THE IDENTIFICATION OF RESILIENCE IN, AND THE DEVELOPMENT OF A CORRESPONDING INTERVENTION PROGRAMME FOR FAMILIES WITH A PARENT LIVING WITH MAJOR DEPRESSIVE DISORDER

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Dissertation presented for the degree of

Doctor of Philosophy

at Stellenbosch University

Promoter: Prof AP Greeff

December 2009

DECLARATION

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SUMMARY

Major Depressive Disorder is a prevalent psychiatric illness that poses critical risk factors to families. Risk factors associated with depression are widely researched, but limited South African and international research exists with regard to family resilience factors and intervention programmes associated with these high-risk families. The aim of the present study was to address these limitations by (a) identifying and describing the qualities of resilience in families in which a parent had been living with Major Depressive Disorder, (b) developing a family intervention programme for parents to strengthen and enhance a quality of resilience and, finally, following the intervention programme, (c) to evaluate the impact of the intervention programme on the identified resilience quality. The research was divided into two phases in order to address the above-mentioned, namely the descriptive phase (Phase 1) and the intervention phase (Phase 2). The results of the descriptive phase revealed various statistically significant correlations between the independent variables and the dependent variable, namely family adaptation, as measured by The Family Attachment Changeability Index 8 (FACI8) (McCubbin et al., 1996). The strongest statistically significant correlation was found between family problem solving and communication, and family adaptation. This steered the development of the intervention programme, aiming it at enhancing family problem solving and communication as a family resilience quality. An experimental design was used to evaluate the impact of the intervention programme. Analysis 1 revealed a trend (not statistical significant on a 5% level), suggesting that negative communication decreased over a three-month period after the intervention programme. Analysis 2 supported this trend on a 5% level. The qualitative post-test data reveal that the participants perceived the intervention programme in a very positive light, namely as a beneficial and educational experience. Furthermore, the three-month follow-up assessment showed that the majority (81%) of the participants indicated that the intervention programme impacted positively on their family's communication.

OPSOMMING

Major Depressiewe Steuring is 'n bekende psigiatriese siekte wat gesinne met kritiese risikofaktore uitdaag. Hierdie risikofaktore is wyd nagevors, maar beperkte Suid-Afrikaanse en internasionale navorsing bestaan met betrekking tot gesinsveerkragtigheidsfaktore en gepaste intervensieprogramme wat met hierdie hoë risiko gesinne geassosieer word. Die doel van die huidige studie was om hierdie beperkings aan te spreek, deur (a) veerkragtigheidsfaktore te identifiseer en te beskryf in gesinne waar 'n ouer met Major Depressiewe Versteuring leef, (b) om 'n gesinsintervensieprogram vir ouers te ontwikkel wat 'n spesifieke veerkragtigheidsfaktor kan versterk en ontwikkel, en (c) om die impak van die intervensieprogram op die geïdentifiseerde veerkragtigheidsfaktor te evalueer. Die navorsing is in twee fases verdeel, naamlik die beskrywende fase (Fase 1) en die intervensie fase (Fase 2) om bogenoemde aan te spreek. Die resultate van die beskrywende fase het verskeie statisties beduidend korrelasies getoon tussen die onafhanklike veranderlikes en afhanklike veranderlike, naamlik familie aanpasbaarheid, wat deur *The Family Attachment Changeability Index 8* (FACI8) gemeet is (McCubbin et al., 1996). Die sterkste statisties beduidende korrelasie was tussen gesin probleemoplossing en kommunikasie en gesin aanpasbaarheid. Hierdie verhouding het die ontwikkeling van die intervensieprogram bepaal wat ten doel gehad het om gesin probleemoplossing en kommunikasie as 'n gesinsveerkragtiheidskwaliteit te ontwikkel. 'n Eksperimentele ontwerp is gebruik om die impak van die intervensieprogram te evalueer. Analise 1 het 'n tendens (nie statisties beduidend op 'n 5 % vlak) uitgelig wat daarop dui dat negatiewe kommunikasie verminder het oor 'n periode van drie maande na die intervensieprogram. Analise 2 het hierdie tendens ondersteun op 'n 5% vlak. Die kwalitatiewe na-toets data het aangedui dat die deelnemers die intervensieprogram in 'n baie positiewe lig ervaar het en as voordelig en opvoedkundig beskou het. Die drie-maande opvolgassessering het ook aangedui dat die meerderheid (81%) van die deelnemers gevind het dat die intervensieprogram 'n positiewe impak op hulle gesinskommunikasie gehad het.

TO MY FAMILY

ACKNOWLEDGEMENTS

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CHAPTER 1

INTRODUCTION AND PROBLEM STATEMENT

1.1 Chapter Preview

In this chapter, a general orientation towards the study, as well as the conceptualisation of the relevant constructs of family resilience, is provided. The problem statement and motivation for the study are discussed, and an outline of the aims and objectives is given. The chapter concludes with an outline of the chapters that are to follow.

1.2 General Orientation to the Study

A positive shift in the field of studying family resilience occurred only during the past two decades (McCubbin & McCubbin, 1996). Even though literature regarding resilience factors in families with a mentally ill member is not readily available, a few studies have been conducted in this field (Birkets, 2000; Enns, Reddon & McDonald, 1999; Greeff, Vansteenwegen & Ide, 2005; Marsh, 1996; Tebes, Kaufman, Adnopoz & Racusin, 2001).

In an earlier study concerning the family's experience of a psychiatric disorder, Marsh (1996) emphasised the importance of recognising family resilience. She declared that it strengthens families and counters the adverse effects of earlier models that pathologise and disempower families. A proposed way of enhancing resilience factors within families is by offering intervention programmes (Beardslee, Gladstone, Wright & Cooper, 2003; Enns et al., 1999).

