worsened by drinking. Alcohol abuse can lead to alcohol dependence (CDC, 2008).

The American Medical Association recognized alcoholism as a disease in 1956 (Mersey, 2003). Early editions of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM) required the presence of tolerance or withdrawal symptoms before a
diagnosis of alcohol dependence could be made. In the fourth edition of this publication (DSM-IV-TR, 2000), the requirements shifted to loss of control and failure to abstain from using alcohol despite evidence of the problems it causes. These DSM-IV-TR requirements are now outlined:

Alcohol dependence is defined as:

a) A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. Tolerance, as defined by either of the following:
   - A need for markedly increased amounts of the substance to achieve intoxication or desired effect
   - Markedly diminished effect with continued use of the same amount of substance

2. Withdrawal, as manifested by either of the following:
   - The characteristic withdrawal syndrome for the substance
   - The same (or a 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 or control substance use

5. A great deal of time is spent in activities to obtain the substance, use the substance, or 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 knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

Alcohol abuse is defined as:

a) A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfil major role obligations at work, school, home (e.g., repeated absences or poor work performance related to substance
use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)
   a) The symptoms have never met the criteria for Substance Dependence for this class of substances (American Psychological Association, 2000).

Mersey (2003) explained that the distinction between addiction and problem use is particularly important in that the problem user may have undiagnosed social or medical problems, but not yet have experienced a major loss of control. There are a number of alcohol induced disorders that are included in the DSM-VI-TR (American Psychological Association, 2000). The diagnostic criteria for these disorders are listed in appendix A.

The following paragraph explores the current patterns and trends in alcohol consumption. This is initially investigated globally, followed by a discussion of the trends within the South African context.

3.3 Global patterns and trends in alcohol consumption

Surveys have shown that alcoholism is the biggest substance misuse problem in the world today, affecting millions of people (Searll, 1989). For example, it is estimated that there are ten million alcoholics in the United States alone. Alcohol misuse and alcoholism are the most costly addiction problems in terms of frequency of usage and potential for harm (Marlatt et al., 1988).

Parry (2000) stated that data from the United Nations Food and Agriculture Organization (FAO) indicates that recorded alcohol consumption in most developing countries is considerably lower than in most developed countries (refer to Figure 3). Figure 3 also reflects the trend towards decreasing consumption in most developed countries, with the exception of Japan and some parts of the former Soviet Union since 1980, and the steady rise in recorded alcohol consumption in most developing countries, albeit from a low base (Parry, 2000).
In recent years there has been much debate regarding the health benefits of moderate alcohol consumption (Parry, 2000). However, it must be noted that such benefits have at best only been established for limited populations, typically in developed countries (Parry & Bennetts, 1998). The pattern of drinking to intoxication by many drinkers in developing countries is unlikely to have the same effect as moderate, regular drinking in terms of providing protection against cardiovascular disease (Parry, 2000). Alcohol's burden on health in the developing regions of the world, although lower than in established market economies, is of considerable magnitude. This range can include up to 10 percent of the burden of disability and death in Latin America (WHO, 2002).

Figure 4 illustrates the three macro-regions of the developing world in which recorded alcohol consumption has in general fluctuated with regional economic fortunes (Parry, 2000). In Eastern and South-Eastern Asia, from the 1960s until very recently, alcohol consumption grew rapidly. Latin America and Africa saw increases from the 1960s through the early 1980s when global recession began to depress national economic development and alcohol consumption (Parry, 2000).
As a result of the complex and inter-related changes that we observe over time in the health and disease patterns of a society or country, a shift has occurred in the relative importance of infectious diseases versus chronic and degenerative conditions in recent years in developing societies (Parry, 2000). Chronic conditions are assuming increasing prominence as problems such as heart disease, liver cirrhosis and malignancy are recognized as important causes of mortality and morbidity (Lozano, Murray, Frenk & Bobadilla, 1995). Alcohol misuse is a contributing factor in many of these disorders, and hence it is likely to be included as a significant component of the health profile of developing countries in the future (Parry, 2000).

Currently, in developing countries, alcohol-related problems commonly result in trauma, violence, organ system damage, various cancers, unsafe sexual practices, injuries to the brain of a developing fetus and general poor nutritional status of families with a heavy drinking parent or parents (Parry, 2000). Many of these problems are associated with intoxication episodes. Besides medical consequences, alcohol use also impacts negatively on the family, the criminal justice system, the employment sector, and the economic and social development of developing countries (Jernigan, Monteiro, Room, & Saxena, in press).

Internationally, as a result of research funded by the World Bank and Harvard University (Murray & Lopez, 1996), there has been greater quantification of the burden of harm associated with the use of alcohol. Over all countries the global burden of alcohol use in 1990 was estimated to be 3.5% of the total disability adjusted life years lost (DALYs) (Parry, 2000). The burden of harm of alcohol use in developing countries specifically was estimated to be 2.7% of total DALYs, as compared to 9.6% in developed countries (Parry, 2000). It was estimated that in 1990 net deaths
from alcohol totalled three quarters of a million persons worldwide, with 80% of this excess mortality occurring in developing regions of the world (Muray & Lopez, 1996).

Figure 5 shows the global burden of harm attributable to alcohol use for different world regions defined by the World Bank (Parry, 2000). The highest estimated burden for a developing region is for Latin America and the Caribbean (9.7%), whereas the lowest estimated burden is for the Middle Eastern Crescent (0.4%) and India (1.6%) (Parry, 2000). These are countries known to have small proportions of the population consuming alcohol. An analysis of trends in different macro-regions suggests that as economic development increases buying power, levels of alcohol use and related harm increases (Jernigan, et al., in press).

3.4 South African context

With chronic alcohol misuse the cost to the individual, the family and society are enormous not only globally, but in South Africa specifically. Alcohol-related accidents on the road, in the home and in the workplace claim many thousands of lives every year. There are thought to be over 300,000 alcoholics in South Africa, and over half a billion rand in production is lost annually as a result of alcohol misuse (Searll, 1989). Alcohol contributes to over half of all motor vehicle deaths each year in South Africa (Robertson, Allwood & Gagiano, 2001). Alcohol misuse has potentially
devastating effects on the family unit, and closely associated problems such as child abuse, poverty, marriage problems, divorce, juvenile delinquency and assault (Searll, 1989). Marriages may be forfeited and families may become estranged due to the toll taken by alcohol (Robertson, et al., 2001). Furthermore, alcohol misuse is causally implicated in a range of chronic health problems (e.g. cirrhosis of the liver; cancer of the mouth, tongue, larynx, oesophagus, stomach and pancreas), increased mortality and morbidity arising from intentional and non-intentional injuries, unsafe sexual practices and increased risk of contracting a sexually transmitted disease and, combined with poor nutritional status, increases susceptibility to opportunistic diseases by compromising the immune system (Department of Health, 2001; Heather, 2001; Office for National Statistics, 2000; Thompson & Cook, 1997). The maternal misuse of alcohol during pregnancy has been linked to foetal alcohol syndrome in infants (Robertson, et al., 2001; Searll, 1989; 1995). Alcohol misuse also impacts on the criminal justice system, with evidence of associations between drinking at risky levels, committing crime, or being a victim of crime (Alcohol and Drug Misuse Research Group, Medical Research Council, 2004). In a study conducted in 1999 among 960 arrestees in nine police stations in Cape Town, Durban and Johannesburg, 22% reported being under the influence of alcohol at the time the alleged crime for which they were arrested took place (Parry, Louw, Vardas, Plüddemann, 2000). Alcoholism furthermore contributes directly to a number of psychiatric complications for the misuser, such as acute intoxication, alcohol withdrawal disorders, dementia, and depression which can lead to suicide (Robertson, et al., 2001; WHO, 2002).

A study of alcohol-related mortality in five of South Africa’s nine provinces was conducted in the first half of 1999. Almost 50% of cases involving death due to homicide and traffic collisions had blood alcohol concentrations \( \geq 0.08\text{g/100ml} \). Just over one quarter of deaths resulting from suicide or other "accidents" had blood alcohol levels \( \geq 0.08\text{g/100ml} \) (Peden, Donson, Mazikom & Smith, 2000).

With regards to alcohol-related trauma, a 1999 study conducted in state hospitals in Cape Town, Durban, Umtata, and Port-Elizabeth found that 61% of patients admitted to trauma units in these cities were alcohol positive with a mean alcohol level of 0.12g/100 ml. The study showed that 74% of violence cases, 54% of traffic collisions and 30% of trauma from other ‘accidents’ were alcohol positive (Peden et al., 2000).

In 1997, 992 children in their first year of school were screened in the rural community of Wellington outside Cape Town. A very high rate of Foetal Alcohol Syndrome (FAS) was found in the sample; 40.5 to 46.4 per 1000 children (and age-specific rates for the entire community of 39.2 to 42.9 per 1000). These rates are 18 to 141 times greater than prevalence estimates for the USA (May et al., in press).
The economic cost associated with alcohol misuse in South Africa is estimated to be in excess of approximately R11.9 billion ($1.7 billion) per year (2% of GNP). This is roughly three times the amount of revenue received by the government in the form of excise taxes (Parry & Bennetts, 1998).

3.4.1 Strategies to address alcohol abuse in South Africa

Countries in the developing world and even provinces or states within developing countries have had widely differing responses to managing the production and distribution of alcohol and addressing alcohol-related harm (Riley & Marshall 1999). Based on international experience, a number of strategies likely to be most effective have been identified to address alcohol abuse (Babor et al., 2003; Parry, 2000; Parry & Bennets, 1998):

3.4.1.1 Regulating physical availability

This involves the implementation of a coherent and enforceable policy regarding liquor outlets, with:

a) effective restrictions or controls on access where there are limits placed on days and hours of business, and public drunkenness is addressed;
b) restrictions are placed on the sale of alcohol to drunk persons, the supply of liquor to employees, the sale or supply of harmful alcohol or packaging;
c) restrictions are placed on outlet locations especially at or near educational institutions, petrol stations, residences, multi-dwelling housing units, places of worship, etc.;
d) regulation of the types of liquor sold in supermarkets and grocery and convenience stores;
e) prevention of the purchasing by minors or the supply to minors;
f) regulation of the use of alcohol in motor vehicles, and
g) the prohibition of the sale of alcohol through vending machines.

In addition, the adequate education and training of the public at large and persons who own or manage liquor outlets or who serve alcohol should be provided (Babor et al., 2003; Parry, 2000; Parry & Bennets, 1998).

Further strategies include strengthening community input in the process of allocating liquor licenses and dealing with complaints; requiring stricter regulations on those liquor outlets in residential areas that are not in business nodes or along corridors, and implementing a program for encouraging existing unlicensed outlets to become licensed and to move to business nodes or corridors. Moreover, improved enforcement and the handling of complaints need to be ensured, and increased access to information needs to be provided while accountability is improved (Babor et al., 2003; Parry, 2000; Parry & Bennets, 1998).
3.4.1.2 Increasing levels of taxation on different alcohol products towards international levels

Levels of taxation on different alcohol products need to be increased towards international levels. In particular, malt beer should be raised to the international average total tax burden of 37 percent while commercial sorghum beer and sorghum powder should be increased to approximately 50 percent of that of malt beer as a percentage of retail sales prices (Babor et al., 2003; Parry, 2000; Parry & Bennets, 1998).

3.4.1.3 Implement more effective drink-driving counter-measures

Random breath testing of drivers, both professional and ordinary drivers, needs to be increased as a matter of urgency. Allowance should be made for automatic administrative license suspension in cases where drivers are caught with alcohol levels above the allowable limits, which are 0.05 g/100 ml for ordinary drivers and 0.02g/100 ml for professional drivers (Babor et al., 2003; Parry, 2000; Parry & Bennets, 1998).

A policy of graduated licenses for novice drivers, whereby persons who receive a driver’s license for the first time are not allowed any alcohol in their systems while driving for a period of 3 years, could furthermore be implemented. Also, traffic police should be allowed to test the alcohol levels of pedestrians (Babor et al., 2003; Parry, 2000; Parry & Bennets, 1998).

3.4.1.4 Implement brief interventions for high-risk drinkers

Such interventions typically consist of one to two sessions of counseling and education. The intention is to motivate high-risk drinkers to moderate their alcohol consumption. This is generally done in primary care settings (Babor et al., 2003; Parry, 2000; Parry & Bennets, 1998).

3.4.1.5 Implement effective treatment programmes for drinkers dependent on alcohol

Treatment for alcohol dependence can occur in an outpatient or an inpatient setting (Babor et al., 2003; Parry, 2000; Parry & Bennets, 1998). Three models of treatment have been shown to be effective in treating alcohol dependence: Twelve Step Facilitation (based on the Minnesota model and AA principles); Motivational Enhancement Therapy (also known as Motivational Interviewing), and Cognitive Behavioural approaches that include relapse prevention training. After treatment, treatment gains tend to be better maintained if the person becomes actively involved in AA or other recovery support groups and develops family and peer relationships that are supportive of recovery (Babor et al., 2003; Parry, 2000; Parry & Bennets, 1998).

In addition, serious consideration should be given to bring labeling on alcohol containers up to the standard of other products. Labels should include alcohol content and standard servings which list:
a) the number of standard drinks per container and the amount of alcohol in a standard serving; 
b) the South African Food Based Dietary Guidelines on sensibly drinking alcohol which is no
more than two standard drinks per day for women or three drinks per day for men, and
calorie information and ingredients per serving so that consumers concerned about excess weight
could put alcoholic beverages in the context of their diet, and can compare beverages in terms of
food allergies (Babor et al., 2003; Parry, 2000; Parry & Bennets, 1998).

As we have seen in South Africa, it is not enough just to have policies to address alcohol abuse.
It is equally important to have mechanisms for translating policy into action (Parry, 2000; Parry &
Bennetts, 1998).

Now that the strategies to address alcohol abuse in South Africa have been highlighted, the
various roles members play in alcohol misusing families are discussed. The family roles described
offer a useful framework for understanding some family dynamics and functionality in families
with alcohol misuse (Lambie & Sias, 2005).

3.5 Roles in alcohol misusing families

Alcohol misuse is circular in nature as it has potentially devastating consequences not only for
the individual using the substance, but for the entire family as well (Lambie & Rokutani, 2002;
Lambie & Sias, 2005; Searll, 1989). All families work to maintain homeostasis and equilibrium, or
balance (Nichols & Schwartz, 2003). Challenges these families face include feelings of guilt and
shame, which are experienced to one degree or another by all co-dependents (Lambie & Sias,
2005). The adolescent often feels it is his or her fault that a parent becomes upset and he or she
struggles with the fact that he or she is not loveable (Daley & Raskin, 1991; Fields, 2004).

Research has indicated that a family history of alcohol misuse substantially increases the risk for
problems among members, and that the same pattern occurs with alcohol misuse and dependence
(Dube, Anda, Felitti, Edwards & Croft, 2002). Although genetics plays a substantial role in alcohol
misuse, the family environment plays a role in both promoting and protecting the individual from
alcohol misuse. Furthermore, it has been found that risk and protective factors suggest that family
relationships have a significant impact on alcohol misuse. For example, adolescents from two-
parent families have reported lower levels of alcohol use than adolescents from single or stepparent
families (Barnes & Windle, 1987; Bjarnason et al., 2003; Burnside, Baer, McLaughlin & Pokorny,
1986; Challier, Chau, Predine, Choquet & Legras, 2000; Hellandsjo Bu, Watten, Foxcroft,
Ingebrigtsen & Relling, 2002; Miller, 1997; Persson, Hanson & Rastam, 1994). These factors may
be of some use in identifying “at risk” families or they may actually be proxy indicators of
underlying risk factors such as lack of social support, poor parental relationships and/or
socioeconomic disadvantage (Ward & Snow, 2008).
In order to cope with the strong negative feelings associated with alcohol misusing families, children have been described as developing roles that are “rigid patterns of behavior from childhood – that were adopted to survive emotionally in a family rendered dysfunctional by alcoholism” (Alford, 1998, p. 250). The majority if not all of these roles are experienced by children of alcoholics, hereafter COAs, and a COA can fulfill more than one role at a time (Lambie & Sias, 2005). COAs are a population without a clear definition. Because the concept of a COA is focused on the child rather than the parent, the definition of a COA is any child whose parent (or parental caregiver) uses alcohol in such a way that it causes problems in the child's life (COAF, 2007).

These roles are seen as influencing the way a child within an alcoholic family makes meaning of his or her chaotic world, often distorting his or her perspectives throughout life (Lambie & Sias, 2005; Wegscheider-Cruse, 1985; 1989). These roles are generalizations and have not been validated by empirical research (von Wormer & Davis, 2003) and should therefore not be used to label individuals. The following are five examples of possible roles and are labeled in terms of the person’s coping mechanisms (Sias & Lambie, 2005).

3.5.1 The chief enabler/family manager

This family member is the person the alcohol misuser relies on the most (Lambie & Sias, 2005). The chief enabler protects the alcohol abuser from the possible consequences of his or her behaviour and denies any dysfunctionality within the system (Johnson, 2003; Sias & Lambie, 2005). Typically, they begin to react to the symptoms of the individual, which results in the ‘concerned person’ unsuspectingly conspiring with the dysfunctional behaviour and actually enabling it to progress and get worse (Johnson, 2003). This enabling behaviour surrounds and feeds the dependence (Johnson, 2003).

Tragically, the enabler’s well-intentioned behaviour plays an increasingly destructive role in the progression of the dysfunctional behaviours by limiting the abuser’s opportunity of gaining insight regarding the severity of his or her behaviours (Johnson, 2003). The enabler continues his or her behaviour as he or she sees all that has been done as a sincere effort to help (Johnson, 2003).

3.5.2 Family hero

These family members work extremely hard to make the family appear healthy and functional (Sias & Lambie, 2005). They tend to be the firstborn, achievement orientated, responsible, perfectionistic, parentified and model students. Their need to achieve is not intrinsic, but rather an attempt at maintaining the family’s façade of being functional (Sias & Lambie, 2005). Often these members are “people pleasers” and seek others’ approval.
This is the member that could also be called codependent. Codependence can be defined as a process whereby someone becomes so preoccupied with someone else that they neglect themselves (Johnson, 2003). In a way it is the belief that something outside of themselves can give them happiness and fulfillment, therefore codependency is when people operate as if they are okay only if they please the people around them (Johnson, 2003). They live with the false belief that the bad feelings they have can be eradicated if they can just ‘do it better’ or if they can win the approval of certain important people in their life. By doing this they make those people and their approval responsible for their own happiness. The families of alcoholics specifically exhibit these codependent characteristics (Johnson, 2003).

3.5.3 Family scapegoat
These members are the opposite of the heroes as they work to divert attention away from the parental alcohol abuse (the real issue) by acting out (Sias & Lambie, 2005). They are often blamed for any problems and tend to be labeled the “identifying client” in counseling, acting as the symptom bearer for the family’s dysfunction. While the family and other systems are focusing on the scapegoat, the underlying parental alcohol misuse goes unnoticed (Sias & Lambie, 2005).

3.5.4. Lost child
The lost child adapts to the system’s chaos by removing himself or herself and hiding, requiring the least amount of energy from caregivers. These members often identify with the other family members’ pain, wanting to reduce it and possibly take it away from them (Sias & Lambie, 2005). They tend to deny their feelings and needs, internalizing their pain which can put them at high risk for self-injurious pain or suicide. Additionally, these members have social skills deficits because they have learned to adapt by removing themselves from situations and are frequently seen as loners who are shy and sensitive (Sias & Lambie, 2005).

3.5.5. Family mascot
The principal function of this role is to redirect attention away from the family’s alcohol misuse and pain through the mascot’s humour, charm, foolishness and self-deprecation (Sias & Lambie, 2005). These members are often the centre of attention while in their family they work to alleviate others’ pain by making them laugh (Sias & Lambie, 2005). They are often compassionate and possess strong aptitudes (Alford, 1998; Fields, 2004; Pitman, 1990; Robinson & Rhoden, 1998; Wegscheider-Cruse, 1985; 1989).

