Consultation of Thesis

Please sign this form to indicate that you have used this thesis in accordance with the *Access to Thesis* form signed by the author of this thesis.

<table>
<thead>
<tr>
<th>NAME (please print)</th>
<th>SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marine Cleghorn</td>
<td>Signature Redacted by Library</td>
<td>3/3/04</td>
</tr>
<tr>
<td></td>
<td>Signature Redacted by Library</td>
<td>9/9/04</td>
</tr>
</tbody>
</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DEAKIN UNIVERSITY
CANDIDATE DECLARATION

I certify that the thesis entitled:

The importance of assessing family dysfunction in conjunction with standardised measures when treating substance abuse

Submitted for the degree of Doctor of Psychology (Forensic), is the result of my own research, except where otherwise acknowledged, and that this thesis in whole or part has not been submitted for an award, including a higher degree, to any other university or institution.

Name: Irene Panagopoulos

Signature: [Redacted by Library]

Date: [Redacted by Library]
The Importance of Assessing Family Dysfunction in Conjunction with Standardised Measures When Treating Substance Abuse.

Irene Panagopoulos BBSc, Grad Dip Psych

This thesis is submitted in partial fulfilment of the requirements for the degree of Doctor of Psychology (Forensic)

School of Psychology
Faculty of Health and Behavioural Sciences
Deakin University (Burwood)
Melbourne, Australia

December, 2002
Abstract

In this thesis, the link between substance abuse and family dysfunction is examined, and an argument is made for the assessment of family dysfunction when treating clients with substance abuse issues. Family dysfunction has been associated with a broad range of problems in children (e.g., low self esteem, increased risk of child abuse) through to adolescence and adulthood (e.g., increased risk of mental disorders such as depressive disorders, substance abuse disorders, and personality disorders) (Kaplan & Sadock, 1998). It is not the purpose of this thesis to suggest that family dysfunction causes substance abuse but rather to highlight that family dysfunction can in some cases place the individual at greater risk of substance abuse. Therefore, in order to understand the reasons why substance abuse developed and how it is maintained in the present requires the assessment of family dysfunction. Further, the importance of assessing the role and impact that family dysfunction may have had on the client, may help to better understand the nature and extent of substance abuse so that relevant and appropriate treatment goals for change may be set, progress monitored, and risk of relapse reduced. Chapter 1 provides a brief introduction to this thesis, and Chapter 2 is a review of the literature on the impact of family dysfunction including poor parental attachment and supervision, neglect, physical and sexual abuse, in adolescence and adulthood. Four case studies are presented to illustrate how family dysfunction and substance abuse may be related, thus highlighting the importance of assessing family dysfunction when treating substance abuse clients. All of the case studies include an individual with a substance abuse disorder (namely heroin) but they are diverse in terms of the types and extent of family dysfunction. The final chapter discusses the case studies in relation to the literature reviewed. Lastly, it gives consideration to the implication of a history of family dysfunction, and how it may impact negatively on treatment and therefore prognosis.
ACKNOWLEDGEMENTS

Thank you to Jane McGillivray for her support and supervision of this thesis.

I would also like to thank my placement agencies for providing me with an opportunity to develop my skills as a practitioner, and in particular my placement supervisors. Your guidance, support, and words of encouragement throughout my placements were invaluable.

Thank you.
# List of Contents

**CHAPTER 1: INTRODUCTION** ........................................... 1

**CHAPTER 2: FAMILY DYSFUNCTION AND SUBSTANCE ABUSE** ........................................... 3

The Association Between Family Dysfunction and Delinquent Behavior, Including Substance Abuse, in Adolescence ........................................... 3

Structural Factors ........................................... 3

*Broken Versus Unbroken (Intact) Homes* ........................................... 3

*Family Size* ........................................... 4

Functional Factors ........................................... 4

*Parental Attachment* ........................................... 5

*Parental Supervision And Discipline Style* ........................................... 6

*Summary* ........................................... 6

Impact Of Family Dysfunction On Adult Adjustment ........................................... 7

Why is it Important to Assess for Family Dysfunction When Treating Substance Abuse? ........................................... 9

Chapter Overview ........................................... 10

**CASE STUDIES** ........................................... 11

*Heroin* ........................................... 11

**CHAPTER 3: THE CASE OF MAX** ........................................... 13

Referral and Presenting Problem ........................................... 13

Background History and Personal Information ........................................... 13

*Family History* ........................................... 13

*Educational History* ........................................... 14

*Employment History* ........................................... 14

*Substance Use History* ........................................... 14

*Criminal History* ........................................... 15

*Social and Relationship History* ........................................... 15

*Psychiatric/Medical History* ........................................... 15
CHAPTER 4: THE CASE OF KATE........................................21

Referral and Presenting Problem........................................21

Background History and Personal Information..........................21

  Family History.........................................................21
  Educational History..................................................22
  Employment History..................................................22
  Substance Use History...............................................22
  Criminal History.....................................................22
  Social and Relationship History.....................................23
  Psychiatric/Medical History..........................................23
  Psychiatric Diagnosis................................................23

Assessment........................................................................23

  Test Behaviour..........................................................23
  Self Image.......................................................................23
  Beck Depression Inventory II..........................................24
  General Health Questionnaire-28.....................................24
  Generalized Self Efficacy Scale.......................................24
  Multidimensional Health Locus of Control Scale..................24
  Minnesota Multiphasic Personality Inventory 2....................25
  Summary and Recommendations.......................................25

Discussion.........................................................................26
CHAPTER 5: THE CASE OF JOHN........................................28
Referral and Presenting Problem.......................................28
Background History and Personal Information......................28
  Family History..................................................28
  Educational History...........................................29
  Employment History...........................................29
  Substance Use History.......................................29
  Criminal History................................................29
  Social and Relationship History.................................29
  Medical History.................................................30
  Psychiatric History...........................................30
  Psychiatric Diagnosis..........................................30
Assessment...................................................................30
  Test Behaviour...................................................30
  Self Image..........................................................31
  Beck Depression Inventory II.................................31
  General Health Questionnaire-28...............................31
  Generalized Self Efficacy Scale.................................31
  Multidimensional Health Locus of Control Scale..............31
  Minnesota Multiphasic Personality Inventory 2...............31
  Summary and Recommendations.................................33
Discussion..................................................................33

CHAPTER 6: THE CASE OF TOM........................................36
Referral and Presenting Problem.......................................36
Background History and Personal Information......................36
  Family History..................................................36
  Educational History...........................................37
  Employment History...........................................37
  Substance Use History.......................................37
  Criminal History................................................38
  Social and Relationship History.................................38
  Medical History.................................................38
  Psychiatric History...........................................38
  Psychiatric Diagnosis..........................................38
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>39</td>
</tr>
<tr>
<td>Test Behaviour</td>
<td>39</td>
</tr>
<tr>
<td>Self Image</td>
<td>39</td>
</tr>
<tr>
<td>Beck Depression Inventory II</td>
<td>39</td>
</tr>
<tr>
<td>General Health Questionnaire-28</td>
<td>39</td>
</tr>
<tr>
<td>Generalized Self Efficacy Scale</td>
<td>40</td>
</tr>
<tr>
<td>Multidimensional Health Locus of Control Scale</td>
<td>40</td>
</tr>
<tr>
<td>Minnesota Multiphasic Personality Inventory 2</td>
<td>40</td>
</tr>
<tr>
<td>Summary and Recommendations</td>
<td>41</td>
</tr>
<tr>
<td>Discussion</td>
<td>42</td>
</tr>
<tr>
<td><strong>CHAPTER 7: FINAL DISCUSSION</strong></td>
<td>44</td>
</tr>
<tr>
<td>Structural Factors within Family Dysfunction</td>
<td>44</td>
</tr>
<tr>
<td>Functional Factors within Family Dysfunction</td>
<td>45</td>
</tr>
<tr>
<td>Conclusions and Implications</td>
<td>46</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>48</td>
</tr>
</tbody>
</table>
CHAPTER 1: INTRODUCTION

The Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) defines the essential feature of substance abuse as being ‘‘...a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.” (APA, 1994, p. 182). In Australia, the lifetime use of illicit substances is on the increase. According to the NDS (National Drug Strategy, 1998) tranquillisers/sleeping pills and ecstasy both doubled in the preceding three-year period from 3%-6% and from 2%-5% respectively. Further, amphetamine use increased by over 50% and heroin and cocaine also increased but at lower levels. Perhaps of even greater concern, is that the proportion of Australians aged 14 years or older who had injected illicit drugs, almost doubled. Thus, not only has the consumption of illicit drugs increased but more dangerous patterns of administration of substances (i.e., injecting) have also increased. Substance abuse has serious implications for the individual, their family, and the broader community, therefore increased prevalence places greater need for continued efforts to enhance the efficacy of the assessment and treatment of substance abuse disorders. One factor that may enhance the efficacy of treatment is the assessment of family functioning, in particular, assessing for evidence of family dysfunction.

Family dysfunction has been defined as the assignment of roles to children without regard to the children’s needs or characteristics (Black, 1981). The literature on children of alcoholics for example, has identified both positive and negative roles that can diminish or heighten the impact of family dysfunction. The positive roles include the ‘hero’ identified by overachievement, controlling, and perfectionist characteristics, and the ‘mascot’ who is humorous, mischievous, and attention seeking. The negative roles include the ‘lost child’ who is characterised as a loner, shy, ignored, and sensitive, and the ‘scapegoat’ who is rebellious, angry, acting out/delinquent, and troublesome (Black 1981; Wegscheider, 1981). Family dysfunction has also been characterised by a range of factors such as poor parental attachment, supervision and discipline style, broken homes (e.g., step-families and single-parent families), family conflict, parental substance abuse, and physical and sexual abuse within the family system (Heck & Walsh, 2000; Hoffmann & Johnson, 1998; Rosen, 1985).
Family dysfunction is particularly important because it has been implicated in a number of psychological disorders such as substance abuse, poor adult adjustment, depression, anxiety, and suicidal behaviour (Gunnell, 2000; Harter, 2000; Martin, 1996; Roesler & Dafler, 1993). The following chapter will define the different types of family dysfunction, which generally fall under the rubric of familial structural factors and functional factors. This will be followed by a review of the literature on the association between family dysfunction and substance abuse in adolescence and adulthood. In particular, the literature on delinquency in conjunction with substance abuse during adolescence will be reviewed, given the relatively small contribution of studies examining the link between family dysfunction and substance abuse among adolescents specifically.