The above-mentioned studies regarding psychiatric disorders are some of the few studies found within the family resilience paradigm. Consequently, this present study will contribute to the limited research on this paradigm, and deliver a specific contribution within the South African context (Der Kinderen & Greeff, 2003; Greeff & Van der Merwe, 2004; Greeff & Human, 2004).

1.3 Conceptualisation of the Constructs

Resilience is the ability to withstand and rebound from disruptive life challenges (Walsh, 2003b). In the emerging salutogenic paradigm, explorations of resilience focus mainly on the individual level (Antonovsky, 1993a, 1993b, 1996; Strümpfer, 1990, 1995). However, the concept of family resilience extends beyond seeing the individual family member as a potential resource, but rather focuses on the family as functional unit (Walsh, 2003b). The concept of family resilience offers a useful framework to identify key qualities that enable families to successfully adapt, despite adverse circumstances (Walsh, 1996; McCubbin & McCubbin, 1996).

As this study aims to participate in the already existing movement in research that focuses on the resilience qualities of families, an elaboration on the family resilience model and theory is required (Hawley, 2000; Hawley & De Haan, 1996; McCubbin, 1995; Patterson, 2002; Rutter, 1999; Silberberg, 2001; Walsh, 1996, 2003b).

The dominant theory regarding family resilience is The Resilience Model of Stress, Adjustment and Adaptation (McCubbin & McCubbin, 1993). Within this framework, resilience is viewed as consisting of two distinct but related processes. The first is adjustment, which involves the influence of protective factors (i.e., communication, time together and spirituality) in facilitating the family's ability to function in the face of risk factors (i.e., biological, social, economic or psychosocial factors). The second is adaptation, which in turn entails the process of altering the environment, the community and the family's relationship to the community to restore family harmony, balance and well-being (McCubbin & McCubbin., 1996). This model serves as the theoretical basis for this study. It describes the effect of family types, and of problem-solving and coping mechanisms, on outcome in the adaptation phase. Family adaptation will thus act as the dependent variable in the study. McCubbin and McCubbin (1993) developed the above-mentioned theoretical model (see Figure 1.1) and related measuring instruments.

bB
Existing & New
Resources

bBB
Social Support

BONADAPTATION

X
Crisis

aA
Pile-up

V
Vulnerability

T
Family
Type

PSC
Problem
Solving &
Coping

XX

ADAPTATION

MALADAPTATION

cC
Situational
Appraisal

cCC
Family Schema
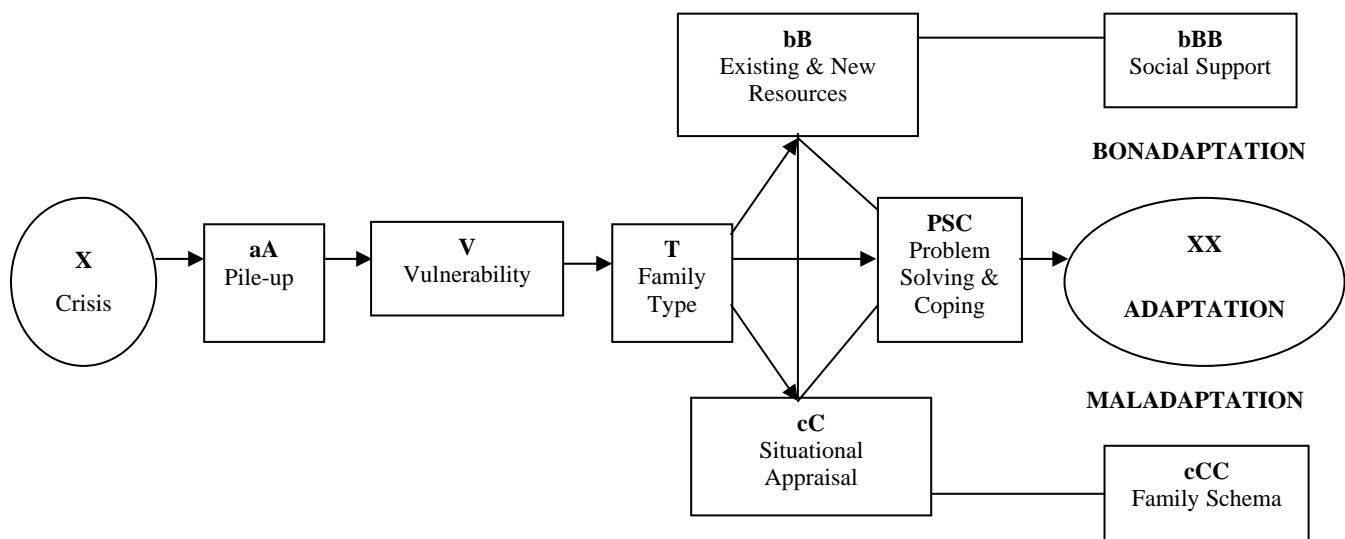
Figure 1.1. The resilience model of family stress, adjustment and adaptation (McCubbin & McCubbin, 1993)[1].

Figure 1.1 gives a layout of the Family Resilience Model, which was used as the theoretical underpinning of the present study.

1.4 Problem Statement and Motivation for the Study

Families with a member living with a psychiatric disorder experience additional stress and problems (Birkets, 2000; Enns et al., 1999; Marsh, 1996). The overall body of literature on family research emphasises risk and pathology factors in families in general, and also in families with a psychiatrically ill member, especially in the case of depression (Beardslee, Keller, Lavori, Staley & Sacks, 1993; Burke, 2003). This study focuses specifically on families with a depressed parent, and this focus is motivated below.