A detailed picture of the roles in alcohol misusing families has been provided. Now some of the possible reasons for alcohol misuse are outlined.
3.6. Reasons for alcohol misuse

Alcoholism is a complex condition that is the result of multiple causal factors (U.S. Congress, 1993). There are a number of factors that contribute to the reason why the adult feels he or she needs to misuse alcohol (Bradizza, Reifman & Barnes, 1999; Kairouz, Gliksman, Demers & Adlaf, 2002; Richter, Leppin & Gabhainn, 2006; Roche & Watt 1999; Smith, Abbey & Scott, 1993; Williams & Clark 1998). These include, but are not limited to biological, psychosocial, relationship and socio-cultural perspectives.

3.6.1 Biological reasons

From a biological perspective, the first cause for alcohol misuse is the individual’s dependence or altered metabolism, and tolerance (Kalant, 1988; 1989; U.S. Congress, 1993). Dependence occurs when, with prolonged use of alcohol, neurons in the brain adapt to the alcohol’s presence so much so that the presence of alcohol is required to maintain normal function in the cells (Kalant, 1988; 1989; Oscar-Berman, Shagrin, Evert & Epstein, 1997; U.S. Congress, 1993). The individual’s body therefore demands that such levels of alcohol be maintained in the system to be able to function. If the alcohol levels drop, the individual experiences withdrawal symptoms (Kalant, 1988; 1989; Oscar-Berman, Shagrin, Evert & Epstein, 1997). Thus, to remove withdrawal symptoms, alcohol levels have to be replenished. In other words, addiction occurs when the individual has to continue drinking in order to remove or prevent withdrawal symptoms and reestablish a sense of normalcy (Kalant, 1988; 1989; U.S. Congress, 1993). This becomes a reinforcing cause and operates according to the principle of negative reinforcement, such as escape training and avoidance training (O’Brien, Childress, McLelland & Ehrman, 1992).

Tolerance to alcohol develops when, following a prolonged period of use, more of the alcohol is needed to produce the same effect (U.S. Congress, 1993). Research has shown that there seems to be a tendency to develop tolerance for the aversive effect of alcohol, but not for the positive mood enhancing effects (Bushman & Cooper, 1990).

The second biological cause for alcohol misuse is possible genetic vulnerability (Elkins, McGue, Malone & Iacono, 2004; Heath et al.,1997; Kendler, Prescott, Neale & Pedersen, 1997; U.S. Congress, 1993). Unlike disorders that result from the presence of alternations in a single gene, a genetic component of alcohol misuse is likely to involve multiple genes that control various aspects of the biological response to alcohol or physiological predisposition to become a misuser (Ackerman, 1992; Blum et al., 1991; Cloninger, Bohman & Sigvardsson, 1981; Crabbe & Harris, 1991; U.S. Congress, 1993). In addition, the complex nature of alcohol dependency, involving many behavioural and environmental factors, indicates that any genetic component acts in consort with other non-genetic risk factors to contribute to the development of alcohol misuse and addiction.
Thus, the presence of a genetic factor does not ensure alcohol addiction, nor does its absence guarantee protection from alcohol addiction (Collins & Marks, 1991; Gelernter et al., 1991; U.S. Congress, 1993). Therefore, while it seems likely that inherited differences exist, a genetic component alone is insufficient to produce alcohol misuse and addiction (U.S. Congress, 1993).

Other hypotheses concerning genetics include a child’s inherited predisposition towards alcohol abuse; a disposition towards impulsiveness, and the inability to plan ahead or to contemplate the consequences of one’s actions. Further supplementary hypotheses encompass emotional instability, risk taking behaviour, the disposition to experience alcohol as stress relieving, and a tendency to develop alcohol tolerance and dependence (Ball & Murray, 1994; Elkins, et al., 2004; Sher, Trull, Bartholow & Vieth, 1999; Zeitlin, 1994).

3.6.2 Psychosocial reasons

Research suggests that individuals who misuse alcohol have psychological vulnerabilities or predisposing personality factors that contribute to the willingness to misuse alcohol (Gorman, 1994). These personality factors that Gorman (1994) highlighted include:

a) emotional immaturity;
b) dependence on praise and acceptance;
c) failure met with feelings of inferiority;
d) frustration intolerance;
e) shyness, impatience, irritability, anxiety and hypersensitivity;
f) inadequacy in their ascribed gender roles, and/or
g) sexual repression.

An estimated 50% of alcohol misusers have at least one mental illness (Brooner, King, Kidof, Schmit & Bigelow, 1997; Halikas, Crosby, Pearson, Nugent & Carlson, 1994). For instance, individuals suffering with an anxiety disorder frequently manifest a co-occurring alcohol use disorder (Bowen, Cipwnyk, D’Arcy & Keegan, 1984; Chambless, Cherney, Caputo & Rheinstein, 1987; Cox, Norton, Dorward & Fergusson, 1989; Himle & Hill, 1991; Kushner & Sher, 1993; Nunes, Quitkin & Berman, 1988; Ross, Glaser & Germanson, 1988).

Often individuals with dual disorders are experiencing tremendous psychological pain, which is apparent in their much higher rates of suicide and suicide attempts than the general population (Kamali, Kelly, Gervin, Browne, Larkin & O'Callaghan, 2000; Lambie & Sias, 2005). Consequently, caretakers with comorbidity are generally less able to meet the emotional, educational and social needs of the children (Lambie & Sias, 2005).
It is suggested that the individuals drink to escape problems, to gain recognition from peers and, in the case of men, to prove their adequacy (Bushman & Cooper, 1990; Krystal 1974; Krystal & Raskin, 1970; McClelland, Davis, Kalin & Wanner, 1972). The criticism with this point of view is that the majority of individuals with such personality traits do not become alcohol misusers (Coggans & McKellar, 1995).

Alcoholism is furthermore associated with attention deficit disorders including hyperactivity (Ohlmeier et al., 2008). Children who exhibit such tendencies are prone to become alcoholics during adulthood. Alcoholism is also associated with depression where the individual drinks to forget his or her sorrows (Addington & Duchak, 1997; Dixon, Haas, Weiden, Sweeney & Frances, 1990; Lehman, Myers & Corty, 1989; Pristach & Smith 1996; Roy, 2003; Williams 2002), or low self-esteem where the individual drinks to feel more socially accepted and to feel like they have a higher self worth (Milkman & Wanberg, 2005; Scheier, Botvin, Griffin & Diaz, 2000).

Alcoholism is further associated with a number of anti-social personality traits, such as non-conformity, acting out and impulsivity and lack of self control (Swadi, 2003). Alcoholism can also co-occur with anxiety (Bushman & Cooper, 1990; Horton, 1943) and schizophrenia (Angold, Costello & Erkanli, 1999; Caron & Rutter, 1991; Raimo & Schuckit, 1998). It is important to note that the aforementioned factors do not have a linear one-to-one causal relationship with alcoholism.

The second psychosocial causal factor is stress reduction and reinforcement. Alcoholics are either unable or unwilling to cope with stress and therefore use alcohol to reduce stress (Cooper, Russell & George, 1988; Lynch, Kaplan & Shema, 1997; Marlatt, 1979). According to these resources, alcohol thus becomes reinforcement as it provides short term relief. It is further reinforcing as it reduces one’s response to stressful situations, e.g. reduces anxiety. These authors further stated that alcohol could in addition be reinforcing because of its euphoric, mood-enhancing qualities and its tendency to diminish negative emotions. Alcohol gives a person false courage and the belief that they are capable and confident, thereby removing self-doubt and inefficiency. Positive expectations concerning the use of alcohol as described above, tends to become a cognitive set, and this in turn serves to maintain the drinking behaviour (Larimer, Palmer & Marlatt, 1999).

The criticism of this point of view is that, from a social learning perspective, if alcohol reduces tension for most people, why then is alcoholism not more common (Bandura, 1978)? This perspective does not explain why some people are able to control their drinking and others not. The long term consequences of alcoholism are devastating and would counter the short term reinforcing effect (Kaplan, 2001). Bandura's counter criticism is therefore that behaviour is controlled more by its immediate, rather than its long term effects (1977; 1978; 1986; 1989; 1997).

An early attempt to evolve a psychoanalytic theory of morbid cravings, including that of alcohol, was made. This theory proposed that alcoholics seem to have over-developed super-egos, which in
turn cause anxiety (Abraham, 1965; 1966; Glover, 1932; 1956; Rado, 1933; 1957; Smith, 2002). It was hypothesized that alcohol is therefore abused by the individual to alleviate this anxiety (Glover, 1932; 1956; Krystal, 1974; Krystal & Raskin, 1970). This perspective postulated that alcohol is misused due to the individual’s oral fixation, and frustration is relieved by oral consumption (Krystal, 1974; Krystal & Raskin, 1970). Alcohol misusers feel a sense of powerlessness and the intake of alcohol gives the individual a false sense of courage.

The *psychoanalytic theory* has since been expanded on to suggest that the presence of poor role models in a child’s life causes the child to identify with the alcoholic parents (Bradley, Carmen & Petree, 1992; Karwacki & Bradley, 1996; O’Farrell, 1995; Perkins & Berkowitz, 1991). The child therefore learns to deal with their problems by mimicking his or her parents and consuming alcohol. Alcoholic parents also tend to not give proper guidance or monitor their children’s behaviour (O’Farrell, 1995; Sher, 1991). Adolescents might start drinking to gain inclusion and acceptance from drinking peers (Bradizza, et al., 1999; Kairouz, et al., 2002; Richter, et al., 2006; Roche & Watt, 1999; Smith, et al., 1993; Williams & Clark 1998). The child is especially vulnerable if his or her emotional needs are not met by the family (Centre for Community Child Health, 2004; Rayner & Montague 2000). He or she thus turns to his or her peer group for support.

4.6.3 Relationship reasons

Interactions with one’s parents can be a significant cause for future alcohol misuse (Bradley, Carmen & Petree, 1992; Karwacki & Bradley, 1996; O’Farrell, 1995; Perkins & Berkowitz, 1991; Perkins, 2002; Sher, 1991; Wechsler, Dowdall, Davenport & Castillo, 1995). Parental involvement and a supportive parent–child relationship make children more receptive to parental influence (Steinberg 2001). Parental control that uses high levels of punishment and authority has been linked with behavioural problems in adolescence (Bender, Allen & McElhaney, 2007). Adolescents from two-parent families have reported lower levels of alcohol use than adolescents from single or stepparent families (Barnes & Windle 1987; Bjarnason, Anderson, Choquet, Elekes, Morgan & Rapinett, 2003; Burnside, Baer, McLaughlin & Pokorny, 1986; Challier, Chau, Predine, Choquet & Legras, 2000; Hellandsjo Bu, Watten, Foxcroft, Ingebrigtsen & Relling, 2002; Miller 1997; Persson, Hanson & Rastam, 1994). Furthermore, as discussed previously, an adolescent might drink to distract attention from underlying conflicts within the family, thus becoming the "scapegoat" and "protecting" the family as the status quo is maintained (Sias & Lambie, 2005).

A further relationship factor includes the quality of *marital interactions* (Howes & Markman, 1989; Jennison & Johnson, 2001; Leonard & Eiden, 2007). Excessive drinking often occurs in times of marital crisis (Coleman, 1976; Collins, 1990; Jackson, 1956). Any situation in a relationship leading to hurt, rejection and self devaluation can cause excessive drinking which is often
connected to either financial or sexual problems (Coleman, 1988; Collins, 1990; Dicks, 1950; Straus, 1950). Furthermore, excessive drinking arises when accustomed marital roles change, for example divorce, a mid-life crisis, children leaving home, and so on (Erlanger, 1997; Jackson, 1956).

*Addictogenic relationships* can be another relationship causal factor in that the alcoholic spouse experiences stress and becomes difficult to live with (Little & Pearson, 1966). When he for example drinks, he becomes more relaxed and pleasant to be with, which becomes reinforcing. His wife will then unconsciously encourage the husband to continue drinking as it relieves the stress level of the family (Leff & Vaughn, 1985; Little & Pearson, 1966).

Other interactional factors maintaining alcoholic behaviour in relationships not mentioned previously are now discussed. If a partner hides the fact that the other has a drinking problem, the persistent denial of the alcoholic is strengthened (Black, 1990; Wegscheider-Cruse, 1989). The interaction pattern of either forgiving or punishing maintains the alcoholic's drinking behaviour (Wegscheider-Cruse, 1989). The alcohol misuser also learns that if he or she drinks heavily and becomes ill as a consequence, he or she will be forgiven (Wegscheider-Cruse, 1989). Punishing has a similar effect. If the alcohol misuser is punished for being drunk, feelings of shame, guilt and remorse are removed. This thus serves as reinforcement (Wegscheider-Cruse, 1989). The partner of an alcoholic might also have an unconscious investment in the other's drinking problem. By assuming either the role of the martyr or the rescuer and helper, non-alcoholic partners boost their own self-esteem (Miller, 2001).

Family games therefore tend to maintain the drinking problem. An example of this is found in the tendency of the non-alcoholic partner to continue keeping liquor in the house, despite the alcoholic partner’s attempts to cease drinking (Miller, 2001; Wegscheider-Cruse, 1989).

### 3.6.4 Socio-cultural reasons

There are a number of cultural factors affecting use of alcohol (Bloomfield, Gmel & Wilsnack, 2006; Kuntsche et al., 2006). Cultures shape individual expectancies about drinking, or the tacit assumptions that people make about the states of body and mind that one can expect from drinking, and what those states mean about a person experiencing them (Schmidt & Room, 1999). Cultural studies of drinking have long shown that societies around the globe vary widely in their overall levels of engagement with alcohol and in social norms regulating drinking and drunkenness (Heath, 1995; Marshall, 1993; McAndrew & Edgerton, 1969; Orcutt, 1991; Room, 1999; Rootman & Moser, 1985).

Alcoholism is additionally influenced by the amount of *stress* produced by a particular culture, and by the degree to which a culture provides substitute means of relieving tension (D’Avanzo,
Frye & Froman, 1994). The more insecurity there is in a particular culture, the greater the amount of alcohol consumption (Mitchell, 2004). Alcoholism is further associated with rapid social change, rapidly changing life styles and social disintegration or de-culturation (Caetano & Kaskutas, 1995).

Alcohol misuse can be used as a social lubricant (Gossop, 2007; Hanson, 1995; Marshall, 1979; Rassool, 1998). In some social settings, excessive drinking is seen as desirable or normal. In many cultures alcohol is associated with fun, gaiety and pleasant social interaction and with positive affective experiences. In these instances, excessive drinking is socially reinforcing, which therefore increases the likelihood of future drinking.

Alcohol misuse is also influenced by a society's attitude towards drinking (Heath, 1990; Klein & Pittman, 1993). Drinking patterns in some countries have developed naturally over a long period of time and consequently alcoholic beverage consumption may be deeply ingrained into the society's culture. This is especially true in the wine-producing nations such as Italy, Spain, France, and Portugal where wine consumption is integrated into the daily lifestyles (Lolli, Serianni, Gloder & Luzatto-Fegiz, 1958; Sadoun, Lolli & Silverman, 1965). Contrary to this viewpoint, abstinence from alcohol is a value which is deeply rooted in Indian culture and religion (Ranganathan, 1994). Hindu scriptures refer to drinking as one of the five heinous crimes, which include murder and adultery (Ranganathan, 1994). Saffer (1989) stated that the way beverages are used has influenced policies and control measures, which have in turn led to changes in drinking patterns, for example, the Indian Constitution which strongly endorses the principle of prohibition (Ranganathan, 1994).

### 3.7 Consequences of parental alcohol misuse

The potential consequences of parental alcohol misuse on a child’s development specifically, can be profound (Lambie & Sias, 2005). Alcohol misuse disrupts families, and each member may be affected differently (Lambie & Sias, 2005). Children raised in alcohol misusing families have different life experiences than children raised in non-alcohol misusing families (NACoA, 1998). The possible consequences on COAs include behavioural, medical, psychological, academic and emotional consequences (COAF, 2007; Lambie & Sias, 2005). Due to the parameters of the current study, the particulars about the consequences of parental alcohol misuse specifically on their children are now discussed.

#### 3.7.1 Behavioural consequences

According to the Children of Alcoholics Foundation (2007), parental alcohol misuse interrupts a child’s normal development, which places them at a higher risk for emotional, physical and mental health problems. Because parents who misuse alcohol are more likely to be involved with domestic violence, divorce, unemployment, mental illness and legal problems, their ability to parent
effectively is severely compromised (COAF, 2007; Corvo & Carpenter, 2000). There is a higher prevalence of depression, anxiety, eating disorders and suicide attempts among COAs than among their peers, and in addition, COAs are 3-4 times more likely than others to become addicted to alcohol themselves (COAF, 2007; Lambie & Sias, 2005).

In families where alcohol is being misused, behaviour is frequently unpredictable and communication is unclear (COAF, 2007). Family life is characterized by chaos and unpredictability while behaviour can range from loving to withdrawn, and structure and rules may be either nonexistent or inconsistent (COAF, 2007). Children, who may not understand that their parent’s behaviour and mood is determined by the amount of alcohol in their bloodstream, can feel confused and insecure. They love their parents and worry about them, and yet feel angry and hurt that their parents do not love them enough to stop drinking (COAF, 2007).

In homes where a parent is misusing alcohol, the physical and sexual abuse of children is more likely (Bosworth & Burke, 1994; COAF, 2007; Lambie & Sias, 2005; Zeitlin, 1994). Sexual abuse is more frequent in chaotic and dysfunctional families where communication has broken down and roles have been blurred (Bosworth & Burke, 1994; COAF, 2007). Children who live in high conflict homes are more likely to have lower self-esteem and less internal locus of control (COAF, 2007; Lambie & Sias, 2005; Sheridan & Green, 1993), and this puts COAs at higher risk for being re-victimized in the future (COAF, 2007). For instance, female COAs are more likely to be involved with men who abuse substances, which leave them open to even more abuse (COAF, 2007).

Even if the children are not themselves victimized by family violence, simply witnessing violence can have emotionally destructive consequences (COAF, 2007). COAs are six times more likely to witness spousal abuse than are other children (COAF, 2007; Wolock & Magura, 1996).

As a result of these stressors, COAs often have difficulty in school (COAF, 2007; Lambie & Sias, 2005). They may be unable to focus on their school work due to the conflicts and tensions at home (COAF, 2007). They are more likely than their peers to have learning disabilities, be truant, repeat grades, transfer schools and be expelled (COAF, 2007). They may also suffer from post-traumatic stress disorder resulting in sleep disturbances, nightmares, anxiety and depression, which may manifest in crying, bed-wetting and isolating themselves (Kinney, 2003).

3.7.2 Medical consequences

Studies of COAs in childhood have documented increased rates of several physical illnesses generally believed to be stress-related, including enteritis, colitis, and asthma (COAF, 2007; Roberts, 2007). Some of these children may allow their feelings to build up until they become sick with stomach aches and headaches (NACoA, 2001). A 1990 COAF study of hospital admissions
compared 595 minor children of Independence Blue Cross subscribers who had received treatment for alcoholism with children of subscribers never treated for alcoholism (COAF, 2007). The study revealed a 24% higher overall inpatient admission rate, a 29% greater average length of stay, and 36% greater average hospital charges for the COAs (COAF, 2007). Admissions for injuries and poisonings, substance abuse, mental disorders, and diseases of the gastrointestinal and respiratory systems were also greater for the COAs (COAF, 2007). In addition, children of alcoholic mothers had more admissions and greater lengths of stays for birth defects (COAF, 2007; Reid, Macchetto & Foster; 1999; Rivinus, Levoy, Matzko & Seifer, 1992).

Child abuse and neglect have been linked to parental alcohol abuse, as has incest (COAF, 2007; Famularo, Kinscherff & Fenton, 1992; Leventhal, Garber & Brady, 1989; Nagaraja Rao, Begum, Venkataramana & Gangadharappa, 2001; Reid, Macchetto & Foster; 1999). The Children of Alcoholics Foundation (2007) stated that, although studies are not conclusive, between 12% and 70% of child abusers have been identified as alcoholics using various data. Such abuse may be the cause of physical as well as emotional trauma, and may bring the COA to medical attention (COAF, 2007; Nagaraja Rao, Begum, Venkataramana & Gangadharappa, 2001).