Finally, one aspect of family dysfunction that is particularly prevalent in cases of substance abuse is the presence of childhood sexual abuse. Childhood sexual abuse will be discussed in the context of additional factors often present in the history of substance abuse clients. In particular, research demonstrating the correlative relationships between childhood sexual abuse and substance abuse will be reviewed. A discussion on the implications of assessing family dysfunction for the treatment of substance abuse will be provided, in particular how this can improve treatment outcome. This will be followed by four case studies, which demonstrate how in some cases, family dysfunction and substance abuse are related, highlighting the importance of assessing family functioning in collaboration with standardised measures, when treating substance abuse. The final chapter will provide a discussion of the four case studies in relation to the empirical research.
CHAPTER 2: FAMILY DYSFUNCTION AND SUBSTANCE ABUSE

In the last century, researchers have begun to look to the family in an attempt to identify which family dynamics might be implicated in adult psychopathologies such as substance abuse. The types of family dysfunction examined have been categorised into structural or functional factors. The structural perspective focuses on factors such as family size, broken versus intact families, birth order, and parental absence (Rosen, 1985). Alternatively, the functional perspective focuses on parental attachment, degree of marital happiness, parental supervision and style of discipline. It is important to note that both perspectives are not entirely mutually exclusive as it is recognised that familial structure necessitates some functional consequences (e.g., larger families result in less supervision over the children's behaviours) (Clark, Barrett & Kolvin, 2000; Rosen, 1985). The following section will examine literature on the role of family dysfunction, familial structure and functions, in adolescents and adults. In adolescents, juvenile delinquency has been linked to substance abuse therefore delinquency and substance abuse will also be reviewed (e.g., Heaven & Virgen, 2001; Loeber, 1996), given that few studies have investigated the relationship between family dysfunction and substance abuse in adolescents.

The Association Between Family Dysfunction and Delinquent Behaviour, Including Substance Abuse, in Adolescence

Structural Factors

Several structural factors have been identified in the literature. The two most predominant: broken versus unbroken (intact) homes and family size will be addressed.

Broken Versus Unbroken (Intact) Homes

Early studies investigating delinquency and the family predominantly found that delinquent boys were more likely to come from broken homes or homes with serious and persistent problems (Power, Ashe, Schoenberg, & Sirey, 1974), mother-only households (Dornbusch et al, 1985) and mother/stepfather homes (Johnson, 1986). Further, broken homes have been found to be more highly associated with 'family' type offences, such as running away and truancy, than with other types of juvenile
delinquency (Rankin, 1983). In a recent study, Heck and Walsh (2000) explored the influence of maltreatment on serious violent and property delinquents as well as on minor misbehaviour offences among 388 white male delinquents. After controlling for type of family structure, verbal IQ, family size, and birth order, maltreatment was found to be a significant indicator of juvenile delinquency. Furthermore, it was found that delinquents who came from broken homes (by desertion) were the most maltreated and the most delinquent.

*Family Size*

Early studies demonstrated the predictive impact of large families on delinquency (Fischer, 1984; Sampson & Laub, 1993). Several reasons may account for this relationship, for example, as the number of children increase, parental supervision and amount of parental attention may decrease. Furthermore, overcrowding in households with large families can result in frustration, irritation, and conflict between family members (Farrington, 1996). More recent research indicates that whilst large family size can contribute to juvenile delinquency it is not a robust factor and that other factors are implicated in this relationship. For example, other risk factors generally present, include harsh discipline, poor supervision, high impulsiveness, and it appears that although some are more direct in their influence than others, large family size is often present (Farrington & Loeber, 2000).

Thus, it would appear that the two most researched structural familial factors, although often present are not always directly related to the development of juvenile delinquency. One reason for this is that so long as the nature of the parent-child relationship is secure than the impact of a broken home or large family size is diminished (Thomas, Stelly, Kerner, & Weitekamp, 1998). Thus, it would seem that the impact of structural factors is more indirect in that they underlie the more direct influence of functional family factors. The following section looks at functional family factors and what the literature has revealed in terms of its role in the development of juvenile delinquent behaviours such as engaging in substance abuse.

*Functional Factors*

The types of functional or family interaction variables most commonly investigated in the literature are parental attachment, supervision, and discipline style. These are discussed separately below.
Parental Attachment

Attachment has been found to be an important predictor of non-delinquency as it facilitates parental supervision and discipline. It has also been suggested that children who are attached to their parents will refrain from acts that may jeopardise their relationship. Children who are concerned about their parents' opinion of them will refrain from illegal acts in particular, as this can entail additional embarrassment and inconvenience to parents (Hirschi, 1995). Recent research by Vitaro, Brendgen, and Tremblay (2000) has explored the way in which the joint influence of parental attachment and parental monitoring moderates the influence of a deviant peer group on delinquency, in a sample of 567 boys aged 13-14. Personal (i.e., attitude toward delinquency) and social (i.e., characteristics of other friends) categories were also examined as possible moderator variables. As expected, deviancy in a best friend significantly predicted adolescents' subsequent delinquent behavior. However, there was a significant interaction between deviancy in a best friend and parental attachment and monitoring. In adolescents who had high levels of parental attachment and monitoring, the influence of deviant friends was reduced (Vitaro et al, 2000).

Parental attachment has also been examined as a possible mediator between parental alcoholism, family dysfunction, and interpersonal distress. Motherseed, Kivlighan, and Wynkoop (1998), administered questionnaires to 152 undergraduate students, to assess this relationship. Whilst parental alcoholism was not a significant predictor of attachment to parents or interpersonal distress, the mediating role of parental attachment was evident when family dysfunction was examined. Thus, as the level of family dysfunction increased, participants reported less parental attachment, and more interpersonal distress.

Parental style has also been found to have an impact on delinquent behaviours during adolescence. For example, Palmer and Hollin (2001) found that a parental style that is perceived to be warm, involved and inductive was associated with lower levels of juvenile delinquency (offenses committed in the past year) in adolescence. In a sample of 94 high school students, the relationship between perceived parenting, sociomoral reasoning (e.g., importance of keeping a promise to a friend), and self-reported delinquency was examined. Self-reported delinquency was higher among
adolescents who perceived a parental style characterised by physical punishment. Thus, it would appear that parental attachment plays a significant role in terms of the child’s perception of the parent-child relationship in buffering or reducing the likelihood of juvenile delinquency. Indeed, previous research has found similar patterns where attachment to parents has been found to reduce the severity of juvenile delinquency (Anderson, Holmes, & Ostresh, 1999).

Parental Supervision and Discipline Style
It has been suggested that parental supervision facilitates proper socialisation and in turn, prevents against the development of juvenile delinquency. For example, children who have regulatory rules such as being home by a certain hour, and who must account for their whereabouts, are less likely than others to be delinquents (Hirschi, 1995). Indeed, early research has shown that one of the best predictors of juvenile delinquency was found to be adequacy of supervision by the mother (Glueck & Glueck, 1950). A related factor to parental supervision is neglect which focuses on measures of supervision and amount of interaction between parent and child. Neglect is considered to be relatively common, highly criminogenic, and a major factor in juvenile delinquency, as neglected children are more likely to become juvenile delinquents (Hirschi, 1995). For example, Heaven and Virgen (2001) found that perceptions of a punitive discipline style were related to delinquency (smoking cigarettes, alcohol use, interpersonal violence, and theft/vandalism) in their sample of 110 adolescent boys aged 12-15. Indeed, recent research indicates a predisposition to crime and deviance among youth that are maltreated, including severe childhood punishment and psychological abuse (Klevens, Restrepo, Roca, & Martinez, 2000; Preski & Shelton, 2001).

Summary
The structural familial and functional factors in conjunction with resulting psychosocial concerns (e.g., socioeconomic deprivation, peer, school, and community influences) can all impact on the developmental continuity of the young child. Loeber (1996) has highlighted three aspects of the developmental continuity of ‘delinquency’, which include developmental sequences in problem behaviour, the persistence of problem behaviour, and catalysts for the continuity of problem behaviours. The developmental sequences in problem behaviour refer to the
different manifestations of the problems displayed in childhood to adulthood. For example, temper, swearing, and running away in childhood through to substance abuse, vandalism, fire-setting, and assault in adolescence. The persistence of problem behaviours pertains to those behaviours that are relatively stable over time. For example, in relation to the development of juvenile delinquency it is significant that externalising behaviours tend to have higher stability over time than internalising behaviours (Rutter, 1982). Finally, Loeber (1996) proposes that certain behaviours function as catalysts (e.g., hyperactivity, substance use) in that other problematic behaviours are likely to persist when such catalysts are present. These aspects of the developmental continuity of ‘delinquency’ are likely to be perpetuated and reciprocally influenced by psychosocial concerns such as socioeconomic deprivation, low academic achievement, peer, school, and community influences, and future employment opportunities. In addition to these outcomes, the following section examines the role of family dysfunction in adult psychopathology, namely, substance abuse.

Impact of Family Dysfunction on Substance Abuse
Retrospective studies of adults with substance abuse disorders have highlighted the role of family dysfunction, and particularly the impact of childhood neglect, physical, and sexual abuse. In particular, childhood sexual abuse has been conceptualised as "...a non-specific risk factor for a wide range of adverse psychological and social adult outcomes." (Romans, Martin, & Mullen, 1997, p. 327). The common presence of childhood abuse among adults with substance abuse issues, is also relevant as childhood abuse in many instances occurs in the context of family dysfunction. For example, a history of childhood sexual abuse in particular, has been of focus in the literature. Roesler and Dafler (1993) interviewed 44 individuals with a history of childhood sexual abuse, 65.9% of who met DSM-II-R criteria for lifetime prevalence of drug or alcohol abuse or dependence. Further, childhood risk factors predicted those survivors who used substances coming from more chaotic home environments (e.g., paternal violence, parental neglect, and incest).