The literature indicates that depression is a prevalent psychiatric disorder (Burke, 2003; Kaplan & Sadock, 1998). It often is recurrent and tends to have a chronic course, which impacts not only on the individual, but also on the family and wider community (Burke, 2003). Depression was also identified as a prevalent psychiatric disorder in the population of the proposed study, at a

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[1] From McCubbin, M.A. and McCubbin, H.I. (1996). Resilience in families: a conceptual model of family adjustment and adaptation in response to stress and crisis. In H.I. McCubbin, A.I. Thompson, & M.A. McCubbin. *Family assessment: resilience, coping and adaptation - inventories for research practice*. (pp. 1-64). Madison: University of Wisconsin System.

military hospital in South Africa, by the State Information Technology Agency (SITA). A high incidence of families with a depressed member was evident in this closed community, with limited visible involvement by the families. This apathy stance of core family members impacted on the treatment process. The question that arose was how to involve these families in a non-threatening, supportive way? The family resilience paradigm provides a contextual framework for this question and these concerns. Instead of focussing on the stress and problems of these families, the family resilience paradigm focuses on the strengths/resilience factors that are exhibited by these families. Some studies have already identified qualities of resilience (i.e., family hardiness, family bonds, family commitment and family support) for families with a member living with a psychiatric disorder (Greeff et al., 2005; Marsh, 1996).

With this in mind, the question arises as to what are the specific qualities of resilience that reduce stress and vulnerability, foster healing and empower a family in which a parent has been living with depression to overcome adversity? Furthermore, the question arises as to whether these qualities can be utilised in compiling an intervention programme to strengthen family resilience. Such research may enable families to withstand and rebound from the challenges they face (Walsh, 1996).

1.5 Primary Aims and Objectives of the Study

The research methodology was divided into two phases, namely the descriptive phase and the intervention phase, in order to address the following research questions and objectives.

Primary Research Questions

1. Which qualities of resilience are present in families in which a parent has been living with depression?

2. What should an intervention programme entail that has been designed to enhance a certain identified quality of resilience in families in which a parent has been living with depression?

3. Does the designed intervention programme succeed in reaching its objective, namely to develop a certain identified quality of resilience in families in which a parent has been living with depression?

Research Objectives

1. The primary objective of the study was to identify and describe qualities of resilience in families in which a parent has been living with depression.

2. The secondary objective was to develop a family intervention programme for parents to strengthen and enhance a certain identified quality of resilience in families in which a parent has been living with depression.

3. Following its implementation, the tertiary objective was to evaluate the impact of the intervention programme on the identified quality of resilience in families in which a parent has been living with depression.

1.6 Outline of the Study

The study will be structured according to the following chapters:

Chapter 1: Introduction and Problem Statement

Chapter 1 serves as an introduction to the present study, and outlines the contextual background against which the study was conducted. The problem statement, motivation and aims of this study are also provided.

Chapter 2: Family Resilience

Chapter 2 discusses the chronological development of resilience as a construct. Firstly, it focuses on the development and definition of individual resilience and related constructs, and secondly on the development of family resilience models. The chapter introduces the particular family resilience framework that is utilised in the study, namely the Resilience Model of Family Stress, Adjustment and Adaptation (McCubbin & McCubbin, 1993).

Chapter 3: Depression and Family Resilience

This chapter defines contemporary families and discusses major depressive disorder (MDD). It deals with the relevance of the current Family Resilience Model (McCubbin & McCubbin., 1996). A literature review of family resilience follows, particularly resilience in families with a member with a psychiatric disorder, and the discussion is presented and structured according to the Family Resilience Model (McCubbin & McCubbin, 1993).

Chapter 4: Descriptive Phase: Research Design and Methodology

Chapter 4 describes the methodology of the descriptive phase of the research. It provides an explanation of the research design and methodology employed for the descriptive phase of the study in order to identify and describe resilience factors associated with families in which a parent has been living with depression. The primary aim, research methods and participants' demographic details are outlined. Sampling procedures are discussed, and an overview is provided of the qualitative and quantitative measures used to gather data. Research procedures and processes, data analyses and ethical considerations are outlined.

Chapter 5: Descriptive Phase: Research Results, Discussion and Integration

Chapter 5 is divided into two sections. Firstly, the research results of the descriptive phase (Phase 1) are reported on, and, secondly, these results are discussed and integrated with the relevant literature. The first section of the chapter provides a description of the research results by reporting on (a) the quantified biographical data, (b) the results obtained with the various measures, which were correlated and regressed (best sub-test technique) on the dependent variable, namely family adaptation, (c) the results of the Beck Depression Inventory (BDI-II) (Beck, Steer & Brown, 1996) and (d) the different themes and interrelations of the qualitative data. The second section of the chapter provides an overview of the findings and concentrates on the results from the current study in comparison with previous research in which the Family Resilience Model (McCubbin & McCubbin, 1993) was used. According to the correlation and regression analyses, family problem solving and communication is a significant predicator of

family adaptation. Because of this finding, it was decided to compile an intervention programme aimed at enhancing this family quality in order to enhance family resilience.

Chapter 6: Intervention Phase: Theoretical Framework, Programme Development, Implementation and Evaluation

Chapter 6 describes the development, implementation and evaluation of the programme. The preceding theory is reviewed and integrated, which allows for the development of a family resilience intervention programme, namely a Family Communication Workshop. The chapter discusses the rationale behind the chosen theoretical framework for the development of the current programme. The reader is guided through the practical steps regarding the development, implementation and evaluation of the current programme.