Significant alcohol intake by the mother during pregnancy has been linked to a variety of birth defects, the most serious of which is the Foetal Alcohol Syndrome (FAS) (COAF, 2007; Zeitlin, 1994). The defining features of FAS are a combination of facial dysmorphia, severe and persistent growth deficiency, central nervous system dysfunction with mental retardation, and other defects (COAF, 2007; Loock, Conry, Cook, Chudley & Rosales, 2005; Sokol & Clarren, 1989; WHO, 2002). Lesser degrees of alcohol-related birth defects are referred to as Foetal Alcohol Effects (FAE) (COAF, 2007; Larkby & Day, 1997). Both FAS and FAE are persistent, lifelong organic dysfunctions requiring specific rehabilitation (COAF, 2007).

The familial nature of alcoholism has been documented in many studies over the years, with both genetic and environmental factors implicated in the transmission process (COAF, 2007; Lambie & Sias, 2005). COAs are at approximately 3 to 4 times greater risk for developing alcoholism compared to children of non-alcoholic parents (COAF, 2007). In addition, COAs are at increased risk for other drug dependence, which in conjunction with alcoholism, accounts for much of the increased incidence of hospitalization for poisoning and accidental trauma in COAs as discussed above (COAF, 2007).

3.7.3 Psychological consequences

Mental retardation and other organic mental dysfunctions have been linked to maternal drinking during pregnancy (COAF, 2007). Attention deficit/hyperactivity disorder has also been linked to parental alcoholism, as have other anxiety and childhood depressive disorders, and conduct

Furthermore, the Children of Alcoholics Foundation (2007) highlighted recent studies that have shown that a disproportionate number of patients suffering from bulimia nervosa and other eating disorders are COAs. Children of addicted parents exhibit symptoms of depression and anxiety more than do children from non-addicted families (COAF, 2007; Earls, Reich, Jung & Cloninger, 1988; Fitzgerald, 1993; West & Printz, 1987).

Adult alcoholics and addicts who had alcoholic fathers show an increased risk of pathological gambling (COAF, 2007). Furthermore, the relationship between antisocial personality disorder (ASP) and parental alcoholism is well-established, as is the strong association between ASP and adult alcoholism and other drug dependence (Bushman & Cooper, 1990; COAF, 2007; Elkins, et al., 2004).

3.7.4 Academic consequences

Children from substance abusing families are more likely to have learning disabilities, repeat more grades, attend more schools, and are more likely to be truant, delinquent and drop out of school because of pregnancy, expulsion or institutionalization (Arman, 2000; COAF, 2007; Fields, 2004; Greenburg, 1999; Hoggard & Christenberry, 1994; Kinney, 2003; Lambie & Sias, 2005; NACoA, 1998). They also tend to do less well on academic measures and are more likely to leave school, be retained, or be referred to the school psychologist than are children of non-alcoholic parents (Sher, 1997).

Children whose parents drink too much may exhibit lower academic achievement and more cognitive deficits with lower intelligence quotient scores and lower arithmetic, reading and verbal scores than their peers (Drejer, Theilgaard, Teasdale, Schulsinger & Goodwin, 1985; Ervin, Little, Streissguth & Beck, 1984; Gabrielli & Mednic, 1983; Lambie & Sias, 2005; Sher, 1991). Their chaotic home environment makes it difficult for these students to complete homework and receive necessary rest, reducing their ability to concentrate in school (Arman, 2000; Fields, 2004; Hoggard & Christenberry, 1994; Kinney, 2003; NACoA, 1998). This is due to the fact that these children may:

a) be preoccupied or tired because of home events and unable to concentrate in school or other activities;

b) work below their potential because their energy is focused on the substance abuser;

c) be reluctant to bring friends home due to embarrassment about the alcoholic parent's behaviour;
d) witness physical or emotional abuse between family members or experience it themselves;

e) be unable to focus on homework because of fighting, tension or worry at home, and

f) take on developmentally inappropriate responsibility for their household, siblings or parents


COAs also tend to think more concretely rather than abstractly, even into adulthood (Lambie & Sias, 2005; Tarter, Hegedus, Goldstein, Shelly & Alterman, 1984). Abstraction and conceptual reasoning play an important role in problem solving, whether the problems are academic or are related to situations encountered in life (Tarter, Hegedus, Goldstein, Shelly & Alterman, 1984; NACoA, 2001). They therefore tend to not develop further than the “here and now” that mature adulthood brings or to be able to transfer what is learned from one context to another (Labouvie-Vief, 1990; Ylvisaker, Hibbard & Feeney, 2006). Furthermore, parental alcohol misuse affects children’s psychosocial development, and thereby likely impedes their ability to establish interpersonal relationships and be successful at school (COAF, 2007; Lambie & Sias, 2005; Sher, 1997).

3.7.5 Emotional consequences

Parents with an alcohol problem often exhibit unpredictable behaviour (COAF, 2007; Roberts, 2007). For the child, the rules may be constantly changing, according to the amount of alcohol in the parent’s blood (COAF, 2007). This lack of consistency can lead to a mistrust of parents and often a mistrust of other adults (COAF, 2007; Lambie & Sias, 2005). Wide mood swings within the family also contribute to additional lack of trust (COAF, 2007). When the parent gives up drinking alcohol there is often a feeling of hope that the problem has been solved, however, if the parent relapses the disappointment is intense (COAF, 2007). These experiences often lead to children distrusting authority figures or adults in general, with an expectation that they will eventually be let down (COAF, 2007).

The environment of children of alcoholics has been characterized by lack of parenting, poor home management, and lack of family communication skills, thereby effectively robbing children of alcoholic parents of modeling or training in parenting skills or family effectiveness (Moos & Billings; 1982). Addicted parents often lack the ability to provide structure or discipline in family life, but simultaneously expect their children to be competent at a wide variety of tasks earlier than do non-addicted parents (Kumpfer & DeMarsh, 1986).

Instead of understanding the parent’s substance abuse as a disease, the child sees the drinking or drug use as a reaction to bad behaviour, and therefore displays feelings of guilt (COAF, 2007).
Family members may blame each other for ‘setting off’ a drinking episode or angry outburst (Arman, 2000; Bosworth & Burke, 1994; COAF, 2007; Fields, 2004; Kinney, 2003).

The COA is often deeply ashamed of the ‘family secret’ (COAF, 2007; Lambie & Sias, 2005). The COA may avoid friendships with other children and feel that he or she cannot have guests as his or her parent might be at home drunk and embarrass him or her (COAF, 2007; NACoA, 2001).

Substance abuse in the family creates confusion in the child when the family fails to validate either the child’s external or internal reality (COAF, 2007). For example, a child may observe his mother drinking, becoming intoxicated, and passing out on the kitchen floor, but be told by his father that she is ‘sick’ or ‘tired’ (COAF, 2007). A parent may suffer from alcoholic blackouts and make promises or reveal inappropriate personal information while drinking. Later, that same parent is genuinely unaware of what transpired and denies the conversation ever took place (COAF, 2007).

Strong ambivalent positive and negative feelings towards the parent may coexist in the child (COAF, 2007). For example, a girl may long for approval and love her substance abusing parent, and simultaneously feel angry and resentful towards him or her (COAF, 2007). Some children of substance abusers fear that their anger towards the parent could cause him to die, or more realistically, that the parent could die as the result of drinking and driving, other alcohol-related trauma, or illness (COAF, 2007; Lambie & Sias, 2005). Low self-esteem, tension, anxiety, depressed feelings, and acting out behaviour are often reflections of insecurity due to a difficult home environment (COAF, 2007; Kinney, 2003; Lambie & Sias, 2005; Sheridan & Green, 1993).

Disruption of normal sexual development can occur if substance abuse interferes with the parent’s ability to nurture and educate the child (COAF, 2007). For example, the child may be exposed inappropriately to sexual behaviour, including in some cases, sexual abuse (Bosworth & Burke, 1994; COAF, 2007; Zeitlin, 1994).

3.7.6 Other effects

A parent’s alcohol misuse can have other effects on children besides parent-child interactions (COAF, 2007). For example, if a parent loses a job because of alcohol misuse, the child suffers the economic consequences, especially if this is the household’s only income. Without employment, a family might lose their home, car or other valuable possessions (COAF, 2007).

A child’s health might also be compromised by a parent’s drinking problem (COAF, 2007). The child might develop stress-related health problems like gastrointestinal disorders, headaches, migraines, or asthma, causing them to miss school (NACoA, 2001). A child whose parent’s substance abuse causes neglect might become injured because of failure to provide adequate childcare (COAF, 2007).
3.8 Conclusion

Besides the implications that have been highlighted with regards to the causes and consequences of alcohol misuse, the majority of COAs do not end up in severe circumstances. Only one in four COAs will become alcoholics themselves (COAF, 2007). Most children and teens are able to draw upon their inner strengths to cope with their circumstances and succeed in life. COAs can be helped in many ways, both formal and informal, to call on their resiliency. Early identification and intervention also hold promise for preventing future alcohol misuse and reducing long lasting problems (Vail-Smith & Knight, 1995).

A variety of approaches to the development (etiology) of addiction and to the modification of addictive behaviours have been described in previous research (Peele, 1985; Shaffer, 1985). A model of helping and coping outlined by Brickman, Rabinowitz, Karuza, Coates, and Cohn (1982) clarifies various conceptual approaches to understanding addictive behaviour. Further research exists outlining genetic and heritability of alcohol misuse (Murray, Clifford & Gurling, 1983; Peele, 1986; Schuckit, 1987). This previous research exists to explain alcohol misuse, addictive behaviour and intervention strategies from the perspective of the misuser, whether the misuser is an adolescent (Chassin, 1984; Jessor, 1986; Kaplan, 1985; Long & Scherl, 1984; Sadava, 1987) or an adult.

This chapter outlined the concept of alcohol misuse in its various forms by exploring the definition of alcohol misuse. The numerous labels and classifications for alcohol misuse were explored and discussed, along with other alcohol-related disorders. Some of the current statistics available on alcohol consumption, both internationally and nationally, were mentioned, and strategies in which alcohol-related harm can be reduced were explored. Furthermore, the causal factors as well as the consequences for alcohol misuse were illustrated.

Although many studies have been conducted with families and alcohol misuse from a problem-orientated framework, there is limited research or literature that exists on resilience from the family’s perspective specifically, as described in the previous chapter. The following chapter therefore focuses on the research methodology that was used in conceptualizing the data received for the current research.
CHAPTER 4
RESEARCH METHODOLOGY

4.1 Introduction

This chapter explores the research methodology used in the current study. The research design is outlined, followed by a description of the participants and sampling procedures. The research procedure that was followed is then explained, and thereafter an overview is given of the measures that were used to gather the data. A description of the process of data analysis follows. A discussion regarding the ethical considerations of gaining informed consent from participants, being aware of coercion, and ensuring participants’ confidentiality marks the conclusion of the chapter.

4.2 Research aim and objective

The aim of the current study is to identify, explore and describe the resiliency factors that enable families to adjust and adapt as a result of having a parent who misuses alcohol.

4.3 Research design

Triangulation was employed in the study, making use of an exploratory, descriptive approach. Triangulation enables the researcher to look at a phenomenon from different angles, and thus gain a fuller picture of what is being studied (Neuman, 2003). There are different types of triangulation that researchers may employ. The most common type of triangulation is triangulation of measures (Neuman, 2003), which involves measuring the same phenomenon in various ways (Henning, 2004; Leedy & Ormrod, 2005). Any discrepancy amongst these measurements then enlightens the research. The second type of triangulation, triangulation of observers, refers to the use of multiple people to observe the same phenomenon in order to gain different perspectives, and thus adds to a more holistic understanding of the phenomenon (Strüwig & Stead, 2001). Triangulation of method indicates the use of both qualitative and quantitative methods simultaneously. The last type of triangulation is triangulation of theory where different theories are used to plan and interpret data (Neuman, 2003).

The current study incorporated triangulation of method. Qualitative and quantitative methods are very different, yet they have complementary strengths. Qualitative research relies on descriptions and interpretations from participants (Dunn, 1999; Smith, 2003). A benefit of including qualitative methodology is the rich perspective that is gained from the participants’ accounts as they answer from their personal experiences. Participants’ accounts are furthermore not limited as their answers need not be right or wrong (Dunn, 1999). Disadvantages of qualitative research are that summarizing data efficiently is time-consuming, and findings cannot be generalized to other
situations (Dunn, 1999). On the other hand, quantitative data relies on numbers and statistical interpretations (Russell & Roberts, 2001; Shaughnessy, Zechmeister & Zechmeister, 2000). An advantage of this approach is that the data is easy to work with. When using specific types of sampling techniques, the data can also be generalized to the larger population (Dunn, 1999). However, a disadvantage is that it fails to capture the individual experiences of participants (Dunn, 1999). Using these two methods simultaneously enriched the data obtained from the proposed study. By using triangulation of method, the researcher was able to gain the advantages of both qualitative and quantitative methods, and in doing so counter the disadvantages of using either methodology singularly.

Exploratory and descriptive research are similar in many ways. The purpose of exploratory research is to gain insight into a relatively new and unstudied area (Rubin & Babbie, 2001; Strüwig & Stead, 2001). Furthermore, exploratory research formulates future research questions (Neuman, 2003). While resilience within individuals has been researched, the study of family resilience in South Africa is new and relatively unstudied. Because of the exploratory, descriptive nature of the current study, the researcher was unable to generalize the results to the population being studied. When conducting exploratory research, the researcher investigates something new, and should therefore remain open-minded and flexible (Neuman, 2003). Hence, in order to assist the researcher in remaining open to discovering new issues, the qualitative component of the current study was used.

Descriptive research focuses more on “how” questions, and describes how things are as they exist (Gravetter & Forzano, 2003; Neuman, 2003). The purpose of this research technique is to measure and capture variables (Gravetter & Forzano, 2003). Descriptive research is less flexible than exploratory research as it provides a precise numerical picture usually presented in statistics (Gravetter & Forzano, 2003; Strüwig & Stead, 2001). According to Jackson (2003), there are various techniques in conducting descriptive research. The observational method is used to observe behaviour, while the case study method provides a more in-depth description. Thirdly, the survey method requires that questions are asked and responses described. The survey method was used to conduct the current research. According to Cozby (2004), survey research uses questionnaires and interviews in order to gain information about people’s demographics, behaviours, and beliefs. These questionnaires can be administered in a variety of ways, for example by post, telephonically, or via the internet (Jackson, 2003). Advantages of surveys include that they allow the participants to remain anonymous, they are convenient, easy to administer, and are non-threatening to participants (Cozby, 2004; Gravetter & Forzano, 2003). Furthermore, surveys allow the researcher to study a greater number of people more easily (Jackson, 2003). Disadvantages include the possible boredom and lack of motivation participates may experience as they complete questionnaires alone (Cozby,
Another concern is whether or not the sample population will adequately represent the population being studied (Jackson, 2003). This was true for the current study as, due to the study’s exploratory descriptive nature, results were not able to be generalized to the broader population. Other disadvantages include the time consuming nature of the questionnaires, participants may misunderstand items, the response rate may be low (Cozby, 2004; Neuman, 2003; Spata, 2003; Whitley, 2002), and posted questionnaires can also be expensive for the researcher (Gravetter & Forzano, 2003). Some of these potential barriers were overcome due to the researcher being available to answer questions and personally collect completed questionnaires as, where possible, questionnaires were administered personally. Where this was not possible, participants with questions were able to contact the researcher via contact details provided. In addition the researcher was able to follow up with participants, and moreover by doing so remind them to return questionnaires. This helped curb the low response rate often associated with surveys. A discussion describing the participants and the sampling procedure that was followed in the current study now follows.

4.4 Participants and sampling

The two general approaches used to select a sample are nonprobability and probability sampling (Goodwin, 2002; Zechmeister, Zechmeister & Shaughnessy, 2001). While probability sampling provides an equal chance for each person in the population to be included, nonprobability sampling means that the probability of anyone being chosen in the population is unknown (Cozby, 2004; Gravetter & Forzano, 2003; Strüwig & Stead, 2001; Zechmeister, Zeichmeister & Shaugnessy, 2001). Advantages of nonprobability sampling include its convenience and cost effectiveness (Cozby, 2004) and while probability sampling holds the advantage of being unbiased, nonprobability sampling is used more frequently (Spata, 2003). The more frequent use of nonprobability sampling can be attributed to the fact that probability sampling is expensive and time-consuming, and not necessary if the purpose of the research is not to generalize results, but rather to investigate relationships between variables (Spata, 2003). Nonprobability, purposive and snowball sampling approaches were used in this study.

Purposive sampling targets participants who have special knowledge or characteristics that are of particular interest to the researcher. This knowledge or characteristics thereby fulfils the goals of the research (Whitley, 2002). This type of sampling is generally used in three scenarios, namely (1) to select distinctive cases which will inform the research, (2) to reach specialized populations with very specific criteria, and (3) to identify cases for in-depth study (Neuman, 2003). A disadvantage of purposive sampling is that the researcher’s judgment is important in selecting the sample, and this could in turn lead to bias and result in the sample being unrepresentative (Strüwig & Stead,
Nevertheless, the advantage of purposive sampling is that it allows the researcher to sample people who have specific characteristics that the researcher is interested in (Cozby, 2007). This sampling technique was appropriate for the current research as it enabled the researcher to select families specifically in which a parent misuses alcohol, as this was the sample group needed for the purpose of this study.

Snowball sampling follows on from purposive sampling in that participants who are selected from purposive sampling are asked to nominate other potential participants who meet the specified criteria, and who they think would be willing to participate (Strüwig & Stead, 2001; Whitley, 2002). Referrals from these participants are obtained, and thus increase the sample size (Neuman, 2003). Sampling ceases either when no new people are nominated, or if the sample size becomes too large for the study (Neuman, 2003). Disadvantages of snowball sampling include potential researcher bias, as well as difficulty in generalizing results to the larger population (Strüwig & Stead, 2001). Another disadvantage is that the chain can become broken, consequently making it difficult to increase the sample size (Strydom, 2005). An advantage of purposive and snowball sampling is that the sample meets a specific purpose. Snowball sampling is also particularly useful in locating members with specific characteristics.

The sample consisted of 63 family units with two members (the substance misuser and an immediate adolescent family member) from each unit participating. The participants’ involvement was voluntary. No less than sixty families were required in order to conduct regression analysis. The researcher originally mailed or delivered a total of 71 sets of questionnaires (142 questionnaires, as one set contained one adult questionnaire and one adolescent questionnaire). There were 67 participants who responded, of which 63 questionnaires could be used as the remaining five did not meet the inclusion criteria for the study. The researcher included an adolescent as research has shown that the adolescent often perceives it is his or her fault that a parent becomes upset and thereafter misuses alcohol. The adolescent consequently struggles with the fact that he or she is not loveable (Daley & Raskin, 1991). Challenges these families face include feelings of guilt and shame, which are experienced to one degree or another by all co-dependents, represented in the current research by the adolescent. By including families with an adolescent, the sample was homogenized to some extent, which thereby ensured that participating families were in a similar family life cycle stage.

Although a Grade 10 level of language proficiency is recommended to understand the questionnaires, prior successful research has been conducted in South Africa with adolescents having a Grade 8 level of proficiency (Greeff & Aspeling, 2004; Greeff & Human, 2004). The researcher therefore specified the use of the questionnaires for participants having a Grade 8 reading
level, and in addition investigated the language level of the structured questionnaires prior to commencing data collection. Because there is no way for the researcher to control and regulate the characteristics of participants to an absolute degree, the researcher developed inclusion criteria, listed below, in order to homogenize the participants as much as possible. This was done in order to facilitate relevance in the conclusions drawn from the findings. The inclusion criteria for the current research were as follows:

a) participants must be part of a family unit living in the same household where a parental member has been seeking treatment for alcohol misuse;

b) participants must have at least a Grade 8 level of proficiency in English or Afrikaans in order to fully comprehend the questionnaires;

c) adolescent participants must be between the ages of 13 and 18;

d) the alcohol misuser must be seeking at the most their third treatment intervention, and

e) the alcohol misuser can be receiving treatment on either an outpatient or an inpatient basis

A detailed discussion of the research design and sampling procedures adopted in this study has been provided. An explanation of the research procedure that the researcher followed is now outlined.