Similarly, in a survey of 1,099 US women, the experience of childhood sexual abuse was significantly linked to higher incidences of drug and alcohol abuse, sexual
dysfunction, and depression. Further, childhood sexual abuse was most strongly related to illicit drug use, with more than one third of the respondents reporting lifetime use of one or more illegal drugs (Wilsnack, Vogeltanz, Klassen, & Harris, 1997). Neumann and Housekamp’s (1996) meta-analytic review of 38 studies examining the relationship between childhood sexual abuse and psychological problems in women, found significant associations between history of childhood sexual abuse and adult symptomatology, across all symptoms. These symptoms included substance abuse, posttraumatic stress responses, and other types of psychopathology (e.g., anxiety, depression, self-mutilation, etc).

A history of sexual trauma has also been linked to the abuse of substances. In a recent study, Young and Boyd (2000) compared African American women who smoke crack cocaine with and without a history of sexual trauma using an interview format. Despite the fact that both groups did not differ on the number of substances used, women with a history of sexual trauma reported being addicted to more substances than women who had not been sexually traumatised. Furthermore, the duration of sexual trauma was positively related to the number of drugs to which the women reported being addicted. This suggests that sexual trauma that continues to occur over a long period of time can have more damaging effects (Young & Boyd, 2000).

It is important to note that there is debate in the literature as to whether the association between childhood abuse and substance use is causal and what the role of family dysfunction is in this equation. For example, it has been found that families characterised by parental adjustment problems, parent-child relationship problems, and parental conflict place their children at greater risk of childhood sexual abuse (Mannarino & Cohen, 1986). Furthermore, it is possible that family dysfunction rather than the effects of the abuse per se, can lead to poor adult adjustment and psychopathology (e.g., substance abuse). For example, some studies have shown that adult adjustment problems (previously identified as being strongly related to childhood sexual abuse) are not statistically related to childhood sexual abuse when the variance associated with family environment has been accounted for (Fromuth, 1986; Higgins & McCabe, 1998). These types of findings highlight the importance of the family environment particularly in the event of adverse experiences such as childhood sexual abuse.
Why is it Important to Assess For Family Dysfunction When Treating Substance Abuse?

Given that previous research indicates that a relationship exists between family dysfunction and substance abuse, treatment programs should routinely assess for family dysfunction. Assessing for the presence of family dysfunction can help to understand the background factors that may have facilitated the development of substance abuse, and how these factors may or may not be maintained in the present. More importantly, failure to address family dysfunction issues (i.e., abuse and neglect) that contribute to the repetition of maladaptive behaviours such as substance abuse, allows for the continuation of such behaviours, increasing the likelihood of relapse. For example, substance abuse may be used as a form of coping with the aftermath of severe family dysfunction. Thus, building self-esteem through skills training, and teaching coping strategies to deal with stress, may help to counter some of the effects on one’s self-esteem and identity that can result from family dysfunction, such as the modelling of maladaptive behaviours (Schwartz & Liddle, 2001; Young & Boyd, 2000).

Some research has demonstrated the importance of assessing and treating childhood abuse (sexual abuse) as a relevant issue in the treatment of substance abuse. Rosenhow, Corbett, and Devine (1988) found a higher occurrence of early relapse in individuals failing to disclose past sexual abuse, in a sample of adults receiving individual therapy for substance abuse. These authors highlighted the role of sexual abuse in perpetuating substance abuse, and the importance of identifying and treating such issues. Similarly, Chiavaroli (1992) found a higher rate of relative success across several categories of treatment for those who dealt with issues of sexual abuse, based on the treatment files of 20 patients in a substance abuse rehabilitation facility. The categories of treatment related to improvements in the following areas: self-esteem, support systems, personal growth (communication), and a reduction in feelings of guilt, self-destructive behaviours, victim-behaviour, and dysfunctional relationships. Whilst both of these studies relate to childhood sexual abuse, dysfunctional families have been found to place children at greater risk of sexual abuse (Mannarino & Cohen, 1986), suggesting that in some cases childhood sexual abuse occurs in the context of a dysfunctional family. Therefore, the findings of Chiavaroli (1992) and Rosenhow et al (1988), may lend support to the importance of
assessing family dysfunction to facilitate more positive treatment outcomes when treating substance abuse. Thus, a more thorough assessment of family dysfunction, could allow for a more complete treatment plan, and in turn reduce the potential for relapse.

Chapter Overview

Overall, it appears that family dysfunction can play a role in the development of substance abuse in adolescence (in the context of delinquency) and in some instances, into adulthood. Further, the degree of family dysfunction in the family of origin and type of family dysfunction (e.g., broken home, poor parental attachment, supervision, etc), can play a lesser or greater role in poor adult adjustment. Functional factors such as parental attachment, discipline style, parental monitoring and supervision, appear to have a greater degree of impact. Furthermore, there is some support for the assessment and treatment of family dysfunction in the context of substance abuse, in relation to reducing the potential for relapse.
CASE STUDIES

The following four chapters outline four case studies of young adults with substance abuse issues, all of who reported family dysfunction to varying degrees. The purpose of this is to highlight that in some cases family dysfunction and substance abuse are related, and the importance of assessing family dysfunction to inform treatment. These cases will be followed with a discussion on the relationship between family dysfunction and substance abuse in relation to the literature reviewed above. The aim of the four case studies is to highlight a range of both structural and functional factors in the context of family dysfunction and how these relate to substance abuse. Each case study provides a detailed personal history and background of the client, including a range of assessments. This information was obtained in a clinical interview and using a range of psychometric tests. The case studies are of three males and one female, all of who presented for rehabilitative treatment for heroin addiction. Before presenting the case studies, a brief description of heroin and its unique effects will be provided. This is important because all of the case studies are heroin users, and some understanding of the unique effects of this substance may help to provide some context and a further understanding of each case. Each case study has been altered with regards to any identifyng information in order to maintain the anonymity of the clients.

Heroin

Heroin (diacetylmorphine) is an opioid (opiates constitute the subclass of opioids which are alkaloids extracted from opium) that has a plasma half-life of 0.5 hr but has a 4-5 hr duration of action. Heroin acts most rapidly when used intravenously, and some of the effects of heroin intoxication include: euphoria immediately after initial ingestion, a dramatic decrease in anxiety or tension, and often a sudden burst of energy within a few minutes post ingestion. Apathy and “nodding”, a state between alertness and sleep generally follow this initial euphoria. Physiological effects include miosis (constricted pupils), slow and regular respirations, slurred speech, hypoactive bowel sounds, and impaired judgement, attention, concentration, and memory (Kaplan & Sadock, 1998; McCrady & Epstein, 1999; Thomason & Dilts, 1991). Chronic effects include symptoms of dependence and withdrawal, and heroin abuse has also been linked to crime, disease, poverty and loss of personal and
social productivity, often requiring long-term treatment and intense psychosocial interventions (McCrady & Epstein, 1999). However, the primary life-threatening effect of heroin use is respiratory depression (a reduction in the responsiveness of brain stem respiratory centers to carbon dioxide), which can result in fatal overdose. Indeed heroin overdose is becoming an increasing health issue for example, in Australia, one study found heroin to be the most common cause of accidental illicit drug overdose over a 20-month period, as identified by 3559 autopsies (Garrick, Sheedy, Abernethy, Hodda, & Harper, 2000). Loss of tolerance, concomitant use of alcohol and other central nervous system depressants, and systemic disease (i.e., liver and lung disease) can also increase one's susceptibility to heroin overdose (Warner-Smith, Darke, Lynskey, & Hall, 2001).
CHAPTER 3: THE CASE OF MAX

Referral and Presenting Problem
Max is a 25 year-old man who self-referred for residential rehabilitation treatment for heroin addiction. Max stated that he began using LSD and amphetamines before using heroin at 18 years of age, injecting up to one gram per day. He stated that he now needs to make changes in his life and would like to learn how to remain abstinent and gain a deeper understanding of the issues behind his drug use.

Background History and Personal Information

Family History
Max is an only child, whose parents divorced when he was 2 years of age, after which Max resided with his father. He has one half-sister on his father’s side and stated that he does not know why his parents divorced or why he resided with his father. Max recalled having very little contact with his mother, who he visited approximately twice a year up until he was 18 years old.

At approximately 6 years of age, Max stated that he became aware of a significant change in his father’s behaviour. Previously his father who was very health conscious, gradually began to drink alcohol and smoke cigarettes on a regular basis. According to Max, this change in his father’s behaviour impacted on their lifestyle, as from this time onwards he resided between his father’s home and his paternal grandparents’ home. When Max was eight years old his father remarried and one year later Max’s half-sister was born. However, approximately two years later, when Max was aged 10, his father and stepmother separated.

Max stated that when he was 15 years of age, his father became ill and was told that he had approximately two weeks to live. According to Max, four weeks later his father died from “drug and alcohol-related problems”, after which Max moved interstate to reside with his mother, stepfather, and stepsister. Max stated that shortly after arriving at his mother’s home, he self-harmed (self-laceration) and was consequently found unconscious. Soon after this incident, Max returned to his home State, after which he maintained minimal contact with his mother. For several weeks following this incident, Max reported that he drank a bottle of spirits on a daily basis.
Max spent the next two years residing with relatives and friends, and at age 17 left school after learning that his best friend had committed suicide. Max stated that he was just beginning to come to terms with his father’s death and that when he learned of his best friend’s death, felt that he could no longer cope with school. It was at this time that Max began to engage in heavy drug use, using up to 7 grams of speed intravenously, per day.

At age 18, Max was drugged and raped by an acquaintance. This incident was the beginning of an abusive relationship where Max would engage in violent sexual encounters, in exchange for drugs, money, and shelter. This stopped when Max relocated. Max reported that he has not told anyone about these experiences.

**Educational History**

Max attended approximately six different primary schools as he stated that his father relocated a number of times. He completed year 10 and left school just prior to completing year 11. He described himself as a very average student who moved between being a loner and mixing with the popular group. Max also stated that he was bullied for being overweight and because of ‘personality clashes’, and went on to describe an incident where he assaulted a student who was subsequently hospitalised.

**Employment History**

Since the age of 18 Max has had a number of jobs, which has either been in the hospitality or art industries. He has held a couple of art exhibitions and also has a TAFE diploma in art studies. In between jobs Max has been on unemployment benefits intermittently since the age of 15.