Chapter 7: Intervention Phase: Research Design and Methodology

Chapter 7 describes the research methodology of the intervention phase (Phase 2) of the study. It provides a description of the methodology employed for this phase of the research, namely the pre-test/post-test (wait-list) control experimental group design. The primary aim, hypotheses and research methods are outlined. The participants' demographical details are discussed, with an outline of the measures used. The sample and sampling procedures are given. The chapter concludes with an outline of the procedures and details regarding the data analysis.

Chapter 8: Intervention Phase: Research Results, Discussion and Integration

Chapter 8 reports on the findings of the intervention phase. The aims and the reliability analysis of the research are discussed. This chapter is divided into two sections. Firstly, an outline is given of the research results of the intervention phase, with a focus on the sample and biographical results, quantitative results and the qualitative results. Secondly, the biographical, quantitative and qualitative results are discussed, summarised and integrated with existing research.

Chapter 9: Conclusions, Critical Review and Recommendations

Chapter 9 focuses on the conclusions, critical review and recommendations of the study. A review is presented of the aims addressed in the descriptive phase and intervention phase of the research, with general conclusions in terms of the research findings. The value added by this research in terms of research in the family resilience field in the South African context is discussed. A critical review is given of challenging aspects and the limitations of the study, and recommendations are made for future research.

1.7 Conclusion

Chapter 1 has served as an introduction to the present study, and has outlined the contextual background and content of the present study. A brief motivation for the study is given, with specific reference to why the study focuses on parental depression in a family set-up. The theoretical underpinning of the study was introduced briefly. The next chapter will focus on family resilience.

CHAPTER 2

FAMILY RESILIENCE

2.1 Chapter Preview

Chapter 2 discusses the chronological development of resilience as a construct. Firstly, the focus will be on the development and definition of individual resilience and related constructs and, secondly, it will be on the development of family resilience models. The chapter aims to introduce the particular family resilience framework that is utilised in the study, namely the Resilience Model of Family Stress, Adjustment and Adaptation (McCubbin & McCubbin, 1993, 1996), which stems from family stress theory.

2.2 Introduction

Resilience theory is a unique, multidimensional field of study that has been studied by a range of health professionals since the 1970s (Patterson, 2002; Van Breda, 2001). This theory is unique and enlightening, in the sense that social research had a long history of focussing on pathology (i.e., disease, deficient and behavioural problems), which was shifted by focussing on the strengths that people and systems demonstrate and that enable them to rise above adversity (Patterson, 2002; Van Breda, 2001; Walsh, 2003a). With this in mind, the following subsections will firstly give an outline of individual resilience as a concept, and then introduce the development of family resilience constructs.

2.3 Individual Resilience

Walsh (1996) defines resilience as "the ability to withstand and rebound from crisis and adversity" (p. 261). Resilience is also described as the relative resistance to individual psychosocial risk experiences and stems from stress and coping theory (Rutter, 1987, 1999). Multiple risk and protective factors were identified among resilient people and the primary focus

was on individual personality traits, cognitive schemas, characteristics and interpersonal processes (Bandura, 1982; Kobasa, 1982; Strümpfer, 1990; Van Breda, 2001).

The salutogenic approach provides a strong framework for conceptualising resilience and was the foremost paradigm for studying wellness and strengths. Antonovsky (1979) coined this term, following a series of studies at the Harvard School of Public Health in 1965. The studies addressed the stressors that underlie health and illness in the lives of poor people (Kosa, Antonovsky & Zola, 1996).

The salutogenic approach was formally published by Antonovsky during 1979. He introduced the neologistic concept of salutogenesis. The concept stems from the Latin word *salus* (health) and the Greek word *genesis* (origins), meaning: the origins of health. The term was recently refined further by the South African researcher, Strümpfer, who proposed a new concept, namely "fortigenesis", which focuses on psychological strength in general (Strümpfer, 1995, 2000, 2002). The concept captures the words "fortify" (to impact physical strength, vigour or endurance, or to strengthen mentally or morally), "fort" (a fortified place), and "fortitude" (strength and courage in adversity or pain). However, for the purpose of this study, the following section will focus on the salutogenic paradigm as basis for the development of recent theory regarding resilience.

Antonovsky (1987) specifically wished to answer the question, How do people manage stress and stay well? – with a specific focus on health instead of disease. Thus, a fundamentally different philosophical question than in the pathogenic realm was raised by Antonovsky, and he became a strong proponent of the theory of health (Antonovsky, 1996).

Antonovsky proposed that various salutogenic constructs (i.e., sense of coherence, life experiences, generalised resistance resources (GRR), sources of GRRs, stressors, management of tension, stress and health) interact simultaneously to predict a person's position on the health continuum (Antonovsky, 1987, 1996; Wolff & Ratner, 1999). The two central, important and

less familiar constructs (sense of coherence [SOC] and generalised resistance resources) will be discussed briefly in the following section.

Generalised resistance resources (GRRs) explain the process of moving towards the health pole of the ease/dis-ease continuum (Antonovsky, 1979, 1987, 1996). In summary, Antonovsky (1979) found that the extent to which a person integrates and possesses GRRs is a primary determinant of the extent to which that person comes to have a generalised, pervasive orientation towards life. It provides a person with life experiences that are meaningful, and enables an individual to "make sense" of life in the cognitive, instrumental and emotional paradigms.

This led to the development of the sense of coherence construct in his book, *Unravelling the mystery of health: How people manage stress and stay well* (Antonovsky, 1987). Antonovsky provided the following definition of sense of coherence and generalised resistance resources:

> Firstly, sense of coherence is a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (a) the stimuli deriving from one's internal and external environments in the course of living are structured, predicted, and explicable; (b) the resources are available to one to meet the demands posed by the stimuli; and (c) these demands are challenges, worthy of investment and engagement (p. 19).