4.5 Research procedure

Before the research commenced, coordinators of treatment centres – whose focus is specifically on the treatment of alcohol misuse – were contacted in order to access potential participants for the study. This was done in person where possible, and where not possible, telephonically. Furthermore, a written explanation of the current research was sent to coordinators electronically or through the postal system (Appendix B). In addition to treatment centres approached in the immediate Nelson Mandela Metropolitan region, treatment centres were approached throughout the country in order to increase the sample size. Furthermore, the participants recruited from the treatment centres were asked if they could provide the researcher with any more potential participants who may be interested in participating in the study. This thus started the snowball sampling. An email was sent to all staff and students working at or attending the Central University of Technology (CUT) campuses in Bloemfontein and Welkom. This email outlined the research study and invited interested people to contact the researcher.

Questionnaires were either mailed or hand delivered to participants. Before the researcher commenced with data collection, the value and purpose of the study was explained to potential participants. Where the researcher was able to do so in person, this was explained verbally as well as presented in a cover letter in the participants’ home language (Appendix C and D). Where it was
not possible for the researcher to be present, this information was explained via the cover letter in the participants’ home language. All cover letters contained the researcher’s contact details should the participants have had any further questions, and all participants received this information. The researcher reassured participants both in person where possible and in the cover letter that the confidentiality and anonymity of their responses would be maintained throughout. Anonymity and confidentiality was preserved by coding the questionnaires. The participants were informed that they could withdraw from the study at any time should they wish to. Participants that were seen in person were then given an opportunity to ask questions. Those participants to whom information and questionnaires were mailed were provided with the researcher’s contact details should they have needed to ask questions. The researcher ensured that informed consent was gained before the biographical and structured paper-and-pencil questionnaires were answered (Appendix E). As some of the participants were adolescents under 18 years of age, a guardian was asked to provide consent on their behalf. Nevertheless, the adolescents’ consent was sought and confirmed regarding their participation or lack thereof. Should their decision have been to not participate, their decision, regardless of prior guardian consent, was respected. Thereafter, the data was collected and analyzed. The open-ended question was analyzed using content analysis, and the structured questionnaires were analyzed using correlation and regression analysis.

4.6 Questionnaires

A biographical questionnaire (Appendices F and G) with an open-ended question was used concurrently with a number of structured paper-and-pencil questionnaires to gather information. These took approximately one hour to complete. The questionnaires that represented the independent variables consisted of the Biographical Questionnaire, the Family Hardiness Index (FHI), the Family Time and Routine Index (FTRI), the Social Support Index (SSI), the Family Problem-Solving Communication (FPSC), the Family Crisis-Oriented Personal Evaluation Scale (F-COPES), and the Relative and Friend Support (RFS). The dependent variable was measured by the Family Attachment and Changeability Index 8 (FACHI8).

Although the questionnaires have not been standardized for the South African population, they have previously been used in South African studies that have been published (Der Kinderen & Greeff, 1996; Der Kinderen & Greeff, 2003; Greeff & Human, 2004; Greeff & Ritman, 2005; Greeff & van der Merwe, 2004). The following is a brief description of these questionnaires.

4.6.1 Biographical questionnaire

The purpose of the biographical questionnaire was to obtain relevant information for the research study, and questions included contributed to meaningful interpretation of the results. Data requested
included family formation, for example number of family members, age and gender of members participating in the study, educational level of family members, and employment status of partners. Separate biographical questionnaires were made available for the adolescent and the alcohol misuser (Appendices C & D).

There was one semi-structured question which was included at the end of the biographical questionnaire. This question was based on the Resiliency Model of Family Stress, Adjustment and Adaptation. The question aimed to uncover the factors or strengths the family believes helped them through their crisis period.

The biographical variables that follow related specifically to the information obtained from the biographical questionnaires completed by the participants. The biographical variables pertaining to the adult participants are discussed first after which the biographical details relevant to the adolescent participants follow. The variables that relate to the adult participants included:

a) city of residence;
b) ethnicity;
c) duration that the adult has been misusing alcohol;
d) number of times the adult has sought treatment;
e) others living permanently in the home;
f) language;
g) gender;
h) level of education, and
i) employment status.

The participants of this research were situated throughout South Africa in order to ensure the researcher’s sample size was large enough and adequate enough to fulfil the criteria for the study. Due to the sensitivity of the research topic, it was expected that a sample size contained in one area only would be too small. This was in line with the researcher’s goals of exploring the resiliency variables of families of this nature within South Africa.

The majority of the participants were Coloured (56%), with a large percentage being Black (25%), while the smallest percentage of participants were Caucasian (19%). Judging by these results, the sample was not evenly distributed between the various ethnic groups represented in South Africa, and did not include a large portion of other ethnic groups that exist in the country. This contributes to the limitations of the current study discussed in chapter 6. It should be noted that, while the researcher made every effort to include the various representative ethnicities during data collection, some questionnaires were never returned, or institutions contacted did not make contact with the researcher again.
As part of the biographical questionnaire, the researcher asked the adult participants to indicate the duration of their misuse of alcohol. The majority of the sample (54%) had been misusing alcohol for between six and nine years, while only 8% of the participants had been misusing alcohol for between one and two years.

The researcher included, as a criterion for sample selection, that the adult participants must be seeking at most their third treatment intervention. The majority of the participants were experiencing their second intervention (43%) while 38% of the adult participants were experiencing their first intervention. The least number of parental participants (19%) were experiencing their third intervention. Research has stated that withdrawal seizures, alcohol withdrawal symptoms which individuals experience as tonic-clonic seizures as early as two hours after cessation, are more common in patients who have a history of multiple episodes of detoxification (Bayard, McIntyre, Hill & Woodside, 2004).

Current findings indicate that the majority of parental participants (74%) had other people residing permanently in the home. Twenty-four percent of the participants did not have someone living in the household.

The majority of participants were English-speaking (46%). For those who spoke Afrikaans (41%), Afrikaans questionnaires were available. For the participants who spoke another language (13%), they could choose to complete the questionnaires in English or Afrikaans based on their proficiency of the language.

At 65% the majority of the participants in this study were male. These results represent the current research available with regards to the sexes and alcoholism. Studies in many cultures have found that the prevalence of alcoholism and heavy drinking generally is higher among men than women (Kendler, Heath & Neale, 1992; Prescott, Aggen & Kendler, 1999; Reich, Edenberg & Goate, 1998). Some evidence from molecular genetic studies suggests that there may be etiologically distinct subtypes of alcoholism. For example, people who have alcoholism characterized by displays of aggression or antisocial personality traits are more likely to carry a gene that is associated with increased activity of the neurotransmitter serotonin in the brain (Preuss, Koller, Soyka & Bondy, 2001). Because this alcoholism subtype is found mostly in men and only rarely in women, this could provide one explanation for why the sexes differ in genetic risk factors for alcoholism.

The highest level of education obtained for parental participants was distributed between high school and tertiary education. As outlined by the inclusion criteria for the current research, it was ensured that the parental participants had at least a Grade 8 level of proficiency in English or Afrikaans in order to understand the questionnaires. Although a Grade 10 level of language proficiency is recommended to understand the questionnaires, prior successful research has been
conducted in South Africa with adolescents having a Grade 8 level of proficiency (Greeff & Aspeling, 2004; Greeff & Human, 2004).

The majority of participants (83%) were employed in some capacity as either permanent or temporary in nature. Seventeen percent of the participants were unemployed at the time of the research.

The biographical variables of the adolescent participants of the study are now discussed. The variables explored are those where the data was different to the information received from the adult participants as well as where data was adolescent-specific. The variables included

a) gender;

b) age; and

c) level of education.

The majority of the adolescent participants (62%) were female. As outlined by the study’s criteria, the adolescent participants had to be between the ages of 13 and 18 years of age. The researcher ensured that this was the case. The average age of the adolescent participants was 15.4 years.

According to Erikson’s theory of lifespan development (1963), the average age of the adolescent participants in the current study fell into the stage of inferiority versus role confusion (Craig, 1996). The primary task during this stage is to form one’s identity. The conditions that foster this process are stability and continuity (Craig, 1996). As discussed in chapter 3, families in which alcohol is misused are characterized by frequent unpredictable behaviour and unclear communication (COAF, 2007). Family life is typified by chaos and unpredictability while behaviour can range from loving to withdrawn, and structure and rules may be either nonexistent or inconsistent (COAF, 2007). This complicated stage of Erikson’s theory where one is forming one’s individuality and sexual identity is already confusing in conventional families. Being part of a family where a parental member misuses alcohol during this stage may add the additional pressure of coping in a family structure that is unstable.

As the research criteria for inclusion in the current study stipulated that adolescent participants must be between the ages of 13 and 18 years of age and that they need to have at least a Grade 8 level of proficiency in English or Afrikaans in order to understand the questionnaires, most of the adolescent participants were in high school upon completion of the questionnaire. A small percentage of participants (4%) were no longer in school due to various reasons not otherwise stated or explored. None of the adolescent participants had yet reached tertiary education.

After participants completed the semi-structured question, the structured questionnaires were administered. The structured questionnaires are outlined in the following section.
4.6.2 Family Hardiness Index (FHI)

The Family Hardiness Index (FHI) was developed by McCubbin, McCubbin, and Thompson in 1986 (2001) and is used to measure the characteristics of hardiness and how it is used as a resource to arbitrate the effects of stress in families and to facilitate family adjustment and adaptation. Family hardiness refers to an active stance in managing stress, maintaining a sense of control over life, and having a positive perception of change (McCubbin, Thompson & McCubbin, 2001). Families employ this characteristic as a resource in times of difficult transitions or crises to help them manage. Low hardiness may result in feelings of powerlessness when facing stressors, and the lack of initiative to make necessary changes in one’s life. The FHI taps into the family resources (BB) and situational appraisal (CC) components of the Resiliency Model of Family Stress, Adjustment and Adaptation.

The FHI consists of 20 items which participants answer on a 5-point Likert rating scale. It consists of three subscales, namely commitment, challenge, and control. Commitment focuses on the family’s dependability, their ability to engage in life, and their ability to derive meaning from life. Control implies being able to impact and influence events in life, while challenge allows the family to embrace and learn from change as opposed to perceiving it as threatening. The FHI taps into the behavioural indicators that would demonstrate these aspects. An example of a statement from the FHI is “Many times I feel I can trust that even in difficult times that things will work out”.

The overall internal reliability of the FHI is .82 (Cronbach’s alpha), and the test-retest reliability is .86 (McCubbin, Thompson & McCubbin, 2001). The validity coefficients are between .20 and .23 for family satisfaction, time, routine and adaptability (McCubbin, Thompson & McCubbin, 2001). The Cronbach alpha reliability coefficient of the FHI for this sample was .65 (Challenge, .52; Control, .63; Commitment, .76). This indicates a low to moderate reliability for the total FHI (Murphy & Davidshofer, 1994).

4.6.3 Family Time and Routine Index (FTRI)

The Family Time and Routine Index (FTRI) was developed by McCubbin, McCubbin, and Thompson in 1986 (2001) to measure both the type of activities and routines families partake in, as well as the degree of meaning the family places on these routines. According to McCubbin, et al. (2001), family time together and routines are reliable indices of family integration and stability. The FTRI links into the family type (T) component of the Resiliency Model of Family Stress, Adjustment and Adaptation. An example of a statement from the FTRI is “Family has a certain family time each week when they do things together at home”.

The FTRI is a 30-item scale and consists of the following eight subscales:
a) Parent-child togetherness: Measures how important it is to establish predictable communication between parents and children;
b) Couple togetherness: Measures how important it is to establish routines to enhance communication between couples;
c) Child routines: Measures how important children’s routines are which ultimately promote a sense of order;
d) Meals together: Measures how important family mealtimes are in an effort to promote togetherness;
e) Family togetherness: Measures how important family togetherness is in terms of e.g. family time, special events;
f) Family chores: Measures how important routine chores for children are;
g) Relatives connection: Measures efforts to set up routines that enhance connection with relatives; and
h) Family management routines: Measures efforts that contribute towards routines that enhance family organization and accountability.

The internal reliability of the FTRI is .88 (Cronbach’s alpha) (McCubbin, Thompson & McCubbin, 2001). The validity was confirmed through significant correlations with various criterion indices of family strengths (McCubbin, Thompson & McCubbin, 2001). The internal reliability coefficient (Cronbach alpha) of the FTRI for this sample was .78, indicating a fairly substantial reliability of the measure for this sample (Murphy & Davidshofer, 1994). Within this study, the FTRI scale appeared to have been unreliably measured due to unacceptable Cronbach alphas, and was therefore not included in any subsequent analyses.

4.6.4 Social Support Index (SSI)

The Social Support Index (SSI) was developed by McCubbin, Patterson, and Glynn in 1982 and looks at the extent to which families find support within their community (McCubbin, McCubbin & Thompson, 2001). According to McCubbin et al. (2001), past research has shown the importance of social support as “a buffer against family crisis factors, a resiliency factor in promoting family recovery, and as a mediator of family distress” (p. 384). The SSI can be linked to the family resources (BB) component of the Resiliency Model of Family Stress, Adjustment and Adaptation. An example of a statement from the SSI is “My friends in this community are a part of my everyday activities”.

The SSI consists of 17 items and uses a 5-point Likert scale to assess how families utilize the community as a support system. It further assesses how much they feel their community is able to provide this support. The internal reliability is .82 (Cronbach’s alpha) and the validity coefficient,
correlated with criteria of family well-being, is .40. The test-retest reliability is .83 (McCubbin, et al., 2001). The Cronbach alpha reliability coefficient of the SSI for this sample was .61, indicating a moderate reliability for this measure for the sample (Murphy & Davidshofer, 1994).

4.6.5 Family Problem-Solving Communication (FPSC)

This Index was developed by McCubbin, McCubbin, and Thompson in 1988 (2001). It measures two dominant patterns in family communication which play an integral part in how families cope with tension and reach family adjustment and adaptation. The two patterns are represented as two subscales, namely incendiary communication which involves communication that exacerbates a conflictual situation, and affirming communication which conveys support and cultivates a calming environment (McCubbin et al., 2001). These patterns represent either a positive or negative pattern of communicating and are important to consider, as the quality of communication impacts the manner in which families adjust and adapt while managing stress (McCubbin et al., 2001). The FPSC measures the problem solving and coping (PSC) component of the Resiliency Model of Family Stress, Adjustment and Adaptation. An example of a statement from the FPSC is “We make matters more difficult by fighting and bring up old matters”.

The FPSC Index consists of 10 items with a 4-point Likert scale. The alpha reliability is .89, and the test-retest reliability is .86 (McCubbin et al., 2001). Multiple studies reported by McCubbin, et al. (2001) supported the validity of the FPSC. The Cronbach alpha reliability coefficient of the FPSC for this study was .58 (Incendiary Communication, .76; Affirming Communication .63). This indicates a moderate reliability level for the total FPSC for this sample (Murphy & Davidshofer, 1994).

4.6.6 Family Crisis-Oriented Personal Evaluation Scale (F-COPES)

The Family Crisis-Oriented Personal Evaluation Scale (F-COPES) was developed by McCubbin, Olson, and Larsen in 1981 (McCubbin, Thompson & McCubbin, 2001). The measure consists of 30 items and measures coping behaviours and strategies on two levels, namely individual to family system (internal coping mechanisms) and family to environment (external coping mechanisms) (McCubbin, et al., 2001). Successful adaptation to stressful situations requires coping mechanisms on both these levels (McCubbin, et al., 2001). The F-COPES taps into the family resources (BB) and family schema (CCCCC) components of the Resiliency Model of Family Stress, Adjustment and Adaptation. An example of a statement from the F-COPES is “Knowing that we have the strength within our own family to solve our problems”.

The measure consists of eight scales (McCubbin, et al., 2001). The following three scales measure internal family coping patterns:
a) **Confidence in problem solving** items measure how the family interprets the problem as well as their belief in being able to manage sudden stressful events.

b) **Reframing family problems** items measure the family’s opinion of whether change is positive, negative or whether they view change neutrally.

c) **Family passivity** items measure the family’s passive behaviours as a way of coping.

The following five scales measure external family coping patterns:

a) **Church / religious resources** items measure the family’s principles in dealing with stressful situations, as well as their participation in religious activities.

b) **Extended family** items measure the extent to which the family obtains support from relatives.

c) **Friends** items measure the extent to which the family obtains support from friendships.

d) **Neighbours** items measure the extent to which the family obtains support from the community.

e) **Community resources** items measure the extent to which the family uses community resources such as counselling services.

The overall reliability (Cronbach’s Alpha) for the whole instrument is .77, and the test-retest reliability for the total scale is .81 (McCubbin, et al., 2001). The construct validity of the questionnaire was established with a factor analysis and a varimax rotation of the axes. Five factors with factor loads between .36 and .74 were isolated. All five factors had eigenvalues greater than one (McCubbin, Larson & Olson, 1982). The Cronbach alpha reliability coefficient for the subscales were as follows: acquiring social support, .66; reframing, .63; seeking spiritual support, .94; mobilising support, .63; and passive appraisal, .79. This indicated a moderate to high reliability of this measure for this sample (Murphy & Davidshofer, 1994).

### 4.6.7 Relative and Friend Support (RFS)

This Index (RFS) was designed by McCubbin, Larsen and Olson (1982) to determine the degree to which family members employ support from family and friends as a coping strategy when dealing with stressors. The RFS links into the family resources (BB) component of the Resiliency Model of Family Stress, Adjustment and Adaptation, and consists of eight items based on a 5-point Likert scale. An example of a statement from the RFS is “Seeking encouragement and support from friends”.

The internal reliability is .82 (Cronbach alpha) and the validity coefficient is .99 (McCubbin, et al., 2001). The Cronbach alpha reliability coefficient of the RFS for this sample was .67, indicating a moderate reliability of the measure for this sample (Murphy & Davidshofer, 1994).
4.6.8 Family Attachment and Changeability Index 8 (FACI8)

The Family Attachment and Changeability Index 8 (FACI8) was adapted from the FACES IIA by McCubbin, Thompson, and Elver in 1995, which in turn was adapted from the Family Adaptability and Cohesion Evaluation Scales II by Olson, Portner, and Bell (1989). In this study the FACI8 is used as a measure to determine the level of family adaptation (XX).

The FACI8 is rated on a 6-point Likert scale and consists of 16 items. It is divided into two subscales of eight items each. The first subscale, Attachment, measures strength of attachment between family members. The second subscale, Changeability, measures the flexibility of family relationships. The two subscales may be used together or separately. The subscales have a low intercorrelation of .13. An example of a statement from the FACI8 is “It is easier to discuss problems with people outside the family than with other family members”.

The measure is designed to be administered to both parents and youth. The internal reliability (Cronbach’s alpha) for the youths’ Attachment scale is .73, while for the youths’ Changeability scale it is .80. For the parents’ Attachment scale the internal reliability (Cronbach’s alpha) is .75, while for the parents’ Changeability scale the internal reliability is .78. The test-retest reliabilities when administered 6-12 months apart varies from .26 to .48 (McCubbin, et al., 2001). Validity was established by determining the FAC18’s relationship to a treatment programme’s successful outcome (McCubbin, et al., 2001). The internal reliability (Cronbach alpha) for the FACI8 for this sample was .39 (Attachment, .79; Changeability, .42), indicating a low reliability for the total FACI8 for this sample (Murphy & Davidshofer, 1994).

4.7 Data analysis

The data that was gathered consisted of both a qualitative and quantitative component. Following is an outline of how each of these components of data was analyzed.

4.7.1 Qualitative data

The qualitative data obtained from the open-ended question on the biographical questionnaire was analyzed using content analysis. Content analysis refers to the systematic classification of text into categories or themes (Leedy & Ormrod, 2005; Strüwig & Stead, 2001). Shaughnessy, Zechmeister and Zechmeister (2000) further explained that content analysis refers to a variety of techniques “for making inferences by objectively identifying specific characteristics of messages, usually written communications…” (p. 529). As Neuman (2003) explained, there are various steps involved in content analysis. Once the researcher has identified what will be analyzed, a system needs to be created to analyze it. For the current research, the qualitative data was analyzed using
Tesch’s eight-step model as outlined in Tesch (1990). The following is a summary of how the researcher applied these steps.

a) The researcher gained a sense of the “gestalt” of the research. As the data came in, the researcher read the material so as to gain an understanding and to formulate ideas around the data. While reading, the researcher jotted down ideas that came to mind.

b) The researcher then picked up a data document to start with, identified topics from the material and captured them in writing. The ultimate goal was to determine what the document was about, and what the underlying meaning was. The procedure was repeated for all data documents. At this stage the researcher focussed primarily on the various topics that began to arise from participants’ answers.

c) During this step, the researcher made a list of all the topics and themes from the data documents that were studied. Themes were then organized into columns that could be classified as major themes, unique themes and leftovers.

d) Once the themes had been identified, the researcher returned to the data and abbreviated the themes into codes. These codes were then written next to the relevant sections in the text. This phase further allowed for the detection of new themes and codes that could be integrated into the text.

e) The researcher thereafter named the themes in descriptive wording and then created categories. From the lists of categories, themes were related to each other. By grouping related themes, the overall list of themes was reduced.

f) Once the researcher had made a final decision of the abbreviation that represents each category, the codes were alphabetized.

g) Related data was then assembled in one place, and a preliminary analysis was completed. The goal was to identify and summarize the content for each category so as to identify information that was relevant to the present study.

h) The last step involved recoding existing data if necessary, depending on whether the categories were inclusive or exclusive enough.