**Substance Use History**

Max began smoking cigarettes at age 11 (shortly after his father and step-mother separated) and at age 15-16 (approximately around the time when his father died), began to experiment with alcohol, mushrooms, and LSD, stating that he has had up to 400 ‘trips’. At age 17 (when Max left school after hearing of friend’s suicide) he began to use speed intravenously and reported using up to 7 grams per day. He also stated that at age 18 he began using ecstasy (up to 300 tablets), prescription drugs (up to 50 tablets a day) and heroin, injecting up to one gram per day.
Criminal History
Max faced approximately 10 charges when he was 18 years old, which were predominantly related to drink driving and high-speed pursuits. He received an 18-month license suspension and $4000 in fines. He is currently on a 12-month good behaviour bond for theft and has no previous convictions.

Social and Relationship History
Max has been involved in three significant relationships. All three of the women he was involved with were aware of his drug use, two of which engaged in drug use, namely alcohol and speed, with Max. Max stated that he is still in a relationship however their relationship is currently on hold whilst she is overseas. Several years after the death of his father, Max had sexual intercourse with his stepmother after a visit that involved drinking to the point of intoxication. Max stated that he has never told anyone about this incident as he feels guilty, ashamed, and angry towards his stepmother.

Psychiatric/Medical History
At approximately six years of age, Max recalled undergoing hypnotherapy for missing his mother and bedwetting.
In the past, Max has unsuccessfully attempted several home detoxification as well as hospital detoxification programs.

Psychiatric Diagnosis
Max has received a diagnosis for Dependent Personality Disorder.

Assessment
Test Behaviour
Max was softly spoken and maintained good eye contact other than when speaking about being sexually assaulted and the nature of his relationship with the perpetrator. He displayed some avoidance of responsibility for his actions with regards to the ramifications of his assault on a peer at school. Max commented that the teachers did not punish him because the assault was justified given the other student's constant bullying toward Max. There also appeared to be considerable denial of his
feelings, which was suggested by his tendency to intellectualise, using emotive terms without appearing to be experiencing the actual emotion, or affect he was describing.

Self-Image
Max reported that as a child he spent a lot of time alone due to his father’s constant work-related travelling, and that he was quiet and shy. He further stated that he enjoyed activities that he could do on his own like drawing, which he preferred over group activities. He did not think of himself as different from other teenagers. He described himself as artistic, sensitive, and passionate, and when asked what he liked about himself, he answered “everything”. However, he did comment that although his sensitivity did preclude him from being a ‘macho’ male, it did make him vulnerable in that he could become easily upset about seemingly unimportant matters.
Max believes his strengths to be his capacity to be diplomatic and a good mediator. He believes his morals come from his father and grandparents, and also from various religions, which he has read about. When alone he enjoys writing and drawing which he feels is an escape.

Beck Depression Inventory II (BDI-II)
(Raw score = 4)
Max’s BDI indicates that he is currently experiencing minimal depression, which appears to be predominantly due to feelings of disappointment in himself.

General Health Questionnaire-28 (GHQ-28)
Max’s GHQ-28 indicates that he is in reasonably good health other than the experience of some somatic symptoms (headaches) which he reported is a result of not wearing prescription glasses.

Generalized Self Efficacy Scale
(Raw score = 39/40)
Max has a very high confidence in his ability to cope and take care of himself.

Multidimensional Health Locus of Control Scale
Max has a much stronger sense of internal control over his health (F=31) than in his health being determined by chance (C=15) and even less confidence in the control health professionals have over his health (P=7).

*Minnesota Multiphasic Personality Inventory 2 (MMPI-2)*
(Code: 5638491720)
Max’s profile is valid with an LFK configuration (43, 58, and 39 respectively) indicating that he may be attempting to create a pathological picture of himself and that there is also a willingness to acknowledge a typical number of unusual experiences. There is also indication of a plea for help and inadequate defenses as he is acknowledging his limited resources for dealing with his problems.

Max’s 5/6 profile is uncommon and indicative of an individual who is aloof, abrasive, morally self-righteous, and perceives themselves in a positive manner on most dimensions, including being liked by others. Indeed when asked what his strengths were Max’s first response was “everything” after which he provided a number of admirable qualities including his ability to make friends easily. He is currently experiencing interpersonal difficulties, which may be related to his sexuality (Mf = 78, Pa = 75). Max rejects culturally stereotypic male values such as the ‘macho’ male image, which he reported in his interview, and tends to be very nurturing and emotionally involved in his relationships. He is artistic, socially perceptive, sensitive, curious, and suppressing (Mf = 78). Max’s profile also indicates that he feels mistreated, resentful, somewhat overly sensitive, self-dissatisfied and projective, which is in part driven by a self-perception that he is special and different from other people (Pa = 75, Pa2 = 76). These are thoughts and emotions that were expressed when exploring the relationship with his mother.

It is likely that Max is experiencing significant psychological distress despite his efforts to deny and repress problems. He is concerned that he may be ‘losing his mind’ as he has had very strange and peculiar experiences, dreams, and thoughts that he believes are best kept to himself (Hy = 66, Sc = 65). Max reported that he has experienced premonitions, which are mostly around negative events and generally come true. Further he stated that he wishes he did not have this ‘psychic power’ or strange abilities. He also spoke of peculiar dreams or stories that come into his mind, one of which was highly violent and sadistic in nature, stating that he could never
carry out such thoughts in real life. It is also highly probable that Max is experiencing anxiety attacks, which are sometimes channelled into either phobias or acting out (Hy = 66, Sc = 65, Pd = 62). This is consistent with his reporting of panic attacks and anxiety for which he has received treatment in the past. Finally, Max has much anger that he has difficulty expressing until he can feel that he is fully justified in doing so (ANG = 70, Pa = 75).

Treatment History
Max has received extensive short-term therapy for his drug use, and for grief issues. He has also undertaken family therapy with his mother and grandparents. His longest experience of treatment was for approximately six months where he was treated by a psychiatrist for depression, anxiety, and panic attacks. Max reported that he has been prescribed anti-anxiety and antidepressant drugs in the past. He was not taking any prescription medication at the time of the assessment.

Summary and Recommendations
There are indications of considerable anxiety in the form of panic attacks and some depression in Max's history. These may be related to feelings of abandonment in his childhood, and unresolved grief surrounding his father and best friend's death in his mid-teens. His experience of being sexually assaulted and the continuation of an abusive relationship with the perpetrator is also a source of trauma and shame for Max. Given his history of anxiety and panic attacks, addressing these issues will require a gradual and supportive therapeutic environment so as not to overwhelm him. There are also strong narcissistic elements in his personality. Overall, a supportive and structured orientation is likely to be most productive. It is also recommended that therapy be reality-focused so that he feels less overwhelmed by his problems (Greene, 2000).

Discussion
It would appear that Max has been deprived of a stable upbringing for several reasons related to his family environment. First, although it is impossible to decipher the strength of the attachment that was formed between Max and his mother prior to the divorce, it seems that Max's reports of bedwetting and crying may have been due to the loss of his mother (who left the family home) and the subsequent lack of contact with her. It also appears that the lack of contact and emotional support that
followed his parent’s divorce has had a significant impact on Max and the nature of his relationship with mother. Indeed, Max stated that he feels abandoned by his mother. He also stated that he feels a mixture of anger, resentment, and love towards her, the latter of which he reports never experiencing in return. Although he feels close to his grandmother, it would seem that his fragmented periods of living with her were not long enough to consolidate a ‘mother-child’ attachment with her. Despite the absence of maternal attachment, it seems that Max did develop some attachment to his father.

There is also lack of clarity around Max’s description of the nature of the changes that took place regarding his father’s lifestyle, which included heavy alcohol and substance abuse. Given the young age at which Max reported these changes to have taken place (approximately six years old), it is likely that there were other contributing factors of which he may not have been aware. Nonetheless, it appears that his father’s substance abuse did impact on his ability to parent Max and to provide a stable family environment. This lack of stability appears to be related to the recurring pattern of Max running away to his grandparents and returning to his father.

Max’s report of his father being an alcoholic is noteworthy given the empirical literature on adult children of alcoholics and the impact this can have on adult adjustment. In a recent review of this literature, Harter (2000) concluded that adult children of alcoholics “…appear to be at risk for a variety of negative outcomes, including substance abuse, antisocial or undercontrolled behaviors, depressive symptoms, anxiety disorders, low self-esteem, difficulties in family relationships, generalised distress and maladjustment.” (p. 311). It was also suggested however, that these outcomes are not uniformly observed or specific to adult children of alcoholics, but that comorbid parental pathology, childhood abuse, family dysfunction, and other childhood stressors could also contribute to or produce similar outcomes (Harter, 2000). In Max’s case whilst it is impossible to identify which factor/s contributed to his substance abuse and depressive and anxiety disorders, there were several of the above factors present, placing him in a more vulnerable position with regards to an outcome of poor adult adjustment.
Clearly, the somewhat sudden death of Max's father was a significant trauma resulting in several changes to Max's life, identity, and sense of family. Max emphasised several times that his father was not only a loving parent, but also provided a friendship that was unconditional and secure. This death resulted in the loss of his primary attachment figure, a loss of family structure, and marked the beginning of Max's heavier drug use. Indeed, the death of a parent has been associated with later emotional problems, in particular susceptibility to depression and divorce (Kaplan & Saddock, 1998). The lack of attachment and emotional support from his mother prevented him from becoming a part of her new family. With regards to his stepmother, it appears that there was no secure attachment established, which was probably due to the relatively short duration of the marriage. However, the isolated sexual encounter with his stepmother several years after his father's death is another example of Max's inability to form appropriate attachments.

Overall, the above case highlights the importance of assessing family dysfunction given the extent of dysfunction in Max's life beginning very early in his life, and the impact this has had on his adjustment as a young adult. The purpose of exploring these types of family structures and relationships, is to demonstrate the significance of family dysfunction with regards to the impact it can have on one's sense of self, being a part of a family system that is emotionally supportive, and understanding substance abuse issues. Given the large degree of both functional and structural family dysfunction evident in Max's family of origin, in line with Chiavaroli (1992) and Rosenhow et al (1988) these factors would need to be addressed and worked through in his treatment. This could serve to reduce his grief and anxiety around his father's death and the sexual encounter with his stepmother, the poor relationship with his mother, and his experience of being sexually assaulted, and in turn, reduce the likelihood of relapse.
CHAPTER 4: THE CASE OF KATE

Referral and Presenting Problem
Kate is 27 years of age and self-referred for residential rehabilitation, as a result of several failed attempts to abstain from heroin use. Kate stated that she both wants and needs to be in treatment in order to fulfil her long-term goal of completing her tertiary studies.