It can further be explained as a generalised orientation towards the world on a continuum as comprehensible (cognitive dimension), manageable (refers to the extent an individual perceives the requisite resources as readily available) and meaningful (emotional dimension) (Antonovsky, 1979, 1987, 1996).

The above-mentioned three components of sense of coherence can be measured by the Sense of Coherence Scale (SOC-29) (Antonovsky, 1993a, 1993b, 1993; McSherry & Holm, 1994). Antonovsky (1979, 1987, 1996) also indicated that one's SOC is shaped predominantly by the

following three life experiences, namely (a) consistency (refers to consistent, stable and predictable life experiences), (b) underload-overload balance (load balance refers to availability of resources at one's disposal, and the sense of manageability) and (c) participation in socially valued decision-making.

The above discussion focussed on the development of the construct of individual resilience, with a specific focus on the salutogenic paradigm, as it is an important building block in the development of the family resilience theory discussed in the next section.

2.4 Family Resilience

In the sphere of family resilience there is a great deal to be learned from the studies of individual resilience conducted over the past two decades, primarily in the field of child development. Most of these studies sought to understand how some children in dysfunctional families, e.g. families with a parent with a psychiatric disorder, were able to overcome early experiences of maltreatment and lead functional lives (Rutter, 1987; Walsh, 1996). Some family researchers began to question the role the system plays in terms of assisting individuals to be resilient.

A review of the literature reveals two units of analysis of resilience and the family (Hawley & DeHaan, 1996). Firstly, resilience is described as an individual factor, with the family serving firstly as a protective factor (i.e., good fit between mother and child; maintenance of family rituals and proactive confrontation of family problems), or as a risk factor (marital discord, overcrowded housing, limited parental abilities) (Hawley & DeHaan, 1996). Thus, the family is basically viewed as a context for individual resilience and remains prominent in the background (Van Breda, 2001). Secondly, in reaction to this, McCubbin and McCubbin (1988, 1993) posed resilience as a family-level construct and an independent entity for analysis. They then proposed the Resilience Model of Family Stress, Adjustment and Adaptation, which will be utilised as the theoretical framework for this study. However, before describing the evolution and development of this theory, a clear definition of family resilience will be provided.

There are various definitions of family resilience. Several common threads have emerged in the definitions over the years. Hawley and DeHaan (1996) summarised them as follows. Firstly, resilience surfaces in the face of hardship and comprises qualities that enable a family to maintain its equilibrium during a crisis. Families with great resilience show a capability to adapt to ways that are productive for their well-being and are described in concepts such as endurance, withstanding, survival and coping. Secondly, resilience has a bouncy quality to it, as when described in terms of bouncing back. It suggests that the family may temporarily be thrown off course under stressful conditions without altering their basic systemic structures and will then return to their previous or increased level of functioning after integrating the crisis. Thirdly, resilience is defined broadly in terms of wellness rather than pathology, and this addresses ways in which families are successful rather than ways in which they fail. Hawley and DeHaan (1996) go a step further by posing the following definition as a way to integrate the literature addressing individual and family resilience:

> Family resilience describes the path a family follows as it adapts and prospers in the face of stress, both in the present and over time. Resilient families respond positively to these conditions in unique ways, depending on the context, developmental level, the interactive combination of risk and protective factors and the family's shared outlook (p. 293).

McCubbin and McCubbin (1996) posed the following definition for understanding family resilience as it is utilised in this study.

> [Family] resilience can be defined as the positive behavioural patterns and functional competence individuals and the family unit demonstrate under stressful or adverse circumstances, which determine the family's ability to recover by maintaining its integrity as a unit while insuring, and where necessary restoring, the well-being of family members and the family unit as a whole. (p. 5)

Walsh (1996, p.263) described family resilience as "…key processes that enable families to cope more effectively and emerge hardier from crises or persistent stresses, whether from within or from outside the family".

2.4.1 Evolution of the Family Resilience Model

The following section aims to provide a chronological explanatory framework for the evolution of the Family Resilience Model to its current form, namely the Resilience Model of Family Stress, Adjustment and Adaptation by McCubbin and McCubbin (1993, 1996). The current form of the model serves as the theoretical basis of the present study, and family adaptation will be utilised as the dependent variable in all analyses.

The development of the Resilience Model stems from the need to explain, describe and understand the different and unique patterns, behaviour and interactions used by families internally and externally in an attempt to deal with difficulties. This development was further activated by the difficulties related to the operationalisation of family resilience for research purposes, as it is a social construct, which is not static, but process orientated (Hawley & DeHaan, 1996; Walsh, 1996).

2.4.1.1 Hill's ABCX Model

Hill's ABCX model stems from family stress research, which dominated during the twentieth century and was embedded in the pathogenic perspective focussing on the identification of family dysfunction and risk factors. It led to the conceptualisation and understanding of family functioning and how the family system deals with stressors (Van Breda, 2001). This provided the foundation for later research on family strengths, prevention of dysfunctionality and the innovative research by McCubbin (Van Breda, 2001). During the 1940s, the family stress researcher's attention shifted to the consequences of World War II. Hill formulated his model during this time (1949) and modified it in 1958 (McCubbin & Patterson, 1982). Hill's model will thus be discussed, as it serves as the cornerstone for more sophisticated models that were

developed subsequently. Hill describes his ABCX model as follows: The stressor [A] can be defined as a life event (e.g., death, purchase of a home, parenthood), which impacts on the family unit. [A] (the event) interacts with [B] (the resources the family has available to meet the crisis), which then produce [X] (the crisis) (Burr, 1973, 1982). This process is divided into three determinates, as follows: Firstly, the external determinate, namely the hardships of the event, which lie outside the family and are an attribution of the event itself. It is described in Hill's original model as the amount of change that gives cognisance to the perception of the event in terms of internal and external context and determines whether the family will cope or fall into crisis (Black, 1993). The second and third determinates are internal and lie within the family, namely the family resources [B] and the family definition [C] of the events. Resources [B] refer to the ability of a family to resist an event from developing into a crisis (Van Breda, 2001). Family definition [C] refers to the family's conceptualisation and definition of the event or stressor. Hill (1958) indicated that the family's own subjective definitions of the stressor were the most important for influencing their response to a crisis.