In order to make every effort to remain objective while analyzing the data, the researcher used Guba’s model of trustworthiness. This model is valuable as it enabled the researcher to determine the internal and external validity, reliability and objectivity of the qualitative data. Guba and Lincoln (1989) outlined four criteria that a qualitative study should meet in order to determine the study’s ‘truth value’, namely credibility, transferability, dependability and conformability. A brief explanation of these constructs is now provided (De Vos, 2005).

Credibility is the alternative to internal validity in which the goal is to demonstrate that the study was conducted in a manner that ensures that the research participant was identified and described in
an accurate way. A researcher should ensure that he/she places adequate parameters around the study. This implies an in-depth description showing the complexities of variables and interactions. This will increase the probability that data gathered from the setting are valid.

*Transferability*, as a criterion of trustworthiness, refers to the degree to which the findings can be transferred to a context outside the study. This construct was not considered for the purposes of the current research as the present study is exploratory-descriptive in nature. It was therefore not the ultimate goal to transfer the findings to other contexts.

*Dependability* is viewed as the alternative to reliability. With reliability the researcher attempts to account for dynamics surrounding the research subject, such as changing conditions as well as changes in the design as the researcher gains a more refined understanding of the setting. The literature (De Vos, 2005; Guba & Lincoln, 1989) suggests a change from the positivist assumptions surrounding reliability, where it is assumed that we live in an unchanging social world where results can easily be replicated. However, these assumptions are in contrast to the qualitative/interpretative view that the world is dynamic and that replication of results is problematic.

*Conformability* represents the last of the four constructs that were proposed by Guba and Lincoln (1989). Conformability captures the traditional concept of objectivity. Guba and Lincoln (1989) stressed the fact that others should be able to confirm the findings of a study. The goal is to remove the subjective influence of some of the characteristics that are inherent to the researcher and rather focus on the data themselves (De Vos, 2005). An independent coder was employed to assist in countering potential researcher bias.

4.7.2 Quantitative data

The data that was gathered from the biographical questionnaire was analyzed using descriptive statistics. Descriptive statistics enable the researcher to make statements about the data by investigating the central tendency and variability of the data (Cozby, 2007). The mean was used to measure central tendency, and standard deviations were used to measure variability. The mean describes the group’s performance by providing the “typical” score in the group (Zechmeister, Zechmeister & Shaugnessy, 2001). The standard deviation measures how much the scores deviate from the mean (Cozby, 2007).

The quantitative data was analyzed using correlation and regression analysis, as outlined by the broader study at the University of Stellenbosch. The structured questionnaires were analyzed using Spearman’s rank correlation coefficients (Spearman $r$) and best-subset regression analyses for both the adults and adolescents.

Correlation research enables the researcher to observe two or more variables and determine the relationship between them (Bordens & Abbott, 2002). These variables are not manipulated in any
way, but are rather merely observed for any relationship that might exist (Bordens & Abbott, 2002). Furthermore, correlation analysis enables the researcher to measure and describe the direction and degree of relationship between variables, as well as make predictions from one variable to another (Gravetter & Forzano, 2003; Jackson, 2003). The value of correlation is that it enables the researcher to look at more than one variable and their relationship (Harris, 1998). Russell and Roberts (2001) described three main categories that the results of correlation analysis can fall into. Positive correlation implies that if one variable increases, the other is also likely to increase. Negative correlation indicates that if one variable increases the other decreases. And finally, when there is no trend between variables and it appears that there is no relationship between them, there is no correlation. For the present study the FACI8 represents the dependent variable, while the remaining measures represent the independent variables. The FACI8 measured the outcome of adaptation resulting from the resiliency process. The independent variables form part of the process which ultimately leads to bonadaptation or maladaptation.

According to Harris (1998), the concepts of correlation and regression are closely related because, unless two variables correlate, one cannot do a regression analysis. Goodwin (2002) explained that “making a prediction on the basis of correlational research is referred to as doing a regression analysis” (p. 291). Regression analysis was used in the study to discover whether a combination of independent variables can predict scores on the dependent variable (FACI8).

Now that the data analysis has been outlined, it is important to discuss the ethical considerations that were taken into account while conducting this research. These ethical considerations are highlighted in the following section.

4.8 Ethical considerations

When undertaking research it is of foremost importance to be aware of ethical considerations, and conduct research in an ethical manner. In psychological research the researcher must be acutely aware of the rights of the participants, and balance these with the goal of the researcher to produce sound data. Ethics are principles that morally guide us (Goodwin, 2002). When conducting research, there are a number of ethical obligations the researcher should be aware of to ensure that participants’ respect and rights are maintained. These ethical considerations are now described.

4.8.1 Informed consent

The first ethical issue to consider is gaining informed consent from participants, which implies that people are autonomous and therefore capable of making decisions about whether they wish to participate or not. In order for potential participants to make an informed decision, it is essential to explain the research in language that is understandable to them (Goodwin, 2002). Cozby (2007)
highlighted the important consideration that certain populations, such as minors, may lack autonomy to make an informed decision about their participation. Russel and Roberts (2001) stated that in such cases, consent should be given by someone with legal authority to do so. As minors were involved in the present research, the researcher took special precautions to ensure ethical practice was upheld. This requires the provision of a letter written in age-appropriate language, and explaining the research project to them (Appendix D). A separate cover letter was given to adult participants using further age-appropriate information (Appendix C). For both adolescent and adult participants, the information was provided in their first language. Furthermore, a letter was provided to the coordinators of those treatment centres that were contacted in order to access potential participants for the study (Appendix B).

Leedy and Ormrod (2005) suggested certain important information is relevant for participants to give informed consent. This information includes the purpose and voluntary nature of the research, who the researcher is, contact details should any questions arise, the issues of confidentiality and anonymity, and an offer to provide feedback on conclusion of the research. This information was made available to potential participants in the form of covering letters and an attached informed consent form for the participating parent (Appendix E). Participants were required to sign the consent form indicating their voluntary agreement to participate. If the minor agreed to participate, written consent was required from a guardian permitting them to participate.

It is recommended by Dunn (1999) that signed informed consent forms are filed separately from other data collected in order to ensure participants’ confidentiality. The researcher took special care to do this in order to respect participants’ rights.

4.8.2 Coercion

A second issue to be aware of is coercion. Coercion refers to potential participants feeling compelled to participate due to external pressure, and thus removing their right to participate completely from their own free will (Cozby, 2004). The researcher can avoid coercion by giving participants all the necessary information about the study, and refraining from making exaggerated claims that fuel participants’ expectations about their participation in the study (Russel & Roberts, 2001).

In order to ensure that participants’ were not coerced in any way to participate in the current study, the researcher emphasized the voluntary nature of the research in a covering letter given to participants. In addition, the researcher reiterated their freedom to participate or discontinue at any time without consequences (Ungar & Liebenberg, 2004).
4.8.3 Confidentiality

Furthermore, it is ethical practice to always consider confidentiality and/or anonymity when undertaking research. Confidentiality refers to “the practice of keeping strictly secret and private the information or measurements obtained from an individual”, whereas anonymity refers to “the practice of ensuring that an individual’s name is not directly associated with the information or measurements obtained from that individual” (Neuman, 2003, p. 72). Mertens (1998) further highlighted that confidentiality means that the privacy of the participants will be protected, in that the data they provide will be handled and conveyed in such a manner that their personal identities will not be revealed in the reporting of the research. In the commenced research, confidentiality was maintained by omitting any identifying data from participants’ answers. Anonymity was ensured as participants’ details were recorded only where they specifically requested feedback from the researcher (Abbot & Sapsford, 2006). It should be noted that these ethical concepts are tied to participants’ right to privacy, which should be protected while the research is in progress, as well as when the research is concluded. Participants’ documents were therefore assigned codes and their data stored in a secure place in order to uphold privacy (Cozby, 2007; Goodwin, 2002; Leedy & Ormrod, 2005). Furthermore, while reporting the results of the study, participants’ identities were excluded.

4.8.4 Protection from harm

The researcher ensured that participants were given information regarding counselling services should the need for counselling have arisen during their participation in the study. Leedy and Ormrod (2005) explained that it is ethical practice for the researcher to protect participants from any risk of mental harm. These authors further emphasized that participants be protected from excessive stress, should they respond to questions about personal experiences (Leedy & Ormrod, 2005). All participants were informed that their participation was on a purely volunteer basis, and they could therefore withdraw from the study at any time should they no longer wish to participate. Participants were furthermore given the researcher’s contact details should they have had any questions. Cultural sensitivity, collaboration and respect were further virtues that the researcher attempted to maintain at all times.

4.9 Conclusion

This chapter outlined the research design of the current study. Triangulation was employed using an exploratory, descriptive approach. The data was gathered using a biographical questionnaire, an open-ended question, and seven structured paper-and-pencil questionnaires. Nonprobability purposive and snowball sampling methods were used to obtain the participating families. At all
times, the researcher abided by the ethical considerations such as informed consent, confidentiality, and coercion. The questionnaires were either hand delivered to participants, or mailed in postage-paid, self-addressed envelopes. Thereafter, the questionnaires were either collected in person or received via mail. The researcher scored the questionnaires and sent the data to the University of Stellenbosch where it was statistically analysed using correlation and regression analysis. The researcher followed the steps outlined in Tesch’s eight-step model to analyse the qualitative component of the study, along with Guba’s model of trustworthiness to ensure the trustworthiness of the data. The results of these analyses are discussed in the following chapter.
CHAPTER 5
RESULTS AND DISCUSSION

5.1 Introduction

Chapter five presents and describes the qualitative and quantitative findings that were obtained from the biographical questionnaire and the seven questionnaires employed in this study. It is important to revisit the aim of the research before discussing the results thereof. The aim of this study was to identify, explore and describe the resiliency factors which enable families to adjust and adapt as a result of having a parental member in the family who misuses alcohol. The results of the qualitative and quantitative analyses are presented and discussed in terms of the study and literature surveyed.

5.2 Biographical description of the sample

As discussed in chapter four, the biographical variables that were mentioned related specifically to the information obtained from the biographical questionnaires completed by the participants. Adult participants received slightly different biographical questionnaires to the adolescent participants. As these variables have been discussed previously, the results of the qualitative analysis now follows.

5.3 Results of the qualitative analysis

The qualitative data was analyzed using Tesch’s model of content analysis. An independent coder was employed to ensure the trustworthiness of the process of analysis. The adults’ and adolescents’ answers to the question were analyzed separately. The question asked of the adults was, “In your own words, what are the most important factors or strengths that help your family in dealing with your alcohol misuse?” while the question asked of the adolescents was, “In your own words, what are the most important factors or strengths that help your family in dealing with your family member and his/her alcohol misuse?” Common themes emerged between the adults and adolescents. The adult participants had five themes that emerged, while the adolescent participants had six. A discussion regarding the common themes expressed by both adults and adolescents is provided, followed by a presentation of the unique themes. The following tables represent the various themes that emerged.
Table 1. Adult themes

<table>
<thead>
<tr>
<th>Theme</th>
<th>f</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family support</td>
<td>10</td>
</tr>
<tr>
<td>Social support</td>
<td>9</td>
</tr>
<tr>
<td>Being able to disclose their status</td>
<td>15</td>
</tr>
<tr>
<td>Counselling and commitment for the process and to sobriety</td>
<td>36</td>
</tr>
<tr>
<td>Prayer</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 2. Adolescent themes

<table>
<thead>
<tr>
<th>Theme</th>
<th>f</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family activities</td>
<td>23</td>
</tr>
<tr>
<td>The ability to offer their support to the parental member</td>
<td>7</td>
</tr>
<tr>
<td>Faith</td>
<td>11</td>
</tr>
<tr>
<td>Social support</td>
<td>15</td>
</tr>
<tr>
<td>Open communication</td>
<td>36</td>
</tr>
<tr>
<td>Forgiveness</td>
<td>5</td>
</tr>
</tbody>
</table>

5.3.1 Family support and activities

Common themes emerged between the adults and adolescents, the first of which was family support and activities. A number of examples that the adult participants mentioned were:

- “I would say family”,
- “Asking them not to use alcohol in front of me”, and
- “My children are proud of my strength which makes me want to not let them down. Their strength is quietly accepting my struggle and not criticizing”.
Adolescent participants mentioned a number of statements under this theme as well. Examples of their statements were:

- “Encouragement always plays a major role because without it some people may not be where they are today. As a family we encourage a lot to show that what this person is doing is an amazing thing and is a much better person because of it”,
- “We do activities as a family because now we want to but also to try new things and help the family member cope and to show alcohol is not needed”, and
- “Close family ties with my mother’s family for support”.

The importance of bonding and developing family cohesiveness was a factor highlighted by both the adult and the adolescent participants. This is congruent with literature as spending time together and taking part in joint activities promote a sense of predictability and cohesiveness (McCubbin, McCubbin, Thompson, Han & Allen, 1997).

5.3.2 Social support

Social support was identified as an important factor in helping both adults and adolescents cope as a result of being part of a family where a parental member misuses alcohol. Examples of the adults’ verbatim responses that highlighted social support as a resource were:

- “I would say friends”,
- “The unconditional and non-judgmental love and support from friends and family”, and
- “I’ve always been an outgoing person, and was worried my friends would no longer accept me if I were to admit this to them. When I finally did, they were so understanding. It helped so much”.

Examples of the adolescents’ responses were:

- “My friends, who are basically part of my family, would stand by me. I could talk to them and they just listened”,
- “Sometimes I don’t feel I can rely on my parents, and when I feel like that my friends always take me out and keep me busy”, and
- “Definitely help from mates”.

Social support has emerged within the qualitative component of this study as a factor in aiding family members being able to cope for both the adult and adolescent participants. Literature has highlighted social support as an important resiliency variable (McCubbin, McCubbin, Thompson, Han & Allen, 1997; Walsh, 1996; 2003a; Wills, Blechman & McNamara, 1996). Hetherington (1989) also specifically highlighted the crucial role that relationships play in the healthy adjustment of children, especially during adolescence.
5.3.3 Communication

Communication was the fourth theme that both adults and adolescents cited as a resource in being a part of a family of this nature. The adult participants seemed to relate more to this theme along the lines of being able to and having the freedom to disclose their status and treatment to their family and others. Examples of the adult participants’ verbatim responses in this regard were:

- “Talking about the fact that I have obtained help to deal with a disease”,
- “Willingness to discuss problem areas”, and
- “Feeling like I can open up about what’s really going on”.

Examples of adolescents’ verbatim responses were:

- “I could talk to my mom and gran(mother) about it and I could discuss it with my brother”,
- “I do feel that I can chat when I need to”, and
- “Even though my mom is the alcohol abuser (misuser), I still feel I can talk to her and she encourages me to open up”.

As was discussed in preceding chapters, communication has been highlighted in literature as an important resiliency variable (Epstein, Ryan, Bishop, Miller & Keitner, 2003; McCubbin, McCubbin, Thompson, Han & Allen, 1997; Olsen, 1993; Patterson, 2002b; Walsh, 1998; 2003a; 2003b).

5.3.4 Spirituality

Another theme that emerged for both the adults and the adolescents was spirituality. Examples of adults’ responses relevant to the belief in God were:

- “I would say friends… and prayer”,
- “We have a strong belief in God”, and
- “Even though my family isn’t particularly religious, He is definitely a strength in my life in helping me cope with this”.

Adolescents’ responses applicable to this theme were:

- “Our faith (Christian) and prayer”,
- “Also God was very important for my family. He gave us hope and I knew he would always be there for us and would try His best to help”, and
- “Prayer”.

Spirituality has been highlighted in literature as a resiliency variable (McCubbin, McCubbin, Thompson, Han & Allen, 1997; Patterson, 2002b; Walsh, 1998; 1999; Werner & Smith, 1992; Yates & Masten, 2004). Research has proven that principle beliefs and practices are key ingredients in healthy family functioning (Walsh, 1999). Participants’ responses are therefore in agreement with
literature in that spirituality is a resource they are able to tap into to help them cope within the context of a family where a parental member misuses alcohol.

5.3.5 Counselling and commitment to process and to sobriety

The first and solitary theme that emerged from the adults’ perspective only had to do with counseling and treatment, as well as the adults’ commitment to the process. A number of examples of responses emerged. Some of the verbatim responses were:

- “Listening to everything my counselor can tell me about my situation”,
- “Willingness to be part of a recognized treatment and therapy program”,
- “I would say support groups”, and
- “Honesty in maintaining my sobriety”.

Being positive emerged as an undertone throughout the participants’ responses. Despite challenges, they chose to focus on the positive as opposed to the negative. Hope is referred to in literature as a protective and recovery factor in aiding family adaptation (McCubbin, McCubbin, Thompson, Han & Allen, 1997). Seligman (1990) referred to learned optimism in explaining the sense that people have when they begin to believe in their efforts. The process of focusing more on the positive as opposed to the negative also contributes to the purpose of this study as coming from a positive psychology paradigm. This study is therefore realistic and does not claim that human nature is all positive, but simultaneously maintains that people have the capacity to thrive, or attempt to thrive, when confronted with challenges (Keyes & Haidt, 2003).

5.3.6 Forgiveness

Being able to forgive their misusing parent and accept the past emerged as a theme for the adolescent participants. Examples of three responses were:

- “It’s been easier to handle my mom’s addiction since coming to terms with it and being able to move forward”,
- “Forgiving my mom was the hardest part, but now that I have we don’t argue as much”,
- “Me forgiving him and him forgiving me”.

Various authors have referred to physical and emotional health of family members as promoting resiliency in the family unit (McCubbin, McCubbin, Thompson, Han & Allen, 1997). According to the adolescent participants, extending forgiveness and accepting the past transgressions of their parents has aided their ability to manage being part of a family where a parental member misuses alcohol. This is congruent with existing literature that cites forgiveness as part of the process of reaching a point of closure and letting go in order to promote one’s own emotional wellbeing (Walsh, 2003a; 2003b).
5.3.7 Summary of qualitative results

Various common themes emerged between the adult and adolescent participants’ responses. These common themes were:

a) family support and activities,

b) social support,

c) communication, and

d) spirituality.

There was one remaining theme identified by the adult participants as an important factor in helping them manage being part of a family where this parental member misuses alcohol. This theme was counselling and commitment to the process and to sobriety. The remaining theme highlighted by the adolescent participants as an important factor in helping them manage being part of a family where the parental member misuses alcohol was forgiveness.

5.4 Results of the quantitative analysis

The structured questionnaires were analyzed using Spearman’s rank correlation coefficients (Spearman $r$) and best-subset regression analyses for both the adults and adolescents. The correlations are presented and discussed first. Thereafter the regression analysis is introduced and discussed.

5.4.1 Correlation results

In order to fulfill the purposes of the current research, the quantitative data was analyzed using correlation statistics. Correlation analysis is used to measure the association between two or more variables and the extent to which the values of one variable can be used to predict the values of another variable. Furthermore, it can be used to describe the direction and the degree of the relationship between certain variables (Wilson & Sapsford, 2006).