Background History and Personal Information

Family History
Kate grew up in a rural area with her mother ('Jan') and stepfather ('John') and younger sister ('Sara'). Jan divorced Kate's biological father when Kate was aged 3 because of his infidelities and apparent mental instability. Kate predominantly grew up on farms and often moved around, changing schools several times. Kate stated that she loves John as a father and described him as fair, hard, very strict, and noted that she was his favourite. In contrast to this, Kate felt that her mother did not love her nor want her. She based this assessment on her perception that her mother was more lenient, supportive and affectionate toward her younger sister Sara. Kate also stated that she feels somewhat resentful about being the first child.

During her childhood, Kate had limited contact with her biological father, which was predominantly by telephone. She stated that contact was always unpleasant, as he would often speak of Kate's mother in a derogatory manner. He would also make promises around his intention to parent Kate and raise her, but never followed through with these promises. Kate stated that these “intense” interactions would leave her feeling very confused and hurt. She subsequently withdrew from social contact, and for approximately one month afterwards would not speak unless spoken to. Eventually, Kate ceased all contact with her biological father. When reflecting on the nature of her relationship with her biological father, Kate commented that she feared for her life as he had arrived at Kate's house on several occasions with a weapon, threatening to kill the entire family. Kate feels that this was the result of his apparent psychiatric condition.

At approximately 14 years of age, Kate’s family relocated to the city, where she became heavily involved with sports. Soon after, Kate sustained a serious leg injury,
disabling her from participating in any sport for a year. During this time, Kate reported that she became depressed and engaged in self-harming behaviours (self-laceration), which she attributed to teenage blues and low self esteem. She stated that her self-harming coincided with phone calls from her biological father, who continued to be critical of her mother and stepfather. Kate stated that these calls placed enormous emotional strain on her at the time.

When Kate was 23 years of age, her sister was killed in an automobile accident. Kate stated that she still feels anger and acknowledges that, despite receiving some grief and family counselling, she has not fully dealt with the loss of her sister. This death was the precursor to Kate beginning to use heroin.

**Educational History**
Kate attended approximately five primary schools and approximately four secondary schools. At school Kate stated that she was often teased and that she was seen as different because of her alternative style of dress. Kate completed school and entered university, and plans to return to university in order to complete her degree.

**Employment History**
Kate's first job was at age 15 where she performed light administrative duties and continued to do this type of work until her early twenties. Kate has also completed a TAFE certificate and is approximately half way through a tertiary degree.

**Substance Use History**
At age 13 Kate began using alcohol, cigarettes, and cannabis, the latter of which she has continued to use intermittently. By age 17 she began experimenting with LSD and believes she has taken up to 100 trips. She also experimented with prescription morphine tablets and speed, and by age 26 reported injecting up to 4 grams of speed per day. Kate first began using heroin at age 21 and reported using up to half a cap ($50) on a daily basis.

**Criminal History**
Kate has only one charge that she received for careless driving, for which she received a fine.
Social and Relationship History
Kate stated that she has always found it easy to make friends and able to maintain friendships. Kate has had two significant relationships. The first relationship lasted several months and involved some drug use. The second relationship lasted several years and Kate feels that she sacrificed more of her needs (e.g., deferring from university to work and help support her partner with his tertiary studies) than her partner did. They used heroin intermittently throughout the relationship, which ended after he disclosed his infidelity.

Medical History
Kate has been on a methadone program for six months, which she is gradually reducing. She reported that she is currently on 20mg of methadone.

Psychiatric History
At age 16, Kate requested that she see a psychiatrist who treated her for depression intermittently over the next two years. Kate reported that this is the only time she has seen a psychiatrist or accessed any other type of counselling.

Psychiatric Diagnosis
Kate has a current diagnosis of Dependent Personality Disorder.

Assessment

Test Behaviour
Kate presented as neatly dressed, and seemed to be very open throughout the interview. At times she questioned the amount of detail requested, and throughout the interview there was a noticeable effort on her part to present herself as a well-adjusted individual, by portraying herself in a positive light when describing her past and present behaviours.

Self-Image
As a girl Kate described herself as being independent, curious, and very attached to her parents and grandparents. She enjoyed riding horses, and playing games with her sister. Despite her descriptions of being different at school she did not think of
herself as different from other teenagers because she had friends that were like her. She now describes herself as open, caring, sensitive, and having a good sense of humour. When asked what it was that she liked about herself Kate responded “all of it, all the good things and all the bad things”. Inconsistent with this statement, Kate went on to state that in particular, she dislikes her drug addiction and her propensity to be emotionally dependent on significant others. She believes her strengths are her determination and that although she can fit in, she’s not afraid to be different. Kate stated that her morals come from her family, education, and through observation. She does not find it difficult or be on her own where she can read, write in her journal, sit and daydream and assess herself.

**Beck Depression Inventory II (BDI-II)**
(Raw score = 3)
Kate’s BDI indicates that she is experiencing minimal depression, although she reports some feelings of sadness, guilt, and self-dislike.

**General Health Questionnaire-28 (GHQ-28)**
Kate’s GHQ-28 suggests that she is in reasonably good health, although she is experiencing some somatic symptoms such as headaches and feeling run down.

**Generalized Self Efficacy Scale**
(Raw score=31/40)
Kate has a strong sense of confidence in her ability to cope and take care of herself.

**Multidimensional Health Locus of Control Scale**
Kate has a very strong sense of internal control over her health (I=34), relative to her beliefs about her health being determined by chance (C=13), or by health professionals (P=15).

**Minnesota Multiphasic Personality Inventory 2 (MMPI-2)**
(Code: 4 36° 97 12850)
Kate’s profile is valid with a LFK configuration (62, 48, and 59 respectively) indicating that she is attempting to avoid or deny unacceptable feelings, impulses, and problems, presenting herself in the best possible light. Although there is no
acknowledgement of distress, there is a willingness to acknowledge a typical number of unusual experiences, however there appears to be a tendency to resort to denial mechanisms such as an unwillingness to seek help for her problems.

Kate’s overall profile is relatively flat as all clinical sales fall within or below the normal range. This corresponds with her lack of acknowledgment of currently experiencing any distress. She may also be protecting herself emotionally for fear of being disappointed and is more likely to turn to her own resources when dealing with problems. She may be responding to situational conflicts or may have adjusted to a habitual level of interpersonal conflict and social conflict (Pd=58). However, she reports feeling very comfortable in social situations which is due to a lack of concern about what others think about her (Pd3=59). Anger may be a problem for Kate in that she is unaware of it ‘building up’ and expresses it by being verbally cutting and sarcastic. This was demonstrated to some degree when describing her sister.

Kate’s profile is also indicative of women who are hostile and angry, but unable to express these feelings in a direct manner, choosing to repress or inhibit such feelings (A=48, R=60). As a result they may resort to irritating other people into attacking or retaliating and then revel over how badly they have been mistreated, denying all responsibility. There is also a propensity for being excessively demanding, dependent, and a strong need for affection (Pd=58, Mf=40, Pa=56, Hy2=63). Kate’s profile further indicates that she attempts to deny or rationalise her feelings of anger and hostility, which is frequently directed toward family members in an indirect passive manner. There was also indication of somatic complaints, tension, and chronic family and interpersonal problems, however, Kate attributed her somatic complaints to her methadone withdrawal (Hy=56, Pa=56).

**Summary and Recommendations**

The most striking feature of Kate was her attempts to repress or inhibit any awareness of her problems by portraying herself as a well-adjusted individual. This characteristic was also evident in her MMPI2 profile, and has serious implications for the potential effectiveness of any therapeutic intervention. Until she is prepared to genuinely acknowledge some of the feelings she has repressed or denied, therapy is unlikely to facilitate any significant changes. Therapy will be difficult until she is
able to deal with the core issues and refrain from intellectualising her problems, which also serves to detract from exploration on a deeper level. Perhaps short-term behavioural interventions that focus on her reasons for entering treatment would be beneficial.

Discussion
One important feature of Kate’s family environment is her insecure attachment to her mother, whom she felt did not love her nor want her. It seems that these feelings have been perpetuated by her perception that her sister Sara received more love and attention from their mother. This appeared significant for Kate and may be the predominant source of her anger and resentment. Furthermore, she has been unable to express her feelings of anger and hostility toward her mother and biological father in a direct manner, choosing to repress or inhibit such feelings. This experience in conjunction with an unstable family structure (i.e., the numerous schools Kate attended as a result of her parents relocating), may also have contributed to Kate’s feelings of insecurity within the family environment. However, to some extent her stepfather seems to have mediated the impact of these circumstances, as she described him as loving and as being his favourite.

Kate’s relationship with her biological father is also significant, particularly her reports of not speaking unless spoken to for weeks after visiting him. She was also able to clearly recall her sense of fear as a child despite not understanding the source of that fear until she was older and informed by her mother of his behaviours. Kate’s report of her depressive episode following her knee injury and the self-harm that took place during her biological father’s temporary contact is also noteworthy. Some research has identified an association between antisocial behaviours such as substance abuse and self-harm in young females (aged 15-16 years) (Patton et al, 1997). However, further, investigation would be required before any conclusions could be made as to the relationship between Kate’s self-harming behaviours and her subsequent substance abuse.

Overall, this case illustrates the importance of assessing the family environment, given that Kate’s relationships with her family members are significant in terms of her previous experiences. In particular, assessing for family dysfunction will allow
for the development of treatment goals that are relevant to her substance abuse
disorder and may even require that the issues pertaining to her family dysfunction be
addressed before her substance abuse issues. Further, she reported no other
significant trauma during her childhood, however, the impact of her depression and
self-harm in her mid-teens, and the loss of her sister cannot be underestimated,
particularly in terms of understanding her substance abuse issues.
CHAPTER 5: THE CASE OF JOHN

Referral and Presenting Problem
John is a 26 year-old man who self-referred for residential rehabilitation treatment for heroin addiction, as a result of pressure from family to engage in treatment. This is his first experience of residential treatment and he stated that despite his initial motivation being family-driven, he is now here for himself.

Background History and Personal Information

*Family History*
John is the youngest of three, with an older brother (aged 28) and sister (aged 31). His mother is aged in her fifties, and his father passed away when John was 19 years of age. John described his family as close and loving, and stated that his father was very supportive and very strict, and that they were particularly close. When describing his mother, John stated that she too was supportive and loving, but also a mediator between him and his father. According to John both his parents showed much affection towards him and his siblings, and towards each other. John stated that he was somewhat close with his siblings but that their relationships had been strained because of his drug use. Both of his siblings do not use drugs and work full time.