A vital contribution of Hill's model is that it provided an underpinning for the development of later models, which will be described in the subsequent sections.

2.4.2 McCubbin's Resilience Models

2.4.2.1 Double ABCX Model

In the 1970s, the research done by McCubbin and his colleagues led to the identification of various shortcomings in Hill's ABCX model (Hill, 1949, 1958). In reaction to this, McCubbin and Patterson (1982, 1983) developed the Double ABCX model in 1983.

Lavee, McCubbin and Olson (1987) summarise this model as follows:

> [The Double ABCX] redefines pre-crisis variables and adds post-crisis variables in an effort
> to describe (a) the additional life stressor and strains, prior to or following the crisis-

producing event, which result in the pile-up of demands [aA], (b) the range of outcome of family processes in response to the pile-up of stressors (mal-adaptation or bon-adaptation) [xX], and (c) the intervening factors that shape the course of adaptation: family resources [bB], coherence and meaning [cC], and the related coping strategies. (p. 912)

McCubbin and Patterson (1983) suggest that the pile-up [aA] factor includes the initial stressor, described as [A] in Hill's model, and its accumulated hardships, normative transitions, prior strains, the consequences of family efforts to cope, and ambiguity, both inter-familial and social. This was an essential change in terms of providing a more accurate understanding of the complex and interacting nature of family stressors, as families seldom have to deal with one stressor at a time (Van Breda, 2001).

Lavee et al. (1987) described adaptive resources [bB] in the double ABCX model as both the existing resources and the expansion and restructuring of resources that are developed and strengthened in response to the demands posed by the stressor event. In Hill's model, resources referred to the existing resources [b] (pre-crisis phase), while in the second half of the double ABCX model, new resources [B] are added to the existing resources [b] in the post-crisis phase. These resources include individual, family or community resources, which are used to meet the demands of the family.

Family definition and meaning [cC] refers to the family's general orientation to their overall situation and circumstance (Lavee et al., 1987). Families often adopt coping strategies to alter their perceptions of a situation, which might give a more acceptable meaning to a difficult situation, like depression, and which in turn can reduce stress (Jansen, 1995). Two forms of meaning are involved, firstly as in Hill's model, where [c] represents the family's perception of only the stressor [a], while the second form of meaning, [C], suggests that families will over time continuously engage in constructive efforts to manage and define the stressor. McCubbin and his colleagues found that what is of essence is the family's perception of the total crisis situation,

which includes the stressor, the added stressors and strains, old and new stressors and the perception of what is needed to deal with the crisis. This is encapsulated in the double ABCX model as the family's ability to give definition and meaning to a situation [cC].

Family adaptation [xX] is the end product of the family processes in response to the crisis and pile-up of demands (Lavee et al., 1987). In Hill's model, the outcome [X] was the degree of crisis remaining. However, McCubbin and colleagues found that some families emerged from stress more resilient and stronger, which indicated that a mere reduction in stress was not an accurate description of the outcome. The presented the concept of family adaptation to describe the continuum of outcomes that reflect family efforts to achieve a balanced fit. This balance continuum ranges from mal-adaptation (negative end) to bon-adaptation (positive end). McCubbin and Patterson (1983) focussed on two important balances or fits, namely member-to-family fit or vice versa and family-to-community fit or vice versa.

The Double ABCX model thus builds and improves on Hill's model with five additions, namely [aA], [bB], [cC] and [xX] factors as well as coping patterns (McCubbin & McCubbin, 1996).

2.4.2.2 The Family Adjustment and Adaptation Response Model (FAAR)

The Family Adjustment and Adaptation Response model (FAAR) evolved naturally as an expansion of the double ABCX model (McCubbin & Patterson, 1983a). It emphasised the processes involved in the family's efforts to balance demands and resources that were not highlighted in the ABCX model (Lavee et al., 1987; McCubbin & Patterson, 1983).

The FAAR model maintains that families use different resources (i.e., financial resources, personal capabilities such as skills and self-esteem, system resources such as cohesion and medical care, and community resources) to meet demands (Jansen, 1995). One of the major family resources in the FAAR model is coping behaviour. It is defined as the action families take to reduce demands or acquire resources, or to make a stressor more manageable by introducing meaning to the situation (Patterson, 1988).

The model encompasses two distinct phases, namely the adjustment phase and the adaptation phase. Family adjustment denotes a short-term reaction to crisis by families that might be sufficient to manage less severe stressors, while the adaptation phase refers to a long-term, integrated restructuring of the family system (McCubbin, 1995). Families use these phases to achieve stability and balance when confronted with a life stressor or transition. The theoretical framework places emphasis on the family types, strengths and capabilities that are needed or created by families to effectively deal with family reorganisation, systemic change and the family's level of vulnerability.

2.4.2.3 T-Double ABCX Model

McCubbin and McCubbin introduced the T-Double ABCX model in 1989 (McCubbin & McCubbin, 1989). This model is a supplementary development on the FAAR model and is also known as the Typology Model of Family Adjustment and Adaptation. It "was introduced to emphasize the importance of the family's established patterns of functioning, referred to as typologies and family levels of appraisal, as buffers against family dysfunction, and factors in promoting adaptation and recovery" (McCubbin & McCubbin, 1996, p.5).