Spearman’s rank correlation coefficients (Spearman $r$) were calculated to determine the interrelationship between family adaptation, as measured by the FACI8, and resilience factors. Spearman $r$ can be thought of as the regular Pearson product-moment correlation coefficient (Pearson $r$) in terms of the proportion of variability accounted for, except that Spearman $r$ is computed from ranks (Gibbons, 1985; Hays, 1981; Hotelling & Pabst, 1936; Kendall, 1948; McNemar, 1969; Olds, 1949; Siegel, 1956; Siegel & Castellan, 1988). Spearman $r$ assumes that the variables under consideration were measured on at least an ordinal (rank order) scale. In other words, the individual observations can be ranked into two ordered series.

When applied to any two sets of results, the Spearman Test produces a Spearman correlation coefficient, $r$. This $r$ can take on values between -1 and +1. When $r = -1$, two sets of numbers exist
that have a perfect negative correlation. That is, without exception, as the value of one quantity in the sample becomes larger, the value of the second quantity becomes smaller. Similarly, an $r = +1$ indicates a perfect positive correlation. Therefore, without exception, every larger value of one quantity is accompanied by a larger value of the second quantity. If $r$ varies between -1 and +1, an $r$ value of 0 means that there is no correlation between the two quantities (Gibbons, 1985; McNemar, 1969).

To assess the significance of these correlations, $p$ values were used. A $p$ value of .05 is the standard value used for most psychological reports and is indicative of a significant relationship (Harris, 1998). For example, a $p$ value of .05 indicates that a significant relationship does exist between family adaptation (FACI8) and resiliency variables. Furthermore, a $p$ value of .01 or .001 is considered to be more significant as these $p$ values are representative of more severe and rigorous levels (Harris, 1998).

With regards to the interpretation of the strength of the correlations, guidelines suggested by Guilford (1946) have been used to interpret the magnitude of the relationship. These guidelines are as follows:

- $< .20$  Slight correlation, almost negligible relationship
- $0.20 – 0.40$  Low correlation, small but definite relationship
- $0.40 – 0.70$  Moderate correlation, substantial relationship
- $0.70 – 0.90$  High correlation, marked relationship
- $0.90 – 1.00$  Very high correlation, very dependable relationship

The correlation results for the research participants are presented in Table 4.
Table 3. Spearman rank correlations between adaptation (FACI8) and potential resilience variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>Adults (n = 63)</th>
<th></th>
<th>Adolescents (n = 63)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spearman r</td>
<td>P</td>
<td>Spearman r</td>
</tr>
<tr>
<td><strong>Family Hardiness Index (FHI)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commitment (family’s sense of internal strengths, dependability and ability to work together)</td>
<td>0.75</td>
<td>&lt; 0.01*</td>
<td>0.80</td>
</tr>
<tr>
<td>Challenge (family’s efforts to be innovative, active to experience new things and to learn)</td>
<td>0.58</td>
<td>&lt; 0.01*</td>
<td>0.73</td>
</tr>
<tr>
<td>Control (family’s sense of being in control of family life rather than being shaped by outside events and circumstances)</td>
<td>0.50</td>
<td>&lt; 0.01*</td>
<td>0.63</td>
</tr>
<tr>
<td><strong>TOTAL FHI SCORE</strong></td>
<td>0.77</td>
<td>&lt; 0.01*</td>
<td>0.79</td>
</tr>
<tr>
<td><strong>Social Support Index (SSI)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The degree to which families find emotional, esteem and network support within their communities.</td>
<td>- 0.64</td>
<td>&lt; 0.01*</td>
<td>0.63</td>
</tr>
<tr>
<td><strong>Relative and Friend Support (RFS)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The family’s ability to utilize relative and friend support to manage stressors and strains.</td>
<td>- 0.28</td>
<td>0.03*</td>
<td>0.25</td>
</tr>
<tr>
<td><strong>Family Crisis Oriented Personal Evaluation Scale (F-COPES)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reframing (family’s capability to redefine stressful events in order to make them more manageable)</td>
<td>0.84</td>
<td>&lt; 0.01*</td>
<td>0.74</td>
</tr>
<tr>
<td>Passive appraisal (family’s ability to accept problematic issues and minimize reactivity)</td>
<td>0.63</td>
<td>&lt; 0.01*</td>
<td>0.52</td>
</tr>
<tr>
<td>Social support (family’s ability to actively engage in acquiring support from relatives, friends, neighbours and extended family)</td>
<td>- 0.35</td>
<td>&lt; 0.01*</td>
<td>- 0.55</td>
</tr>
<tr>
<td>Spiritual and religious support (family’s ability to acquire spiritual/religious support)</td>
<td>- 0.37</td>
<td>&lt; 0.01*</td>
<td>- 0.26</td>
</tr>
<tr>
<td>Mobilization (family’s ability to acquire community resources and accept help from others)</td>
<td>0.39</td>
<td>&lt; 0.01*</td>
<td>0.62</td>
</tr>
<tr>
<td><strong>Family Problem Solving Communication (FPSC)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incendiary communication (pattern of family communication that is inflammatory)</td>
<td>- 0.27</td>
<td>0.03*</td>
<td>- 0.52</td>
</tr>
</tbody>
</table>
Affirming communication (patterns of communication that convey support and care)

<table>
<thead>
<tr>
<th>TOTAL FPSC SCORE</th>
<th>0.69</th>
<th>&lt; 0.01*</th>
<th>0.75</th>
<th>&lt; 0.01*</th>
</tr>
</thead>
</table>

**Family Time and Routine Index (FTRI)**

Family activities and routines that the family use and maintain, and value the practices thereof.

The FTRI scale appeared to have been unreliably measured due to the unacceptable Cronbach alphas, and was therefore not included in any subsequent analyses.

* p < 0.05

In order to understand the relationships indicated in the above table it is necessary to discuss the relationships within the context of the literature relevant to the variables of resilience and the literature applicable to alcohol misuse as discussed in chapters two and three respectively. The results indicate that for both the adult and the adolescent participants, family adaptation, as indicated by the FACI8 total score, is positively correlated to a variety of potential resiliency variables. These variables, as described by the measures utilized in this study, are discussed in the following section.

In this study, the FACI8 is used as a measure to determine the level of family adaptation. In the Resiliency Model of Family Stress, Adjustment and Adaptation, family adaptation is indicated as XX. Family adaptation ranges from positive *bonadaptation*, implying that the family has accepted and is able to function congruently with new patterns of functioning, to negative *maladaptation*, which propels the family back into a crisis situation (McCubbin & McCubbin, 2001).

There were a number of resiliency variables that showed significant positive correlations with the FACI8 for both the adults and adolescents. These variables were:

a) Family Hardiness Index (FHI) – total score
b) Family Crisis Oriented Personal Evaluation Scales (F-COPES)
   i) Reframing
   ii) Passive appraisal
   iii) Mobilization
c) Family Problem Solving Communication (FPSC) – total score

The Family Crisis Oriented Personal Evaluation Scales (F-COPES) variable indicated a significant negative correlation with the FACI8 for both the adult and adolescent participants on the Social support and Spiritual and Religious support scales. Furthermore, there were two variables in which the adult and adolescent results differed. With these variables, the adults illustrated a negative correlation while the adolescents demonstrated a positive correlation with the FACI8.
These variables included:

a) Social Support Index (SSI)

b) Relative and Friend Support (RFS)

The unique findings of the current study are now outlined. The significant positive correlations as well as the significant negative correlations are explored first. The variables where the adults illustrated a negative correlation while the adolescents demonstrated a positive correlation with the FACI8 are then discussed.

5.4.1.1 Family Hardiness Index (FHI)

The first measure that showed a positive correlation with the FACI8 was the Family Hardiness Index (FHI) – total score. This measure showed a positive correlation for both the adults and the adolescents. The FHI was used to measure how hardiness is used as a resource to mediate the effects of stress in families and, in turn, facilitate family adjustment and adaptation. Family hardiness refers to an active viewpoint in managing stress, maintaining a sense of control over life, and having a positive perception of change (McCubbin, Thompson & McCubbin, 2001). Kobasa (1979) suggested that a commitment to various areas of one’s life, having a sense of control and viewing change as a challenge allows a hardy person to develop. Various authors have noted that family hardiness aids family adaptation (McCubbin, McCubbin, Thompson, Han & Allen, 1997; Svavarsdottir, McCubbin & Kane, 2000).

The FHI taps into the family resources (BB) and situational appraisal (CC) components of the Resiliency Model of Family Stress, Adjustment and Adaptation. The family’s appraisal is comprised of five processes, namely

a) family’s schema,

b) family coherence,

c) family paradigms,

d) situational appraisal, and

e) stressor appraisal.

Situational appraisal (CC) can be described as the family’s ability to weigh up their resources against new demands on their established patterns of functioning which is created by a crisis (McCubbin & McCubbin, 2001). The family’s resources (BB) include the family’s strengths and capabilities. McCubbin and McCubbin (2001, p.3) defined a resiliency resource as “a characteristic, trait or competency of one of these systems that facilitates adaptation”. The systems that McCubbin and McCubbin refer to are the three resources that a family can draw on. These include individual family members, the family unit, and the community.
The positive correlation between the FACI8 and the Family Hardiness Index (FHI) – total indicated that family hardiness is a resource for the current sample that aids family adaptation. The level of significance for this correlation for the adults was high ($r = 0.77, p < 0.01$) indicating a marked relationship between family hardiness and adaptation. The level of significance for the adolescent participants was also high ($r = 0.79, p < 0.01$), also indicating a marked relationship between family hardiness and adaptation. This specified that family hardiness was important for both adults and adolescents.

All three subscales of the Family Hardiness Index (FHI) for both the adult and adolescent participants were found to have a high level of significance, and a substantial to marked relationship between each subscale and family adaptation. The Commitment scale (adults: $r = 0.75, p < 0.01$; adolescents: $r = 0.80, p < 0.01$) indicated that both adults and adolescents make a commitment to work together to solve crises. The Challenges subscale (adults: $r = 0.58, p < 0.01$; adolescents: $r = 0.73, p < 0.01$) indicated that families are able to reframe and define their hardships as challenges rather than problems, allowing them to develop hardiness.

The third subscale, the Control scale (adults: $r = 0.50, p < 0.01$; adolescents: $r = 0.63, p < 0.01$), indicated a high level of significance and a substantial relationship. This can be interpreted as families having a sense of being in control of family life. The high level of significance of this subscale contradicts existing research on families where alcohol is misused. Authors have stated that homes in which alcohol is misused tend to be high conflict households. It has been concluded then that these children are therefore more likely to have lower self-esteem and less internal locus of control (COAF, 2007; Lambie & Sias, 2005; Sheridan & Green, 1993). A lower internal locus of control contributes to the individual feeling that his or her life is shaped more by outside events and circumstances. The results of this subscale oppose this theory.

On the whole, the correlations discussed above are corroborated by results from other studies in South Africa which have shown that family hardiness characteristics, such as internal strengths and durability of the family unit, play a significant role in the family’s resilience (Greeff & Human, 2004; Greeff & van der Merwe, 2004). Furthermore, these results support available literature on the measures adolescents especially take to create a sense of control. As discussed in chapter 3, children have been described as developing roles that are “patterns of behavior” in order to cope with the strong negative feelings associated with alcohol misusing families (Alford, 1998, p. 250). All families work to maintain homeostasis and equilibrium, or balance (Nichols & Schwartz, 2003) and, although genetics plays a substantial role in alcohol misuse, the family environment plays a role in both promoting and protecting the individual from alcohol misuse (Dube, Anda, Felitti, Edwards & Croft, 2002). Consequently, a strong sense of managing stress, maintaining a sense of control over
life, and having a positive perception of change has been proven to play a considerable role in these participants’ lives.

5.4.1.2 Family Crisis Oriented Personal Evaluation Scale (F-COPES)

A significant positive correlation was found between family adaptation and selected subscales of the Family Crisis Oriented Personal Evaluation Scale (F-COPES). The F-COPES is used to identify how the family solves problems and what strategies they use in crisis situations. This instrument examines how the cumulative effect of demands (AA), family resources (BB) and meaning (CC) of the Resiliency Model interact. Literature on resilience indicates that a family’s resistance resources are the abilities and capabilities that a family has to address and manage the stressor and its demands, while maintaining and promoting harmony and balance (McCubbin & McCubbin, 1996). As such, three subscales of the Family Crisis Oriented Personal Evaluation Scale (F-COPES) were viewed as significant for the current sample, namely Reframing, Passive appraisal and Mobilization.

The first subscale to show a significant positive correlation with the FACI8 was Reframing. The purpose of this subscale is to indicate the family’s capability to redefine stressful events in order to make them more manageable. The significance for this correlation was high for both the adults and the adolescents (adults: \( r = 0.84, p < 0.01 \); adolescents: \( r = 0.74, p < 0.01 \)) where a marked relationship existed between the family’s ability to reframe and family adaptation.

Reframing refers to the family’s capability to redefine stressful events in order to make them more manageable. Reframing and placing emphasis on the positive rather than the negative is referred to in literature as a protective and recovery factor in aiding family adaptation (McCubbin, McCubbin, Thompson, Han & Allen, 1997). The term learned optimism has been used to explain the sense that people have when they begin to believe in their efforts (Seligman, 1990). Positive psychology itself refers to the attempt to understand better how to make meaning out of life and how to function optimally as a human being (Linley & Joseph, 2004), and this is achieved through reframing.

The second subscale of the F-COPES that demonstrated a significant correlation with the FACI8 was the Passive appraisal subscale. The purpose of this subscale is to indicate the family’s ability to accept problematic issues and minimize reactivity. The significance for this correlation was high for both the adults and the adolescents (adults: \( r = 0.63, p < 0.01 \); adolescents: \( r = 0.52, p < 0.01 \)). The magnitude of the relationship was substantial indicating that a moderate relationship existed between the family’s ability to accept problematic issues and family adaptation.

The last subscale to show a significant correlation with the FACI8 was the Mobilization subscale. The Mobilization subscale measures the family’s ability to acquire community resources
and accept help from others. This measure showed a significant positive correlation for both the adults and the adolescents. The magnitude of the relationship for the adults was low ($r = 0.39, p < 0.01$) indicating a definite but small relationship between mobilization and adaptation. The magnitude of the relationship for the adolescent participants was moderate ($r = 0.62, p < 0.01$) indicating a substantial relationship between mobilization and adaptation. This result indicated that families are able to acquire community resources and accept help from others in a time of crisis.

A possible reason why the magnitude of the adult’s relationship is lower with that of the adolescent’s could be related to the stigma experienced by alcohol misusers attributed to them by society. Because of the social stigma that has been placed on alcohol misuse treatment, many people may feel that alcohol misuse is a sign of moral weakness, and shame may prevent some from seeking treatment. Society therefore imposes stigma on addicted individuals because many still believe that addiction is a character flaw or weakness that in all probability cannot be cured (Rosenbloom, 2007). This may in turn cause parental misusers to shy away from seeking help or accessing resources in the community.

The first F-COPES subscale to show a significant negative correlation with the FACI8 was the Social support subscale. The Social support subscale of the F-COPES measures the family’s ability to actively engage in acquiring support from relatives, friends, neighbours and extended family. For both the adult and adolescent participants, the correlation was negative, indicating that as social support decreases, adaptation increases. The magnitude of the relationship was low for the adult participants ($r = -0.35, p < 0.01$) indicating a small but definite relationship. The magnitude of the relationship for the adolescent participants was moderate ($r = -0.55, p < 0.01$) indicating a substantial relationship between social support and adaptation.

Past research has shown the importance of social support as “a buffer against family crisis factors, a resiliency factor in promoting family recovery, and as a mediator of family distress” (McCubbin et al., 2001, p. 384), and the SSI can be linked to the family resources (BB) component of the Resiliency Model of Family Stress, Adjustment and Adaptation. However, a negative correlation means that as one variable increases, the other decreases (Russell & Roberts, 2001). It can therefore be concluded that some of the participants perhaps did not fully comprehend the questions posed within the structured questionnaires. Due to the fact that the adult and adolescent participants mentioned this resource in their qualitative responses, it cannot be concluded that they do not rely on social support as a resource.

The second subscale of the F-COPES to indicate a significant negative correlation with the FACI8 was the Spiritual and Religious support subscale. This subscale measures the family’s ability to acquire spiritual/religious support. For both the adult and adolescent participants, the correlation was negative, indicating that as spirituality decreases, adaptation increases. The
magnitude of the relationship was low (adults: $r = -0.37$, $p < 0.01$; adolescents: $r = -0.26$, $p = 0.04$) indicating a definite but small relationship between spirituality and religious support and adaptation. As with the result of the Social support subscale, the Spiritual and Religious support subscale result contradicts literature which states that spirituality may be seen as an important paradigm (CCC) that shapes and guides the family’s development of patterns of functioning (McCubbin, Thompson & McCubbin, 2001). The use of religion to cope in situations of health-related stress has been documented as offering hope, comfort, acceptance and strength (Siegal, Anderman & Schrimshaw, 2001). Religious institutions are seen as organizations which offer emotional support and practical assistance in times of serious illness. They can furthermore help families in their psychological adjustment to the specific illness they are dealing with (Siegal, Anderman & Schrimshaw, 2001). As such, the various resources of religion and spirituality offered to families may be seen as buffers to the stress of health-related crises (Pargament 1995). It can therefore be concluded that some of the participants possibly did not understand the questions posed within the structured questionnaires. It cannot be concluded that they do not rely on spirituality as a resource as many of the adult and adolescent participants mentioned this resource in their qualitative responses.

5.4.1.3 Family Problem Solving Communication (FPSC)

The next measure which showed a positive correlation with the FACI8 for both adults and adolescents was the Family Problem Solving Communication (FPSC) Index – total score. The FPSC measures the problem solving and coping (PSC) component of the Resiliency Model of Family Stress, Adjustment and Adaptation. Within the Resiliency Model, coping behaviour is defined by McCubbin and McCubbin as “a specific effort (covert or overt) by which an individual family member or the family functioning as a whole attempts to reduce or manage a demand on the family system and bring resources to bear to manage the situation” (2001, p. 49).

The FPSC was used to measure two dominant patterns in family communication which play an integral part in how families cope with tension and reach family adjustment and adaptation. The two patterns of communication are presented as two subscales, namely Incendiary communication and Affirming communication. Incendiary communication involves communication that exacerbates a conflictual situation, while Affirming communication conveys support and cultivates a calming environment (McCubbin et al., 2001). Various authors have noted that a positive (Affirming) communication style aids the family’s ability to recover from a crisis and to adapt, thereby aiding the family’s functioning (Epstein, Ryan, Bishop, Miller & Keitner, 2003; McCubbin, McCubbin, Thompson, Han & Allen, 1997; Olsen, 1993; Patterson, 2002b; Walsh, 1998; 2003a; 2003b). Alternatively, a negative (Incendiary) communication style can contribute to making a stressful
situation worse and can thereby increase the family’s vulnerability (McCubbin, McCubbin, Thompson, Han & Allen, 1997; Olsen, 1993; Patterson, 2002b).

The first subscale, Incendiary communication, showed a negative correlation with the FACI8. The magnitude of the relationship for the adult participants was low ($r = -0.27$, $p = 0.03$) with a definite but small negative relationship existing between incendiary communication and adaptation. The magnitude of the relationship for the adolescent participants was moderate ($r = -0.52$, $p < 0.01$), indicating a substantial negative relationship between incendiary communication and adaptation. A negative correlation denotes that as one variable increases, the other decreases (Russell & Roberts, 2001). The negative correlation between Incendiary communication and the FACI8 therefore indicated that this style of communication worsened family adaptation.

The second subscale, Affirming communication, showed a positive correlation with the FACI8. The magnitude of the relationship for the adult participants was moderate ($r = 0.69$, $p < 0.01$) with a substantial relationship existing between affirming communication and adaptation. The magnitude of the relationship for this correlation for the adolescent participants was high ($r = 0.75$, $p < 0.01$), indicating a marked relationship between affirming communication and adaptation.

In order to observe the strength of the relationship between Family Problem Solving Communication and family adaptation, the researcher examined the total FPSC score. The magnitude of the relationship for this correlation for both the adults and the adolescents was moderate (adults: $r = 0.51$, $p < 0.01$; adolescents: $r = 0.68$, $p < 0.01$) indicating a substantial relationship between family problem solving communication generally and adaptation. This specified that problem solving communication was important for both adults and adolescents.