In contrast to his earlier reports, John stated that during his early teenage years, there was much violence between him and his father. In his earlier years John stated that when fighting with his brother, he would always be disciplined because he was identified as the instigator. When asked why, he stated that this was probably because of his substantially larger body frame in comparison to his brother, who was a smaller build. The source of these conflicts was usually due to John’s drug use and him returning home drug affected. John described several altercations between him and his father, some of which resulted in his father being hospitalised. John also commented that up until age 16 he was scared of his father, after which time his father feared him. John also provided one example of his father disciplining him, by forcing John to kneel on grains of rice for up to one hour at a time.

John reported that his father had suffered with chronic pain for some years and that as a result, had become addicted to morphine which he administered intravenously.
From his early teens John would administer his father's medication, when his father was experiencing severe pain. According to John, this was kept secret and no one outside of the family was made aware of his father's addiction. It was not possible to ascertain exactly what caused his father's death as John became highly distressed when speaking about his father.

*Educational History*
John left school just prior to completing his final year in order to gain employment to support his drug habit. In primary school he described himself as being very naughty, starting fights, and stealing, which continued into his secondary schooling. In secondary school John engaged in several fights, truancy, and drug use.

*Employment History*
John has worked in a variety of jobs as an unskilled tradesman, his longest term of employment being five years.

*Substance use History*
John began smoking cannabis at age 12, after which he began drinking alcohol, binge drinking on the weekends. By age 15, John began injecting speed and in his early 20s began to abuse prescription medication. Not long after this, John began to use heroin on a daily basis.

*Criminal History*
John began to engage in criminal behaviour during his early adolescence, for which he received good behaviour bonds. In recent years he has continued to engage in crime in order to support his drug habit which has resulted in several orders and one prison term.

*Social and Relationship History*
John has experienced three significant relationships. All three partners were unaware of John's drug use which he concealed as these women did not engage in any drug use. John also reported experiencing some confusion regarding his sexual identity, but was clear about not wanting to explore this in more detail.
Medical History
John stated that at approximately seven years of age he was diagnosed with Attention Deficit Disorder and that he was placed on medication. He also stated that according to his mother this treatment was brief, as the medication appeared to exacerbate his symptoms. In recent years, John has undergone detoxification for cannabis and amphetamine abuse in his early twenties. However, he was unable to remain abstinent, relapsing shortly after treatment on both occasions.

Psychiatric History
John stated that during his late teens he engaged in self-mutilating behaviours on several occasions (body piercing and self-laceration and mutilation), and that he has made several serious attempts at suicide by overdose. These attempts were accompanied by hallucinations for which John was placed on anti-psychotic and anti-depressant medication after hospitalisation. However, John abused this medication whilst continuing to use amphetamines and heroin.

Psychiatric Diagnosis
John received a diagnosis of Mixed Personality Disorder, with borderline features.

Assessment

Test Behaviour
John presented to the interview neatly dressed, and had several tattoos and body piercings. He displayed a range of emotions throughout the interview, crying when he spoke about the loss of his father and pets, however his overall affect was flat and he often appeared drowsy. He became hostile when asked to explore the ambiguity surrounding his sexuality only to later raise this topic without prompting. He was able to express himself clearly, and was fidgety and restless for most of the interview, constantly moving around in his chair. At times he was quite child-like becoming embarrassed when asked to discuss his intimate relationships and sexual history.
**Self-Image**

As a child, John describes himself as having too much energy and always getting into trouble. Growing up he felt different from his peers because of this. He enjoyed spending time with his relatives, particularly his grandparents, who he still feels close to. Initially he found it difficult to identify positive attributes about himself, but did acknowledge his patience and ability to interact easily with people. He dislikes that he is quick tempered, shy at times, and can be a bit paranoid.

**Beck Depression Inventory II (BDI-II)**

(Raw score = 30)

John's BDI-II score indicates severe depression, which appears to be predominantly driven by feelings of agitation and irritability, loss of interest, pessimism, self-dislike and criticalness, and feelings of punishment and past failure. He is also experiencing changes in his sleep patterns, sleeping a lot less than usual.

**General Health Questionnaire-28 (GHQ-28)**

John's GHQ-28 indicates that he is currently in a poor state of health, experiencing elevations in his somatic symptoms, anxiety and insomnia, his ability to function socially, and severe depression.

**Generalized Self Efficacy Scale**

(Raw score = 25/40)

John has moderate confidence in his ability to cope and take care of himself.

**Multidimensional Health Locus of Control Scale**

He has a strong sense of internal control over his health (I=28) and a slightly lesser belief in is health being determined by chance (C=20). John has almost no confidence in the control health professionals have over his health (I=1), which is consistent with the statements he made in the interview with regards to doctors in general.

**Minnesota Multiphasic Personality Inventory 2 (MMPI-2)**

(Code: 86 47 190235)

Although John's profile is technically invalid with an LFK configuration (48, 120, and 33 respectively) suggesting that he has greatly exaggerated his problems, it
appears that he is genuinely suffering from severe anxiety and is requesting help in acknowledging that he has few coping resources of his own.

John's overall profile is extremely elevated which is relative to the level of distress he reported at the time of the assessment. His profile suggests that he is currently feeling isolated, alienated from his environment, misunderstood, secretive, impulsive, and experiencing a great deal of generalised anxiety. He is also likely to be going through an identity crisis and in response to acute stress will withdraw into daydreams and fantasy, finding it difficult to separate reality from fantasy (Sc=98). Indeed John spoke of his ability to "zone out" when alone, allowing him to detach from his anxiety and stress. There was also indication that he could be hallucinating and John did report having experienced auditory hallucinations in the form of other people talking (although he was unable to understand what they were saying), and his father calling his name in the same tone that he would use before disciplining John. He has experienced these hallucinations a couple of times since entering treatment. It would appear that these experiences are primarily driven by changes in the perception of himself such as feelings of depersonalisation and estrangement (Sc6=120), not being in control of his impulses (Sc5=89), and experiencing autonomous thought processes in the form of strange and puzzling ideas over which he believes he has no form of control (Sc3=90).

John's profile also indicates that he harbours much anger, resentment, hostility, and suspicion, and that he commonly uses projection as a defense mechanism (Pa=97). Whilst he did endorse many items pertaining to feelings of persecution it would appear that these feelings are not imagined but rather, very real for John who stated that due to conflict with ex-partners in crime, they now wish to harm him. Conversely, his strong persecutory ideas are also indicative of his propensity to externalise blame for his problems, frustrations, and failures, and also projecting responsibility for his negative feelings (Pa1=94).

John also has a tendency to 'bend the rules', engaging in repeated patterns of acting out, as evidenced by his extensive criminal and substance abuse history, and whilst remorseful about acting out, this has been insufficient in deterring him from repeating such patterns (Pd=87, Pt=85). It is also clear that he is lacking confidence
in his own ability to deal with his emotional distress and anxiety (Es=30, PK=105, PS=104).

Summary and Recommendations
John is currently experiencing a significant degree of anxiety and depression which he is struggling to cope with. He has few internal coping resources and is currently in a state of crisis, and feels unsure of who he is. He also has a tendency to project his emotions which are often accompanied by explosivity and impulsivity, both of which are characteristic of John's behaviour. It would seem that all of these defenses work to protect him from his severe anxiety and possibly unresolved conflict.

The level of self-harm that John has engaged in for some time is of concern, given that he currently continues to self-harm through piercing his body. It would appear that these behaviours are in response to overwhelming internal anxiety in conjunction with his lack of internal coping resources. Helping John to access his feeling states of how it is for him when he is about to self-harm, and using cognitive strategies to teach him to dissuade himself, may reduce his current level of self-harm.

It is suggested that a central goal of therapy should be to concentrate on establishing trust and providing support, as John finds it difficult to trust people in general. Once this is established he may be more forthcoming about his previous experiences. It will also be helpful to provide him with new adaptive behaviours and strategies that he can employ independently as a means of coping with his anxiety and providing him with a sense of empowerment over his thought processes. John also needs assistance with expressing his anger in an appropriate and self-modulated way.

Discussion
Any interpretations or conclusions can only be made with caution given that John's MMPI-2 was invalid. This is consistent with his reports of a loving and well-adjusted family, which seemed inconsistent with the level of violence and his father's style of discipline, which was abusive and punitive. It was clear however, that John harbours significant anger and hostility which has only been expressed in the form of violent, almost lethal outbursts of rage, over which he claims to have had little control. It might be that given the depth and magnitude of John's hostility and anger,
he has experienced more than he was willing to discuss in the assessment, particularly in relation to his family relationships. However, one can only speculate on such matters.

Some of John’s hostility and anger may be related to his reports of being the ‘scapegoat’ or always identified as the instigator of fights between him and his brother. This may be significant, as the impact of assignment of roles in a family has been shown to heighten the impact of a dysfunctional family. In a study of 674 college students, Fischer and Wampler (1994) reported that the scapegoat and lost child role were associated with alcohol abuse outcomes. John has been a polydrug user, and he has engaged in alcohol abuse during his early teens. On the basis of the findings of Fischer and Wampler (1994), John’s perception of his role in the family may be linked to his substance abuse.

It also seems that John’s family relationships and experiences have impacted on his adult relationships. For example, most of John’s relationships with his family, girlfriends, and employers have been to a large extent based on secrecy on his part. It may be that the secrecy surrounding his father’s drug use legitimised John’s practice of keeping his drug use a secret, to the extent that he would resign from his job at the first sign of his employer or co-workers having learned of his drug use.

John’s role in his father’s drug use (injecting his father with morphine from the age of 15) is also noteworthy, in relation to his own drug use. A study on the drug use of male adolescents highlighted that both the drug consumption behaviour of parents and peers, and their relationship with the adolescent can have an important influence on the latter’s own use pattern (Lopez, Redondo, & Martin, 1989). Indeed John began using drugs intravenously from a relatively young age (at approximately 15 years). Also, throughout the interview John emphasised the intimacy and closeness he felt and still feels, towards his father. A possible link is indicated between John’s role in his father’s drug use and his own drug use.