The T-Double model advanced the FAAR model by integrating family typologies [T] and the life cycle perspective in family typologies and adaptation. It further introduced vulnerability [V] due to pile-up as a factor in both adjustment and adaptation. The family life cycle stage is clarified in this model through an understanding of both vulnerability and family resilience. Family schema is defined and included as an additional level of family appraisal [cCC], which emphasises the importance of the family's shared views, values and beliefs.

2.4.2.4 Resilience Model of Family Stress, Adjustment and Adaptation

The Resilience Model of Family Stress, Adjustment and Adaptation is the most recent theory of family resilience and will be used as the theoretical framework for the current study. It will thus be discussed in depth and will be referred to as the Resilience Model. McCubbin and McCubbin

introduced the model in 1993 (McCubbin & McCubbin, 1993, 1996). The Resilience Model advances the T-Double and FAAR models with the following five additions (McCubbin & McCubbin, 1996):

1. Relational perspectives of family adjustment and adaptation.

2. Established and instituted patterns of family functioning included as part of adjustment and adaptation.

3. Integration and inclusion of family problem solving and family coping.

4. Four domains of family systems functioning, namely (a) interpersonal relationships, (b) development, well-being and spirituality, (c) community relationships and nature and (d) structure and function.

5. Five family levels of appraisal in relationship to patterns of functioning and problem solving and coping: schema [cCCCC], coherence [cCCC], paradigms [cCC], spiritual appraisal [cC], and stressor appraisal [C] (p. 13).

The following section will describe the model in depth, although some of the concepts have already been discussed in the earlier models. The Resilience Model also distinguishes between two phases, namely the adjustment and the adaptation phase, and should be read in conjunction with Figure 2.1.

bB
Existing & New
Resources

bBB
Social Support

BONADAPTATION

X
Crisis

aA
Pile-up

V
Vulnerability

T
Family
Type

PSC
Problem
Solving &
Coping

XX
ADAPTATION

cC
Situational
Appraisal

MALADAPTATION

cCC
Family Schema
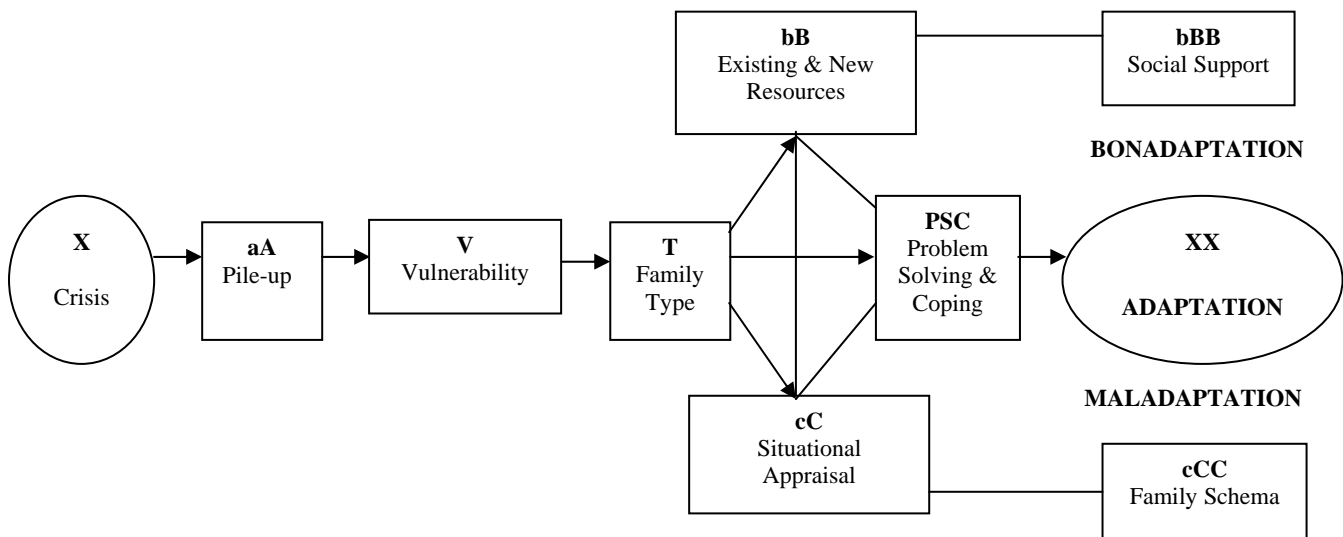
Figure 2.1. Resilience model of family stress, adjustment and adaptation (McCubbin & McCubbin., 1996).

2.4.2.4.1 Family Adjustment Phase

The adjustment phase is described by McCubbin and McCubbin (1996) as a sequence of components that interact to shape family processes and outcomes. The level of adjustment after a crisis situation [X] and into the adaptation stage or exhaustion is determined by the interaction of several factors or variables. Firstly, the stressor or event [A] interacts with the family's vulnerability [V]. The [V] factor represents the interpersonal and organisational condition of the family system. It is determined by (a) the pile-up of demands with the onset or impact of another stressor, and (b) the family's life-cycle stage (e.g., the onset of parental depression tends to be traumatic if it occurs during adolescence). The vulnerability factor [V], in turn, interacts with the family type (profile of family functioning) [T]. The family type basically predicts how the family functions, operates, appraises and behaves. This is affected by and affects the family resistance resources [B], which interact with the family's appraisal [C] of the event. The [B] factor refers to the family's resources for meeting the demands of stress events and directly influences the family's definition, viewpoint or appraisal [C] of the stressor. These two factors interact further with the family's management [PSC] of the stressor through its problem-solving and coping skills.