The magnitude and the significance of the correlation between family problem solving and communication for the adolescent participants were slightly more elevated than that for the adult participants. Reasons for the slight difference in correlation could be speculated. A possible reason for the greater importance placed on communication by the adolescents could be linked to their developmental stage. According to Erikson (1963), the primary task during the stage of identity versus role confusion is forming one’s identity (Craig, 1996). The conditions that foster the formation of one’s identity are stability, continuity and positive feedback. The conditions that hinder the formation of an adolescent’s identity are unclear feedback and unclear expectations (Craig, 1996). Positive feedback could be linked to affirming communication, while the latter conditions could be linked to incendiary communication. Because these conditions have been emphasized as having particular importance during this specific stage of development, one could speculate that this may be the reason that the adolescent participants have viewed communication as slightly more significant in family adaptation than the adult participants.
5.4.1.4 Social Support Index (SSI), Relative and Friend Support (RFS) and Family Time and Routine Index (FTRI)

There were two variables in which the adult and adolescent results differed. With these variables, the adults illustrated a significant negative correlation while the adolescents demonstrated a significant positive correlation with the FACI 8. These variables include social support (as measured by the SSI) and relative and friend support (as measured by the RFS).

The Social Support Index (SSI) is used to determine the degree to which families find support within their communities. Social support is an important resource when available to families in their development of resiliency. Social support links with the family resources component (BBB) of the Resiliency Model of Family Stress, Adjustment and Adaptation (McCubbin, Thompson & McCubbin, 2001). Literature indicates that the family’s internal resources, which help to determine the level of successful adaptation, include their sources of social support, i.e. extended family, neighbourhood, church, community and friends (McCubbin, Thompson & McCubbin, 2001).

The results of the SSI indicated a moderate negative correlation ($r = -0.64$, $p < 0.01$) for the adult participants, with a substantial relationship existing between social support and adaptation. The adolescents’ results indicated a moderate positive correlation ($r = 0.63$, $p < 0.01$) with a substantial relationship existing between social support and adaptation.

The Relative and Friend Support (RFS) scale measures the degree to which family members use relative and friend support as a coping strategy when dealing with stressors. This instrument taps into the family resources component (BB) of the Resiliency Model of Family Stress, Adjustment and Adaptation (McCubbin, Thompson & McCubbin, 2001). The results of the RFS indicated a low negative correlation ($r = -0.28$, $p = 0.03$) for the adult participants, with a small but definite relationship existing between relative and friend support and adaptation. The adolescents’ results indicated a low positive correlation ($r = 0.25$, $p = 0.04$) with a small but definite relationship existing between relative and friend support and adaptation.

For both these scales it can be suggested that many adults may feel that alcohol misuse is a sign of moral weakness and shame may prevent some individuals from seeking treatment. As discussed under the F-COPES section, society imposes stigma on addicted individuals and their families because many still believe that addiction is a character flaw or weakness that in all probability cannot be cured (Rosenbloom, 2007). This could contribute to the adults specifically feeling unable to approach those outside of the family network for support due to the awareness of the stigma toward alcohol misuse, especially when that adult is the misuser. However, the themes of social support and family support emerged from the adults’ qualitative data. This contradicts the information received from the quantitative data and could indicate that the alcohol misusers are possibly fairly selective with whom they choose to disclose certain information.
The Family Time and Routine Index (FTRI) was used to measure both the type of activities and routines families partake in, as well as the degree of importance which they place on these activities and routines. Literature has stated that family time and routines serve as a resiliency factor in aiding family adaptation (McCubbin, McCubbin, Thompson, Han & Allen, 1997). According to McCubbin et al. (2001), family time together and routines are reliable indices of family integration and stability. Family time and routines often help the family amidst a crisis to maintain a sense of stability and continuity. Spending time together and having routines helps the family system create a sense of predictability (McCubbin, McCubbin, Thompson, Han & Allen, 1997).

The FTRI links into the family type (T) component of the Resiliency Model of Family Stress, Adjustment and Adaptation. A family’s typology describes how the family unit usually behaves, in other words their established patterns of functioning. There are four typologies of patterns of functioning as described in detail in chapter 2 (Hawley, 2000). These are the regenerative typology, the versatile typology, the rhythmic typology, and the traditionalist typology.

The Cronbach alphas indicated that the FTRI did not reliably tap into this variable for the current sample. While the study was particularly aimed at families including an adolescent, a number of questions tapped into the activities of much younger children and their parents. This manner of questioning may not have been relevant to the specific sample required by this particular study. Nevertheless, as discussed previously, family activities emerged as a qualitative theme for the adolescent participants.

5.4.1.5 Summary of quantitative results

In conclusion and as demonstrated, a number of resiliency variables showed significant positive correlations with the FACI8 for both the adults and adolescents. These variables were family hardness (as measured by the FHI), the family’s ability to use resources and draw on strengths to cope in a crisis (as measured by the F-COPES) and the family’s ability to communicate affectively through a crisis (as measured by the FPSC).

The Family Crisis Oriented Personal Evaluation Scales (F-COPES) variable indicated a significant negative correlation with the FACI8 for both the adult and adolescent participants on the Social support and Spiritual and Religious support subscales. There were also two variables in which the adult and adolescent results differed. These variables included the degree to which families find support within their communities (as measured by the SSI) and the family’s ability to utilize relative and friend support (as measured by the RFS).

With the above variables, the adults illustrated a negative correlation while the adolescents demonstrated a positive correlation with the FACI8. Furthermore, as the FTRI did not reliably tap into this variable for the current sample, it was not included in any subsequent analyses.
5.4.2 Results of the regression analysis

A best-subtest regression analysis was conducted for both the adult and adolescent participants in the sample. It is important to note before interpreting the analysis that the sample size was large enough in order to meet the purposes of regression analysis. The results are presented in Tables 4 and 5. Firstly, the adults’ results of the regression analysis are interpreted, followed by an interpretation of the adolescents’ regression analysis.
Table 4. Adults’ results of the regression analysis

<table>
<thead>
<tr>
<th>Variables</th>
<th>B</th>
<th>SE B</th>
<th>B</th>
<th>p-level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Support Index (SSI) – total score</td>
<td>-0.21</td>
<td>0.08</td>
<td>-0.13</td>
<td>0.01</td>
</tr>
<tr>
<td>Family Crisis Oriented Personal Evaluation Scales (F-COPES) – Reframing</td>
<td>0.78</td>
<td>0.08</td>
<td>0.29</td>
<td>0.00</td>
</tr>
<tr>
<td>Family Crisis Oriented Personal Evaluation Scales (F-COPES) – Spirituality</td>
<td>0.30</td>
<td>0.09</td>
<td>0.09</td>
<td>0.00</td>
</tr>
<tr>
<td>Family Problem Solving Communication (FPSC) – total score</td>
<td>0.25</td>
<td>0.08</td>
<td>0.13</td>
<td>0.00</td>
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</table>

R² 0.79

The identified variables declared 79% (R² = 0.79) of the variance in FACI8 scores. The following variables were, according to the adults, the best predictors of family adaptation (FACI8):

a) Family Crisis Oriented Personal Evaluation Scales (F-COPES) – Reframing (family’s capability to redefine stressful events in order to make them more manageable);

b) Family Crisis Oriented Personal Evaluation Scales (F-COPES) – Spiritual and Religious support (family’s ability to acquire spiritual/religious support), and

c) Family Problem Solving Communication (FPSC) – total score (patterns of communication)
Table 5. Adolescents’ results of the regression analysis

<table>
<thead>
<tr>
<th>Variables</th>
<th>B</th>
<th>SE B</th>
<th>B</th>
<th>p-level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Crisis Oriented Personal Evaluation Scales (F-COPES) – Social</td>
<td>- 0.39</td>
<td>0.03</td>
<td>- 0.41</td>
<td>0.00</td>
</tr>
<tr>
<td>Family Problem Solving Communication (FPSC) – total score</td>
<td>0.80</td>
<td>0.03</td>
<td>0.75</td>
<td>0.00</td>
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<tr>
<td>R²</td>
<td>0.94</td>
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The identified variables declared 94% (R² = 0.94) of the variance in FACI8 scores. The Family Problem Solving Communication (FPSC) – total score (patterns of communication) was, according to the adolescents’ results, the best predictor of family adaptation (FACI8).

5.5 Integration of the qualitative and quantitative results

As the results of the qualitative and quantitative analyses have illustrated, the researcher observed four noteworthy aspects when integrating both the qualitative and quantitative data. The first observation was that there was a correlation between certain of the qualitative and quantitative results. The second observation was that new themes emerged in the qualitative data that were not tapped into via the structured questionnaires. The third and last observation was that certain themes emerged in the qualitative results, yet not in the quantitative results, despite a measure tapping into that theme. Table 6 is representative of this integration between the qualitative and quantitative results, depicting these three noteworthy aspects.
Table 6. Integration of the qualitative and quantitative results

<table>
<thead>
<tr>
<th>Adults</th>
<th>Qualitative themes</th>
<th>Quantitative themes</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>FHI</td>
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<tr>
<td>Family support</td>
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<td>Social support</td>
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<td>Being able to</td>
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<td>disclose their</td>
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<td>Counselling</td>
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<td>and</td>
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<td>commitment</td>
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<td>for the process</td>
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<td>and to sobriety</td>
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<tr>
<td>Prayer</td>
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<table>
<thead>
<tr>
<th>Adolescents</th>
<th>Qualitative themes</th>
<th>Quantitative themes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>FHI</td>
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<tr>
<td>Family activities</td>
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<td>The ability to</td>
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<td>offer their</td>
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<td>support to the</td>
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<td>parental member</td>
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<tr>
<td>Faith</td>
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<tr>
<td>Social support</td>
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<tr>
<td>Open communication</td>
<td></td>
<td></td>
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<tr>
<td>Forgiveness</td>
<td></td>
<td>†</td>
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</tbody>
</table>
### Key

<table>
<thead>
<tr>
<th>Positive correlations between qualitative and quantitative results</th>
<th>‡ ‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>Themes that emerged that were not tapped into via the structured questionnaires</td>
<td>†</td>
</tr>
<tr>
<td>Themes that emerged in qualitative results but not quantitative results (even though the measure tapped into this theme)</td>
<td>*</td>
</tr>
</tbody>
</table>

#### 5.6 Conclusion

The results, together with a discussion of these findings, were presented in this chapter. Firstly, the themes that emerged from the qualitative component of the study were illustrated and related to previously discussed literature. The results of the correlation and regression analyses were then discussed and, where possible, these results were explored and explained in relation to literature cited in earlier chapters. Following this, the qualitative and quantitative themes were weighed and compared with one another. The conclusions of the current study, its limitations and recommendations for future research are outlined in the following chapter.
6.1 Introduction

This chapter provides a summary of the conclusions that were reached based on the key findings of the current study. The limitations of the study as well as the value of the study are also discussed. The chapter is concluded with an outline of recommendations for future research.

6.2 Conclusions of the study

When discussing the conclusions of the results of the study, it is necessary to use the aim of the research as a departure point. This study aimed to identify, explore and describe the resiliency factors that enable families to adjust and adapt as a result of having a parental member in the family who misuses alcohol. This was done for both adults and adolescents within a family of this nature.

The results of the qualitative analysis contributed towards helping the researcher identify, explore and describe, from the participants’ perspectives, which factors helped them manage being part of a family of this demographic. There were numerous themes that emerged from the analysis for both adult and adolescent participants.

The themes that emerged from the adult participants’ qualitative responses included the following:

a) family support;
b) social support;
c) being able to disclose their status;
d) counselling and the commitment to the process and to sobriety, and
e) prayer.

Moreover, there were a number of themes that emerged from the adolescent participant’s responses as well. The themes that surfaced most frequently, and those which the adolescent participants viewed as the most important resiliency factors in helping them manage being a part of a family where alcohol is misused were the following:

a) family activities,
b) the ability to offer their support to the parental member;
c) faith;
d) social support;
e) open communication, and
f) forgiveness.
Structured questionnaires were used in order to yield results for the quantitative analysis of the sample. There were a number of resiliency variables that showed a significant positive correlation with the FACI8 for both the adults and adolescents. These variables were family hardiness (as measured by the FHI), the family’s ability to use resources and draw on strengths to cope in a crisis (as measured by the F-COPES) and the family’s ability to communicate affectively in a crisis (as measured by the FPSC).

The Family Crisis Oriented Personal Evaluation Scales (F-COPES) variable indicated a significant negative correlation with the FACI8 for both the adult and adolescent participants on the Social support and Spiritual and Religious support subscales. Furthermore, variables existed in which the adult and adolescent results differed. With these variables, the adults illustrated a negative correlation while the adolescents demonstrated a positive correlation with the FACI8. These variables included degree to which families find support within their communities (as measured by the SSI) and the family’s ability to utilize relative and friend support (as measured by the RFS).

According to the best-subset regression analyses, the variable that indicated the best predictors of family adaptation within the adolescent participants was the Family Problem Solving Communication (FPSC) variable. According to the best-subset regression analyses the adult participants illustrated a number of variables which were the best predictors for family adaptation. These included:

a) Social Support Index (SSI)

b) Family Crisis Oriented Personal Evaluation Scales (F-COPES)
   i) Reframing
   ii) Spiritual and religious support

c) Family Problem Solving Communication (FPSC)

The current research project has made a valuable contribution to general resiliency research in many ways. The following section is a discussion relating to the value of the research study.

6.3 Value of the research

The research conducted embraces the field of salutogenesis as described by Antonovsky (1987). By doing so it sought to investigate what allows families to move towards health with the recognition that a variety of factors influence health. More specifically, the present research contributes to the growing body of research focusing on family resilience. This perspective holds great value for the field of family psychology (De Haan, Hawley & Deal, 2002; Hawley & De Haan, 1996; Patterson, 2002a; Walsh, 2002; 2003). This positive approach views families with respect and recognises their resources and successes when faced with a crisis situation (Patterson,
With regard to families where a parental member is an alcohol misuser, the value of the change from a pathogenic model focusing on the negative impact that these parents might have on their children, to one where the focal point is on diversity of change and outcome is of paramount value (Keyes & Haidt, 2003; Compton, 2004). The study of resilient families holds promise for the conception of adequate and relevant family interventions (Hawley, 2000; Hawley & De Haan, 1996; Walsh, 2002). Research and support programs are progressing to an area where they are based on enhancing the parent-adolescent relationship and increasing wellbeing, resilience and protective factors in families (Ward & Snow, 2008). This research thus contributes towards what has previously been forecast as a developing focal area of study.

Knowledge about resiliency within a family context is restricted (McCubbin & McCubbin, 2001). As discussed in chapter three, with alcohol misuse distributing worldwide, there is value in understanding what contributes towards success and resilience of this particular family structure. The value of this research then is that it contributes towards describing what variables families of this nature employ in helping them manage being part of a family where a parental member misuses alcohol.

An additional contribution that this study has made is from a qualitative perspective. It has been noted that qualitative investigations are needed to compliment the study of resilient families (McCubbin & McCubbin, 2001; Patterson, 2002a). There has been a variance in research specifically surrounding the feelings and perceptions of children regarding their experiences in any family formation. Therefore, a supplementary value that this study has provided is that, through the qualitative component provided in the questionnaire battery, both the adult and adolescent participants were given the opportunity to convey their experiences and contributions as a result of being in a family where a parental member misuses alcohol.

A large amount of research exists with regards to alcohol misuse where the focus is on the adolescent as the alcohol misuser (Liddle, 2004; Liddle, et al., 2001; Lowman, 2004; O’Farrell & Fals-Stewart, 2003; Ouelette, Gerrard, Gibbons & Reis-Bergan, 1999; Perry, et al., 1996; Rowe & Liddle, 2006; Williams & Chang, 2000). Interventions based on this research are therefore aimed at and tailored for a family dynamic of this nature, rather than for families where a parental member is the alcohol misuser. Furthermore, as discussed in chapter three, it has been found that family relationships have a significant impact on alcohol misuse (Barnes & Windle, 1987; Bjarnason et al., 2003; Burnside, Baer, McLaughlin & Pokorny, 1986; Challier, Chau, Predine, Choquet & Legras, 2000; Hellandsjo Bu, Watten, Foxcroft, Ingebrigtsen & Relling, 2002; Miller, 1997; Persson, Hanson & Rastam, 1994), and that most children from these families are able to draw upon their inner strengths to cope with their circumstances and succeed in life (Vail-Smith & Knight, 1995). This study therefore holds value in a two-fold manner. Firstly, it contributes towards informing and
improving intervention and psycho-educational efforts aimed at families where a parental member misuses alcohol, and secondly, it looks at how these families come out of these crises and remain resilient. By revealing what resiliency variables were found by the participants in order to aid their adaptation, this study has contributed towards these efforts.

Due to the social stigma that has been placed on alcohol misuse treatment, many people may feel that alcohol misuse is a sign of moral weakness, and shame may prevent some from seeking treatment. Society imposes stigma on addicted individuals and their families because many still believe that addiction is a character flaw or weakness that in all probability cannot be cured (Rosenbloom, 2007). By studying families where a parental member misuses alcohol, the researcher hopes to have contributed in affirming these families’ effective functioning which may, consequently, aid their resilience. In addition, although the rate of alcoholism in adults is significantly high, there is a percentage of families that manage to function and sustain themselves. The value of this study therefore also lies in exploring what factors contribute to these families embracing the challenge of adapting and helping them remain resilient. This is congruent with the resiliency perspective that states that instead of focusing on how families have failed, we should focus on their ability to succeed by paying attention to their ability to survive and grow (Walsh, 1998).

While the current study holds numerous valuable contributions to research, there are also a number of limitations to this research that have been observed by the researcher. The following section is an examination of these limitations.

6.4 Limitations of the study

It is important to consider the various limitations associated with this research. No research project is without its limitations; there is no such thing as a perfectly designed study (Marshall & Rossman, 1999). As Patton notes, “There are no perfect research designs. There are always trade-offs” (1990, p. 162). A discussion of the study’s limitations demonstrates that the researcher understands this reality and that she will make no presumptuous claims about generalizability or conclusiveness relative to what she has learned (Marshall & Rossman, 1999). A discussion of these limitations reminds the reader what the study is and what the study is not, its boundaries, and how its results can and cannot contribute to understanding (Marshall & Rossman, 1999). The present study has certain limitations that need to be taken into account when considering the study and its contributions as it is bound and situated in a specific context (Marshall & Rossman, 1999).

The first limitation of the current research study relates to the research methodology. Non-probability sampling was used to collect the data required for this study. With purposive and snowball sampling, the sample was not randomly selected and was therefore not representative of
the general population. As a limitation of the current research, this therefore means that the results may not be generalized to the broad population of families where a parental member misuses alcohol.

Although the current research sample complied with the criteria to complete regression analysis, the sample is nevertheless unrepresentative of the various ethnicities throughout South Africa. The researcher made every attempt to include all ethnic groups in the study through various data gathering techniques by targeting diverse areas of South Africa. However, despite these attempts to include an ethnically representative sample, the relatively small sample size does not adequately represent the diverse ethnicities within the whole of South Africa.

Regarding the Family Time and Routines Index (FTRI), a limitation existed concerning the nature of a number of the questions. While the study was particularly aimed at families including an adolescent, a number of questions tapped into the activities of much younger children and their parents. This manner of questioning may not have been relevant to the specific sample required by this particular study.

Authors like Walsh (2002) have called for longitudinal family research since resilience could be viewed as a process that occurs and changes over time (De Haan, Hawley & Deal, 2002; Hawley, 2000). Although this type of research is recommended, conducting this type of research was not part of the aim of the current research. In line with the aim of the study, a single measurement of the families’ adjustment and adaptation was obtained and the measures were not re-administered.

Due to the nature of this research project being throughout South Africa, it was at times impossible for the researcher to be in attendance in person to hand out and administer tests batteries and protocols. This was witnessed significantly with the FTRI results where, due to the inability of the researcher to be present during a good number of the questionnaire administrations, the participants may have misunderstood the questioning and answered incorrectly. This therefore yielded results that were inconclusive as the Family Time and Routine Index (FTRI) appeared to have been unreliably measured due to the unacceptable Cronbach alphas.