John also seems to have a strong attachment to his father and significant unresolved grief associated with his father’s death. John was unwilling to explore the possibility that his father may have played some role in John’s problems. In fact he became quite angry at this line of inquiry and could only offer praise and gratitude toward his father. This presents some discrepancy with reports of his harsh treatment from his
father when he was a child. The validity of the reports is unknown but there was some sense that John was in denial of any possible link.

John's confusion around his sexual orientation is also noteworthy. Schneider, Farberow, and Kruks (1989) found that family dysfunction, in particular physical abuse and paternal alcoholism was a characteristic of gay male youths most likely to report suicidal ideation. Whilst John did not report paternal alcoholism there was significant physical abuse and it may be that his numerous attempts of self-harm and mutilation, and intended suicide may have been related to confusion around his sexual orientation. However, this can only be speculated given that John did not clearly articulate his motivation behind self-harming and attempting suicide, and became quite hostile and resistant when discussing his sexual orientation.

Overall, the discrepancy between the level of family violence, self-harming behaviours (including several serious attempts of suicide), substance abuse and violent behaviours, and John's reports of a functional family, in conjunction with his invalid MMPI-2 profile, suggests that there are gaps in John's reports of his previous experiences. Based on John's reports, the source of his anger and hostility are unclear. Further, self-harming behaviour has been associated with psychiatric morbidity (e.g., depression, anxiety) in an Australian study of 1996, 15-16 year-old secondary school students (Patton et al, 1997). John's current psychopathology (i.e., substance abuse, self-harming behaviours, suicidality) suggests the possibility that family dysfunction may have been present in his family of origin, and that this has played some role in his substance abuse. This highlights the importance of assessing family dysfunction, in particular, in conjunction with standardised measures that comprise validity scales such as the MMPI-2. The reasons for this include avoiding planning treatment based purely on self-reported information, and again, highlighting some of the core issues that may serve to perpetuate maladaptive behaviours such as substance abuse, and in turn increase the likelihood of relapse.
CHAPTER 6: THE CASE OF TOM

Referral and Presenting Problem
Tom is a 30 year-old man who self-referred for a family placement in residential treatment, after voluntarily placing his three children in the care of the Department of Human Services (DHS). His partner and the mother of their children, is currently in prison. Tom maintained that the sole purpose of entering treatment was to keep his children and family together. He acknowledged that he needed to deal with his substance abuse, which he has engaged in for the last 10 years. His partner is due for release soon and plans to join the family in treatment.

Background History and Personal Information
It is important to note at the outset that Tom has little memory of his past and fewer still of his childhood, which made it difficult to fully explore his previous experiences. Tom knows of no possible organic reason for his limited memory and reports that he has many “blanks” from as recent as one-to-two years ago.

Family History
Tom is the youngest of two and his older sibling Jack is aged 34. His parents Jan (aged 50) and Jason (aged 58) divorced when Tom was one year old and initially he lived with his mother and stepfather, until he was two years old. Tom then resided with his father and stepmother, who went on to have two children together approximately ten years later. Tom reported that his mother had informed him that he was placed with his father because he did not like his stepfather.

As a young child, whilst living with his father, Tom recalled often running away to a hideaway cave that he had found in a nearby park, and was brought back home by the police on several occasions. His predominant memory at this time is of being physically abused by his stepmother who he described as very dominant. He has no memory of his father or what his father was like at that time, other than to comment that he was docile and compliant. According to Tom, at age 9 his father placed him in a boy’s home without his mother’s consent, because of his uncontrollable behaviour. Approximately two months later Tom stated that his mother came to visit him, where upon learning that he had been placed in a home, removed him immediately. His mother then took Tom to reside with her and his stepfather. He
did not like his stepfather who he described as an alcoholic, who would often argue with his mother. Tom reported that his mother and stepfather divorced soon after he arrived to live with them.

At approximately 8 or 9 years of age, Tom recalls being raped by a teenage neighbour. He thinks that the rape took place in the context of a game, as he does not recall being physically or violently restrained. This appears to have been an isolated event.

During the time Tom resided with his mother, there appeared to be a lack of parental control or supervision as he recalled that she was often out drinking with friends. At 17 years of age, he left school to begin an apprenticeship. Tom failed to complete the apprenticeship and at age 18 began to travel.

Tom has three children, two boys aged 5 and 6, and a daughter aged 7, with his partner of ten years, Jess (aged 40). Tom and Jess have also experienced several miscarriages and stillbirths.

*Educational History*

Tom has little recollection of his primary school years but recalls that in secondary school he was short, overweight, very quiet, shy, and didn’t make friends very easily. Shortly before leaving school he was subjected to bullying and was beaten on a daily basis for several months. During work experience Tom was offered an apprenticeship which he commenced immediately and did not return to school.

*Employment History*

Tom has been employed as an unskilled labourer and in a variety of other odd jobs, many of which lasted approximately two years. In his mid-twenties he opened his own car wash business, which he stated was relatively successful. He stated that he prefers being self-employed, and would like to start his own business again.
Substance Use History
Tom first started smoking cigarettes at age 12, and has been a polydrug user up until entering treatment. In his mid-twenties, he began using speed intravenously (up to 7 grams per day), and within a year was using heroin on a daily basis, injecting up to 3 grams per day. Tom began smoking cannabis on the weekends at age 16, and for the last 10 years has continued to smoke cannabis on a daily basis.

Criminal History
Tom has received several convictions for offences related to possession, theft, and for breaching orders.

Social and Relationship History
Tom has had few relationships most of which have been with women who were significantly older than he. He described his current relationship with Jess as affectionate and commented that they had been through a lot together over the past 10 years. Tom and Jess have both used drugs throughout their entire relationship. He also stated that he is anxious about her release, as he is unsure about where their relationship will go.

Medical History
Tom stated that he was told he was very “hypo” as a young child and that he was placed on medication at one stage to “help calm [him] down”. Tom stated that he is currently not on any medication.

Psychiatric History
Tom stated that his father has suffered with depression for the past 10 years for which he is taking medication. He also recalls his mother “having a nervous breakdown” when he was a child and her going to hospital for several weeks.

Psychiatric Diagnosis
Tom was diagnosed with Narcissistic Personality Disorder, with anti-social traits.
Assessment

Test Behaviour

Tom was quite anxious and nervous at times which were evidenced by his restlessness (moving around in his chair) and through the use of humour at inappropriate times. It seemed that his humour was used as a mechanism for deflecting difficult questions. Although Tom acknowledged his tendency to do this, he continued to display this defense throughout the rest of the interview. This predominantly occurred when the questions focused on Tom and what he likes and dislikes about himself.

For the most part his affect was appropriate and he seemed clear in his thinking. He lacked psychological insight, and stated at one point that he perceives himself to be fairly intact and that if he were to leave treatment now he would not relapse.

Self-Image

As a boy, Tom described himself from what others have told him, which seems to predominantly focus on his “uncontrollable behaviour”. As a teenager he recalls feeling very different from his peers as he was not socially accepted and felt that he was unattractive and overweight. After much prompting Tom described himself as “an all right” person, stating that he made very little impact on people and did not allow other people to have any impact on him. He could not find anything that he likes about himself and described himself as being unhappy about many things, which he attributed to his low self-esteem, the way he thinks other people perceive him (in a negative light), his tendency to avoid confrontation sacrificing his own needs, and his general lack of self confidence. Tom also stated that he is unhappy with his physical appearance. Tom felt that he has no strong points but eventually stated that perhaps his commitment to his children was a strength in him.

Beck Depression Inventory (BDI-II)

(raw score = 14)

Tom’s BDI indicates mild depression which appears to be predominantly driven by feelings of self dislike, past failure, pessimism, and sleeping a lot less than usual.

General Health Questionnaire-28 (GHQ-28)

Tom’s GHQ-28 indicates that he is currently in a reasonable state of health although he is currently experiencing some difficulty in his ability to function socially.
Generalized Self Efficacy Scale
(Raw score = 27/40)
Tom has moderate confidence in his ability to cope and take care of himself.

Multidimensional Health Locus of Control Scale
Tom has a stronger sense of internal control over his health (I=27) than he does in his health being determined by chance (C=19). He has substantially less confidence in the control health professionals have over his health (P=11).

Minnesota Multiphasic Personality Inventory 2 (MMPI-2)
(Code: 40 27813569)
Tom’s profile is valid with an LFK configuration (61, 64, and 68 respectively) indicating that he is highly defensive and not likely to be interested in examining the appropriateness of his defensiveness. He may be repressing unfavourable aspects of himself, that he has adjusted to, and which may be why he has reported little distress. It is also possible that he needs to project a favourable image given he needs DHS to see him as being acceptable to regain custody of his children.

Tom’s profile highlights an overall sense of social maladjustment and an absence of pleasant experience. In particular it seems that he is currently fighting against some form of internal conflict. There is also indication that as a child he had no one to turn to and as a result developed the coping mechanism of numbing or suppressing his vulnerable feelings in order to survive. This corresponds with Tom’s presentation as he exhibited a general numbness with regard to his life and his previous experiences. He is also likely to suppress vulnerable and emotional feelings in order to protect himself against disappointments (Pd=82). He is currently feeling very uncomfortable with himself, has regret for things he has done (i.e., placing his children in the care of DHS) and because of his pessimism may relapse into using drugs again (Pd5=67).

A very strong theme inherent in Tom’s profile is that he is shy, introverted, socially insecure, and has a tendency to withdraw. As a result he is less likely to act out than he is to engage in ruminative behaviour. He may withdraw from and avoid significant others which he admitted having done in the past with his family, although he has recently re-established contact with them. Such individuals are often socially introverted as children, whose childhood was characterised by an absence of
affection and physical contact (Si = 70). This seems likely to correspond with Tom’s childhood given that his few memories are of the abuse that he experienced from his stepmother and neighbour. It would appear that a sense of alienation from himself and others, and a pervasive lack of self-esteem and self-confidence drive his shyness and introversion. He may also question his judgement and experience nervousness, indecision, and uneasiness among groups of people (Si1 = 71, SOD = 71). Indeed Tom reported that he feels uncomfortable in group therapy preferring not to self disclose.