Based on the various limitations of the study that have been discussed, recommendations for future research can be made. The focus of the following section now shifts to recommendations for future research.
6.5 Recommendations for future research

Firstly it is recommended that, should this study be replicated in the future, and even though the current research sample was adequate for the confines of this study, a larger representative sample be used so that the results can be generalized to the larger populations of families where a parental member misuses alcohol. A significant amount of literature cited in this study originates from international sources. This supports the researcher’s recommendation for further research in South Africa relevant to this particular family’s adaptation. It is further recommended that future studies in this area attempt to include a representative sample of each ethnic group in South Africa. This would contribute towards understanding the life of these families from the diverse ethnic backgrounds within South Africa.

It is recommended that future studies regarding families of this nature include longitudinal studies prior to alcohol misuse, especially as the process of research in the area of family resilience continues and progresses. The field of family resiliency research will at that stage no longer be so new, with sufficient time having lapsed for longitudinal studies to be successfully conducted (De Haan, Hawley & Deal, 2002). Longitudinal research is supported and encouraged by literature (Hawley & De Haan, 1996; Patterson, 2002a).

6.6 Conclusion

This study aimed to identify, explore and describe the resiliency factors that enable families to adjust and adapt as a result of having a parental member who misuses alcohol. This was completed for both adults and adolescents within a family of this nature. Although the results of this study cannot be generalized to the broader population of families where a parent misuses alcohol, there nevertheless exists valuable contributions that the current study has made to current available literature (Marshall & Rossman, 1999). This had been observed through the various positive correlations that were indicated between resiliency and adaptation in chapter 5. Participants also identified, from their own perspectives, resiliency variables which have helped them to adapt. As a result of this study, recommendations for future research have been made. On the whole, the results of this study contribute towards a growing body of research in the field of family resilience in South Africa.
REFERENCES


APPENDICES
Appendix A: Alcohol-Induced Disorders

1. Alcohol intoxication (303.00)
   A. Recent ingestion of alcohol.
   B. Clinically significant maladaptive behavioural or psychological changes (e.g., inappropriate sexual or aggressive behaviour, mood lability, impaired judgement, impaired social or occupational functioning that developed during, or shortly after, alcohol ingestion.
   C. One (or more) of the following signs, developing during, or shortly after, alcohol use:
      1) slurred speech
      2) incoordination
      3) unsteady gait
      4) nystagmus
      5) impaired attention or memory
      6) stupor or coma
   D. The symptoms are not due to general medical condition and are not better accounted for by another mental disorder.

2. Alcohol withdrawal (291.81)
   A. Cessation of (or reduction in) alcohol use that has been heavy and prolonged.
   B. Two (or more) of the following, developing within several hours to a few days after Criterion A:
      1) autonomic hyperactivity (e.g., sweating or pulse rate higher than 100).
      2) increased hand tremors
      3) insomnia
      4) nausea or vomiting
      5) transient visual, tactile, or auditory hallucinations or illusions
      6) psychomotor agitation
      7) anxiety
      8) grand mal seizures
   C. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
   D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.
3. Alcohol withdrawal delirium (Delirium tremens)

Delirium resulting from abstinence or marked reduction of severe alcohol intake.

A. Disturbance of consciousness due to withdrawal resulting in reduced awareness of environment, and reduced ability to focus, maintain or shift attention.

B. Cognitive defects such as disorientation, reduction in memory and language disturbance.

C. Perceptual disturbances not due to dementia:
   1) visual and tactile hallucinations (react to hallucinations or delusions as if they are genuine dangers)
   2) hallucinations influenced by suggestion
   3) delusions

D. Sensory disturbances caused by
   1) disorientation of time, place and person
   2) clouded consciousness

E. Other symptoms:
   1) autonomic hyperactivity
   2) palpitations, sweating, hypertension, fever, tachycardia etc.
   3) insomnia
   4) anxiety
   5) agitation
   6) unpredictable behaviour (can be a danger to themselves and others)
   7) fluctuating activity levels (hyper-excitability to lethargy)
   8) tremors of the hands, tongue and lips
   9) coated tongue and foul breath

F. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

G. Other information:
   1) symptoms usually last 3 to six days followed by deep sleep
   2) slight remorse
   3) often stop drinking for a few months

4. Alcohol-Induced Persisting Dementia

Dementia caused by chronic abuse of alcohol.

Dementia
• Multiple impairments of cognitive functioning, but no impairment in consciousness.
• Impairments so severe that they interfere with the person’s social and occupational functioning.
A. Impaired memory - Long term memory (inability to recall episodic or semantic memory) - Short term memory (inability to retain new information) - inability to learn new information or to recall previously learned material. Impairment of orientation can also result from the loss of memory - e.g. the person can go to the bathroom and then forget how to get back to the bedroom.
B. At least one of the following symptoms:
   1) aphasia
   2) apraxia
   3) agnosia
   4) disturbance in executive functioning
C. Dementia causes impairment and significant decline in social and occupational functioning.
D. Alcohol-Induced Persisting Dementia does not occur exclusively during substance intoxication or withdrawal.
E. There is evidence of long term alcohol abuse.

5. Alcohol Induced Persisting Amnesic Disorder (Korsakoff's syndrome)
   A. Irreversible memory deficits (mostly short term memory) caused by prolonged use of alcohol.
   B. Memory gaps (difficulty retrieving stored information)
   C. Confabulation as an attempt to hide memory defects.
   D. Distorted associations
   E. Inability to form new association (difficulty storing new information).
   F. Difficulty recognizing persons, places or objects.
   G. Memory defects cause significant occupational and social impairments.
   H. Due to long term abuse of alcohol (depletion of Thiamine/vitamin B12).
   I. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.
   J. Other symptoms:
      1) permanent brain damage in 80% of cases
      2) diminished intellectual functioning
3) confusion, ataxia & even delirium
4) blackouts common
5) cirrhosis of the liver
6) lack of restraint (lowered moral and ethical standards)
7) vulgar and coarse behaviour

6. Wernicke’s syndrome
   Similar to Korsakoff’s, but the symptoms are reversible.

7. Alcohol Induced Psychotic Disorder (ICD 10: F10.50-53)
   A. Prominent hallucinations and delusions occurring within one month of substance intoxication or withdrawal, due to long term abuse of alcohol.
   B. Mostly auditory hallucinations (voices accusing or threatening them, exposing weakness etc.).
   C. Hallucinations usually unstructured.
   D. Hallucinations usually last less than a week.
   E. Impaired contact with reality.
   F. Does not occur exclusively during delirium.
   G. Not better accounted for by psychosis (schizophrenia or delusional disorder) that is not substance induced.
   H. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

8. Alcohol induced mood disorder
   Mood disorder (depression, mania or mixed pattern) directly linked to chronic abuse of alcohol. Often follows either intoxication or withdrawal.

(American Psychological Association, 2000)
Appendix B: Facility cover letter

April 2008

Dear Sir/Madam

In line with the requirements for a Master’s degree in Counseling Psychology, it is necessary to complete a research treatise as part of my coursework. The title of my treatise is Resilience in families where a parent misuses alcohol. The aim of the research is to explore and describe the factors that facilitate the adjustment and adaptation in families after a member has been misusing alcohol for a period of time. I am therefore writing to you in order to be granted access to your facility.

In recent decades there has been a shift in psychology from looking at a person’s pathology to rather focusing on his/her strengths for development. Research on family adaptation and functioning where alcohol abuse is a factor has also shifted focus from what constitutes unhealthy and dysfunctional families to a positive orientation that identifies the characteristics of healthy, strong and successful families. Research at the University of Cape Town (2002) highlighted two needs of families with a relative who misuses alcohol, namely support and education. Support includes the family member being able to relay their experiences of living with a relative who misuses alcohol to a health professional who is empathetic, containing, respectful and sensitive. Education is viewed as knowledge that can be gained of how families could improve their functioning to be effective and constructive caregivers.

With the above in mind, the benefit and value for participants in this research is great, as further understanding of how to cope with day-to-day life for the participant and dependent, through understanding what ‘resiliency’ areas could be improved upon, will be gained. This in turn will allow for better management of the dependent’s condition and facilitate healthier family relations.

Each participant will receive an envelope with a number on it. This number will appear on each questionnaire and will enable the researcher to keep track of the questionnaires to ensure that all information remains organized. In the envelope will be a consent form, a biographical questionnaire
and seven other brief questionnaires relevant to the adjustment and adaptation of a family where a parent misuses alcohol. All documents will be provided in the participants’ home language (English/Afrikaans). The researcher will provide instructions for completing the questionnaires. The questionnaires will take approximately one hour to complete.

The participant will be asked to complete and sign a consent form and provide his/her surname and initials. His/her identity and that of his/her family will at all times remain confidential. Please note that this information is **strictly confidential. Only** the researcher may have access to this data. The researcher will at a later date provide your facility with the findings of her research.

In order for the research to be valid, the study requires the participation of 60 families with two members per family participating (the substance misuser and an immediate adolescent family member). The criteria for participants are as follows:

a) participants must be part of a nuclear family unit (living in the same household) where a parental member has been seeking treatment for alcohol misuse;

b) participants must have at least a Grade 8 level of proficiency in English or Afrikaans in order to fully comprehend the questionnaires;

c) adolescent participants must be between the ages of 13 and 18;

d) the alcohol misuser must be seeking at the most their third treatment intervention, and

e) the alcohol misuser can be receiving treatment on an outpatient and an inpatient basis.

Participation in this research is completely voluntary, and each participant has the right to withdraw at any given time. Once participants have completed all the questionnaires they will be returned to your facility from where they were obtained. The researcher will provide you, the coordinator, with a postage-paid envelope in which to post the data back to the researcher by a specific date.

In consideration of granting access, please note that this study undergoes strict evaluation by the Research Ethics Committee (Human) at the Nelson Mandela Metropolitan University (NMMU) in Port Elizabeth. You are free to contact the director of Research Management at 041 504 4536, or me at any time on 072 5966 234.

Your assistance is greatly appreciated.

Yours sincerely

____________________________________  _______________________
Ruth Fisher                     Ms Ottilia Brown-Baatjies
(Researcher)                       (Supervisor)
Prof Greg Howcroft  
(Co-supervisor)  

Prof Mark Watson  
(Head of Department)
Appendix C: Adult cover letter

April 2008

Dear Sir/Madam

In line with the requirements for a Master’s degree in Counseling Psychology, it is necessary to complete a research treatise as part of my coursework. The title of my treatise is *Resilience in families where a parent misuses alcohol*. The aim of the research is to explore and describe the factors that facilitate the adjustment and adaptation in families after a member has been misusing alcohol for a period of time. The benefit for you as a participant is to gain further understanding of how to cope with day-to-day life for you and your family through understanding what ‘resiliency’ areas could be improved upon. This would allow for better management of your condition and facilitate healthier family relations, if needs be.

If you decide to participate in this research, you will receive an envelope with an identifying number on it. This number will appear on each questionnaire and will enable the researcher to keep track of the questionnaires to ensure that all information remains organized. This will furthermore ensure confidentiality and your anonymity. In the envelope will be a consent form, a biographical questionnaire and seven other brief questionnaires relevant the research conducted. Instructions for completing the questionnaires will be provided. The questionnaires will take approximately one hour to complete.

You will be asked provide your surname and initials on the consent form. However, your identity and that of your family will at all times remain confidential, and only the researcher will be aware of this information.

Please indicate if you would like to receive general feedback by completing the relevant section in the biographical questionnaire. All responses to the questionnaires will be regarded as confidential. For this reason you are requested to answer the questions as honestly as possible. Once you have completed all the questionnaires, you are requested to place these questionnaires in the
envelope and return these to the alcohol rehabilitation society’s coordinator by ____________ 2008.

Your participation is greatly appreciated.

Yours sincerely

__________________________  __________________________
Ruth Fisher               Ms Ottilia Brown-Baatjies
(Researcher)               (Supervisor)

__________________________  __________________________
Prof Greg Howcroft        Prof Mark Watson
(Co-supervisor)            (Head of Department)
Appendix D: Adolescent cover letter

April 2008

Dear Sir/Madam

I am currently working towards a Masters degree in Counseling Psychology. In order to complete my degree, I need to conduct research. I have decided to focus on resilience where a parent misuses alcohol. This means I would like to find out what qualities and factors help families to remain strong despite facing the difficult process of having a parent who misuses alcohol.

With this in mind, I would like to ask for your help in this study by completing the enclosed questionnaires. Your responses will remain confidential, which means that your name will not be attached to any of your responses so no-one will be able to identify what you have written. It is also important to know that you can withdraw from this study at any time without consequences should you want to.

If you are under 18 years, a consent form, which outlines your rights as a participant in this study, has been given to your parent also taking part in this study and will be signed on your behalf should you be willing to participate. If you are 18 years, could you please sign this form and return it with your completed questionnaires.

Please show if you would like to receive feedback from this research by ticking the box in the biographical questionnaire. All of your answers to the questionnaires will be regarded as confidential. For this reason you are requested to answer the questions as honestly as possible. Once you have finished all the questionnaires, place these questionnaires in the envelope and return these to the alcohol rehabilitation society’s coordinator by ________________ 2008.

Your participation is greatly appreciated.
Yours sincerely

Ruth Fisher
(Researcher)

Ms Ottilia Brown-Baatjies
(Supervisor)

Prof Greg Howcroft
(Co-supervisor)

Prof Mark Watson
(Head of Department)
Appendix E: Participants’ Consent Form

NELSON MANDELA METROPOLITAN UNIVERSITY

INFORMATION AND INFORMED CONSENT FORM

(Please delete any information not applicable to your project and complete/expand as deemed appropriate.)

| Title of the research project | “Resilience in families where a parent abuses alcohol” |
| Reference number              |                                                         |
| Principal investigator        | Miss Ruth Fisher                                        |
| Address                       | NMMU Department of Psychology                           |
| Postal Code                   | PO Box 77000                                            |
| Contact telephone number      | 041 504 2330                                            |

A. DECLARATION BY OR ON BEHALF OF PARTICIPANT
(Person legally competent to give consent on behalf of the participant)

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A.1 I HEREBY CONFIRM AS FOLLOWS:

1. I, the participant, was invited to participate in the above-mentioned research project that is being undertaken by Miss Ruth Fisher of the Department of Psychology in the Faculty of Health Sciences of the Nelson Mandela Metropolitan University.

2. The following aspects have been explained to me, the participant:

   2.1 Aim: The researcher is studying resilience in families who have a member abusing alcohol. The information will be used to gain an understanding of the factors that contribute to families’ abilities to overcome the condition where an immediate family member abuses alcohol.

   2.2 Procedures: I understand that I will be provided with questionnaires that will take approximately one hour to complete and will receive general feedback regarding the results of the study after its completion.

   2.3 Risks: Will not remain anonymous to researcher and supervisors.
### 2.4 **Possible benefits:**
As a result of my participation in this study, more insight can be gained into the factors that make families living with a member who abuses alcohol, resilient. This information can be used in intervention programmes to offer families information and support.

### 2.5 **Confidentiality:**
My identity will not be revealed in any discussion, description or scientific publications by the investigators.

### 2.6 **Access to findings:**
Any new information/or benefit that develops during the course of the study will be shared as follows: The researcher will provide information in the form of a psychological report or feedback session to the participants.

### 2.7 **Voluntary participation/refusal/discontinuation:**

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<th>My participation is voluntary</th>
<th>YES</th>
<th>NO</th>
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| My decision whether or not to participate will in no way affect my present or future care/employment/lifestyle | TRUE | FALSE |

### 3. The information above was explained to me/the participant by

<table>
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<tr>
<th>Miss Ruth Fisher</th>
</tr>
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in

<table>
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<tr>
<th>Afrikaans</th>
<th>English</th>
<th>Xhosa</th>
<th>Other</th>
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and I am in command of this language/it was satisfactorily translated to me by

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<th>(name of translator)</th>
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I was given the opportunity to ask questions and all these questions were answered satisfactorily.

### 4. No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation.

### 5. Participation in this study will not result in any additional cost to myself.
A.2 I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT

<table>
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<tr>
<th>Signed/confirmed at</th>
<th>Signature of witness</th>
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Signature or right thumb print of participant

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<th>Full name of witness</th>
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B. STATEMENT BY OR ON BEHALF OF INVESTIGATOR(S)

I, Ruth Fisher, declare that

- I have explained the information given in this document to (name of patient/participant) and/or his/her representative (name of representative)

- he/she was encouraged and given ample time to ask me any questions;

- this conversation was conducted in **Afrikaans** English Xhosa Other

and no translator was used / this conversation was translated into (language) by

- I have detached Section D and handed it to the participant YES NO

Signed/confirmed at

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<th>Signature of witness</th>
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Signature of interviewer

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<th>Full name of witness</th>
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</table>
C. DECLARATION BY TRANSLATOR (When applicable)

I, [I.D. number]
Qualifications and/or
Current employment

confirm that I
- translated the contents of this document from English into (indicate the relevant language) to the participant/the participant’s representative;
- also translated the questions posed by (name) as well as the answers given by the investigator/representative; and
- conveyed a factually correct version of what was related to me.

Signed/confirmed at ______ on ______ 20

I hereby declare that all information acquired by me for the purposes of this study will be kept confidential

Signature or right thumb print of translator

Signature of witness

Full name of witness

D. IMPORTANT MESSAGE TO PATIENT/REPRESENTATIVE OF PARTICIPANT

Dear participant/representative of the participant

Thank you for your/the participant’s participation in this study. Should, at any time during the study:
- an emergency arise as a result of the research, or
- you require any further information with regard to the study, or
- the following occur

(indicate any circumstances which should be reported to the investigator)

Kindly contact Miss Ruth Fisher at telephone number 041 504 2330

(it must be a number where help will be available on a 24 hour basis, if the research project warrants it)
Appendix F: Adult biographical questionnaire

All information in this questionnaire is strictly confidential and your information will be anonymously processed. No one else will see this information.

Please complete the statement in the space provided, or cross ✗ the box □ most applicable to you.

1. Area of residence (town / city / suburb): ____________________________

2. Ethnicity: ____________________________

3. Number of years that you have been misusing alcohol:
   □ 1 – 2 years □ 3 – 5 years □ 6 – 9 years □ 10+ years

4. Number of times you have sought treatment: ______time(s).

5. Is there anyone else who lives permanently with you in your home?
   □ No
   □ Yes, please give details: ____________________________

6. What is your home language? □ English
   □ Afrikaans
   □ Other: ____________________________

7. What is your gender? □ Male □ Female

8. What is the highest level of education attained by yourself?
   □ Primary School (grade passed: _____)
   □ High School (grade passed: _____)
   □ Diploma □ Degree □ Other: ________

9. Are you employed?
   □ No
   □ Yes, please give job title: ____________________________

[Please Turn Over]
10. In your own words, what are the most important factors or strengths that help your family in dealing with your alcohol misuse?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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________________________________________________________________________
________________________________________________________________________

Your cooperation is greatly appreciated.

Please indicate if you would like to receive general feedback:
Yes □  No □
Appendix G: Adolescent biographical questionnaire

All information in this questionnaire is strictly confidential and your information will be privately and anonymously handled. No one else will see this information.

Please complete the statement in the space given, or cross ✗ the box ☐ most suitable to you.

1. Area of residence (town / city / suburb): ________________________________

2. Relationship of family member misusing alcohol to you (mother / father):

3. Number of years that family member has been abusing alcohol:

<table>
<thead>
<tr>
<th>1 – 2 years</th>
<th>3 – 5 years</th>
<th>6 – 9 years</th>
<th>10+ years</th>
</tr>
</thead>
</table>

4. What is your age? ___________ years

5. Is there anyone else who lives permanently with you in your home?
   
   ☐ No
   
   ☐ Yes, please give details: ________________________________

6. What is your home language?
   
   ☐ English
   
   ☐ Afrikaans
   
   ☐ Other: ________________________________

7. What is the highest level of education reached by yourself:
   
   ☐ High School (if so, grade you are in now: ________________________________)
   
   ☐ Diploma ☐ Degree ☐ Other: ________________________________

8. What is the highest level of education reached by your family member misusing alcohol:
   
   ☐ Primary School (grade passed: ___) ☐ High School (grade passed: ___)
   
   ☐ Diploma ☐ Degree ☐ Other: __________

[Please Turn Over]
9. In your own words, what are the most important factors or strengths that help your family in dealing with your family member and his/her alcohol misuse?

________________________________________________________________________________________
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Your cooperation is greatly appreciated.

Please indicate if you would like to receive general feedback:
Yes □ No □