Although Tom’s profile suggests that he is experiencing no distress, this is more likely to be a reflection of his attempts to inhibit to suppress any awareness of his problems (A =46, R = 85). This seems to be a pattern that Tom has engaged in from a very young age, which he recognises to some degree, although he generally lacks insight into his own behaviour. Furthermore, he has little confidence in his ability to deal with his problems (Es = 42).

Summary and Recommendations
Tom is currently in treatment primarily for the purpose of keeping his children. Should he leave, they will return to the care of DHS. This is consistent with his MMPI-2 profile which revealed his attempts to project a favourable image of himself. He maintains that he wants to stop “injecting” drugs but will probably continue to smoke cannabis post treatment. This statement is of concern given the extent of Tom’s substance use history and the fact that cannabis seems to have been the most consistent substance he has used.

Tom has experienced significant trauma during his childhood, particularly in relation to his experience with both of his parents and their respective partners. There was some indication that his lack of memory was serving to suppress his emotions. This is further perpetuated by his significant lack of self-confidence and self esteem and there are some body image issues as well (e.g., Tom feels that he is “ugly and too skinny”). When asked to explore difficult issues he relies on the defence mechanisms of intellectualisation and denial, as he will often inappropriately make derogatory jokes about himself in an attempt to avoid answering confronting questions.
Tom's motivations for treatment at this point in time are external (i.e., DHS involvement) and therefore he is less likely to genuinely engage in any therapeutic process. Should Tom take the opportunity to engage in therapy the initial goals would be to work on building self esteem and self confidence in order to provide him with a much more grounded sense of self. This would provide him with some internal support in terms of beginning to explore his past experiences and his substance abuse issues.

Discussion

There are several issues that are significant in Tom's experience of his family. First, it is unclear as to why he resided with his father. Tom stated that this was because he did not get along well with his stepfather, however this seems unclear given that he was 12 months old. Despite the lack of clarity around this decision, if Tom had formed a secure attachment to his mother (there is no apparent reason to suggest otherwise) then the separation and relocation with his father may have had an impact developmentally and/or emotionally. It seems unlikely that Tom formed an attachment with his stepmother, who he stated physically abused him. It is also unlikely that he was well attached to his father, whom Tom described as withdrawn and emotionally unavailable. Furthermore, it may well have been these circumstances (e.g., stepmother's continual physical abuse) that precipitated and later perpetuated Tom's behavioural problems (i.e., continually running away). Indeed, his MMPI-2 profile indicated that Tom had no one to turn to as a child and that this may have resulted in his tendency to suppress vulnerable feelings as a coping mechanism. The short-lived attachment with his mother may also "shed some light" on the fact that all of Tom's intimate relationships have been with significantly older women.

Although Tom reported that he was physically abused and on one occasion sexually abused, he appeared to regard these events as relatively insignificant, particularly in comparison to his experience of moving between his mother and father's homes and the family dysfunction he reported (i.e., lack of parental support and supervision). Indeed, some research shows that adult adjustment problems are not statistically related to the experience of child sexual abuse per se, when the variance associated with family environment has been accounted for (Fromuth, 1986; Higgins & McCabe, 1998). Other research has highlighted that a variety of childhood risk
factors such as poor relationship with parents, poor parental mental health, being physically abused as well as childhood sexual abuse, can lead to negative outcomes such as psychiatric disorder, low self-esteem, difficulties in intimate relationships, and deliberate self-harm (Romans et al, 1997). Thus, these findings suggest that Tom’s experience of family dysfunction in both his parents’ homes may be linked to his substance abuse.

Overall, this case illustrates the importance of assessing family functioning in conjunction with the standardised assessments when treating substance abuse. Further, it is significant that his primary attachment with mother was severed at an early age and that it appears he was unable to re-establish a parental attachment with another significant adult. These themes were supported by the standardised measures which also provided more insight into the way in which Tom deals with his past and present experiences, and the extent of his social dysfunction which was not as apparent in the interview. Given the degree of both functional and structural family dysfunction evident in Tom’s family of origin, and particularly in his own present family, these issues would need to be addressed in treatment in order to minimise the possibility of relapse. In particular, it would be important to address how Tom’s own experience of family dysfunction with his parents, impacts on his capacity to be a father to his own children. Thus, treatment would require not only exploring connections between his family of origin and his present family, but also teaching him practical parenting skills and coping skills that would reduce his chances of relapsing, particularly in times of high stress related to his children or partner.
CHAPTER 7: GENERAL DISCUSSION

The increase in substance abuse disorders has serious implications for the individual, their family, and the community. In an attempt to understand the underlying factors that may place an individual at greater risk of developing a substance abuse disorder, some researchers have looked to the family of origin. Dysfunction within the family of origin has been implicated in a range of psychological disorders (Gunnell, 2000; Harter, 2000; Martin, 1996; Roesler & Dafler, 1993). The aim of the current thesis was to examine the link between substance abuse and family dysfunction, and the importance of assessing family dysfunction when treating clients with substance abuse issues. This was examined in the context of four case studies, all of who were assessed for the treatment of heroin addiction. In particular, all of the case studies revealed family dysfunction, which was discussed in relation to current empirical research on the relationship between family dysfunction and substance abuse in both adolescents and adults. The following section provides a discussion and concluding comments in relations to both structural and functional dimensions of family dysfunction in relation to the four case studies presented.

Structural Factors within Family Dysfunction

The two primary structural factors reviewed in the present thesis were broken homes (e.g., step-families, single-parent families) and family size. Whilst the latter was not as relevant in the case studies presented, three of the four cases came from broken homes. These included both step-families and single-parent families, but more importantly a pattern of moving back and forth between family including relatives (i.e., grandparents, aunts). Thus, not only was the family unit "broken" there was also no security in terms of providing a consistent or permanent family unit. Indeed research has shown that such family arrangements have been associated with substance abuse and delinquency (Heck & Walsh, 2000; Rankin, 1983). These factors were certainly present in three of the four case studies presented and most prevalent in the case of Max and Tom. The constant relocation for both Max and Tom may have also contributed to both leaving school early, after which both left their respective family homes. Failing to complete school or 'dropping out' has also been associated with a variety of disorders in particular, substance abuse (Franklin, 1992). However, many of the youths recruited for this study had also been victimised through physical abuse, sexual abuse, and chronic family dysfunction. In particular,
the aspects of family dysfunction included parental substance abuse, situational crisis (i.e., family conflict), and family patterns of overachievement (Franklin, 1992). These additional findings may also explain why John left school prematurely, as he too was exposed to family conflict and physical abuse, despite coming from an ‘unbroken’ home.

More importantly, research has also highlighted that parental maltreatment, poor supervision, harsh discipline, and functional factors are often present in broken homes and large families (Farrington, 1996; Farrington & Loeber, 2000). Indeed structural factors alone were not present in any of the case studies, but rather each of the case studies demonstrated both structural and functional factors within the family of origin. This is noteworthy, as it has been suggested that the parent-child relationship may be more important in predicting substance abuse than the number of parents residing in the home (Selnow, 1987). The following section discusses functional factors in the context of family dysfunction, with regards to the four case studies and existing empirical research.

*Functional Factors within Family Dysfunction*

The range of functional factors within the family of origin that have been highlighted as placing an individual at risk of a range of psychopathologies including substance abuse, include: poor parental attachment, supervision and discipline style, family conflict, parental substance abuse, and physical and sexual abuse within the family system (Heck & Walsh, 2000; Hoffmann & Johnson, 1998; Rosen, 1985). These types of family dysfunction were disclosed in all of the case studies presented.

In both the empirical research and in the case studies presented, it appears that parental attachment is an important factor when considering the link between family dysfunction and substance abuse. All of the case studies reported some level of poor or inappropriate attachment, which seems to have continued as a pattern in their adult relationships. For example, in the case of both Max and John, both reported that their father’s were substance abusers (including illicit and licit/prescription drugs). Further, it has been suggested that being raised by drug-abusing parents may create problems with intimacy in later life (Newcomb & Rickards, 1995). Indeed, in the case of Max and John, both have been unable to establish and sustain intimate
relationships with peers and significant others, and in Max's case, has engaged in inappropriate relationships (e.g., with his stepmother and the sexually abusive relationship with an acquaintance).

Furthermore, the impact of poor parental attachment, or parents who are withdrawn and emotionally unavailable, on the child's self-esteem and later adult adjustment cannot be underestimated. For example, in the case of Kate, she reported feeling anger and resentment as she felt that her mother was more emotionally available to her younger sister. Indeed, Kate's MMPI-2 profile highlighted a propensity to protect herself emotionally for fear of being disappointed, and having a strong need for affection. In the case of Tom, poor self-esteem was strongly evident, and to a lesser degree in the remaining cases of Max and John.

Conclusions and Implications
Overall, the case studies presented highlighted significant family dysfunction and substance abuse from an early age. It is not the intention of this thesis to imply that this relationship is causal, but rather to suggest that in some cases family dysfunction may place some individuals at greater risk of substance abuse. The family dysfunction reported in all three case studies was substantial and pervasive, as was the level of substance abuse. Further, the use of psychometric tests in the assessments was also imperative in order to substantiate the self-reports to some degree, and to provide a more thorough assessment of the client, particularly in terms of understanding the nature and extent of substance abuse, family dysfunction, and recommending treatment goals.

So what are the implications for treatment when one assesses family dysfunction in substance abuse clients? Jarvis and Copeland (1997) highlighted the need for greater liaison between drug and alcohol treatment and counselling services based on their study of 180 women in and outside drug and alcohol treatment. Specifically, it was found that child sexual abuse (CSA) survivors had higher overall levels of distress (e.g., anxiety, somatisation, dissociation, self-harm, eating disorders, sexual dysfunction, and suicidality) compared with drug and alcohol treatment clients who had not experienced any CSA. Thus, clinical issues such as CSA, which may have occurred in the family of origin, and family dysfunction, are important issues to assess for when treating substance abuse. For example, the impact of family
dysfunction on relapse might be influenced by the types of treatment utilised to address such issues. Similarly, the findings of Chiavaroli (1992) and Rosenhow et al (1988) highlighted the importance of assessing and treating issues such as family dysfunction, which can serve to perpetuate substance abuse. Thus, a thorough assessment utilising self-report and standardised measures is imperative in order to identify important clinical issues such as family dysfunction, when treating substance abuse, in order to facilitate relapse prevention.
REFERENCES


National Drug Strategy Household Survey 1998. Australian Institute of Criminology, webmaster@aic.gov.au