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The outcomes or results of this process vary along a continuum from the more positive (bon-adjustment) to the other extreme (maladjustment). These components will be discussed in further detail in the next section.

2.4.2.4.1.1 Balance and Harmony

Balance and harmony are keys element in the Resilience Model and is seen as the place to which families tend to rebound from stressors and adversity. Families strive for balance and harmony in the following four domains: (a) interpersonal relationships, (b) structure and function, (c) development, well-being and spirituality, and (d) community interaction and integration (McCubbin & McCubbin, 1996). This element also manifests in the explanation of the following concepts.

2.4.2.4.1.2 The Stressor [A]

McCubbin and McCubbin (1996) describe the stressor [A] as "a demand placed on the family that produces, or has the potential of producing changes in the family system" (p. 17). These changes, or the threat of change, may influence all areas of family life, including the marital relationship, family goals, parent-child relationships and the family's level of balance and harmony. The severity of the stressors (i.e., parent living with depression) is determined by the amount to which the stressor threatens the stability of the family system, disrupts the family system, or puts considerable demands on or depletes family resources and capabilities (McCubbin & McCubbin, 1996).

2.4.2.4.1.3 Family Vulnerability [V]

"Vulnerability [V] refers to the inter-personal and organisational condition of the family system" (McCubbin & McCubbin, 1996, p. 17). Vulnerability ranges from high to low and is firstly determined by the pile-up or accumulation of demands on or within the family unit (i.e., financial debts, depression of a member or changes in parental work role). Secondly, it is

dominated by the normative trials and tribulations coupled with the family's current life cycle stage.

2.4.2.4.1.4 Family Typology of Established Patterns of Functioning [T]

Family typology [T] "is defined as a set of attributes or cluster of behaviours that explain how the family system typically operates or behaves", while family type "is a predictable and discernible pattern of family functioning" (McCubbin & McCubbin, 1996, p. 18). Researchers have specified the importance of understanding the broad range of family types and patterns, such as the normative transitions of resilient families, who manage transition better as they exhibit established patterns and are able to be flexible. This plays a critical role in assisting the development, reinstallation and preservation of harmony and balance in the family unit.

2.4.2.4.1.5 Family Resistance Resources [B]

McCubbin and McCubbin (1996) describe family resistance resources [B] as:

> a family's ability and capability to address and manage the stressor and its demands and to maintain and promote harmony and balance in an effort to avoid a crisis, or disharmony and imbalance, and substantial changes in or deterioration in family's established patterns of functioning. (p. 19)

Resistance resources assist families to resist and withstand a crisis, by being resilient and finally enjoying a successful adjustment. Crucial family resources are social support, economic stability, cohesiveness, flexibility, hardiness, shared spiritual beliefs, open communication, traditions, celebrations, routines and organisation (Curran, 1983, as cited in McCubbin & McCubbin, 1996).

2.4.2.4.1.6 Family Appraisal of the Stressor [C]

The family's appraisal of the stressor is explained in terms of the definition the family attaches to the gravity and impact of the stressor and the hardship related to it (McCubbin & McCubbin,

1996). This appraisal [C] of the stressor might range from viewing the stressor as being a constructive challenge and manageable, to viewing the stressor as destructive and unmanageable.

2.4.2.4.1.7 Family Problem Solving and Coping [PSC]

The family's problem solving and coping [PSC] component "indicates the family's management of stress and distress through the use of its abilities and skills to manage or eliminate a stressor and related hardships" (McCubbin & McCubbin, 1996, p. 20).

Problem solving involves the family's ability to contain stressors and difficulties in manageable components, and further to work around a plan of actions or solutions for each component. It also involves the implementation of steps to resolve discrete issues, as well as engaging in a constructive pattern of problem-solving communication, which is needed to work towards maintaining or restoring balance and harmony (McCubbin & McCubbin, 1996).

Coping, on the other hand, refers to the family's active or passive strategies, patterns and behaviours coordinated to maintain or restore the family as a unit. It further involves the upholding of the emotional stability and well-being of the family members, by mobilising family and community resources to mange the situation or hardship (McCubbin & McCubbin, 1996).

2.4.2.4.1.8 Family Bon-adjustment, Maladjustment and Crisis [X]

If one focuses on the family's response to a stressor, most researchers are of the opinion that, if the stressor is not too great and if the family can withstand the hardship a state of bon-adjustment will evolve. The process of bon-adjustment is mobilised and influenced by the families' ability to positively appraise the stressor, the availability of functional family patterns and resistance resources as well as effective problem-solving and coping skills. However, on the other side of the continuum the stressor might be too severe, intense or chronic and the demands too great for the family to effectively mobilise the above-mentioned process. These families might need to make substantial second-order adjustments to cope, but would resist these changes in order to try and sustain balance and harmony.

This will then probably end in a state of maladjustment and a condition of family crisis [X]. McCubbin and McCubbin (1996) refer to a crisis as a "continuous condition of disruptiveness, disorganisation, or incapacitation in the family social system" (p. 22). Family stress is a disparity between the demands and the family's ability to deal with the demands, while family crisis represents family imbalance, disharmony and disorganisation. Within the Resilience Model, a family crisis is seen as a normative and growth-producing element that the family may initiate in order to bring about changes in the patterns of family functioning. This process of initiating changes marks the beginning of the adaptation phase of the Resilience Model.

2.4.2.4.2 Family Adaptation Phase

The Resilience Model focuses primarily on the family's change and adaptation over time. It is a resilience-focussed process, with specific focus on several post-crisis or adaptation-oriented elements in an effort to explain the family's behaviour and functioning in the process of adaptation (McCubbin & McCubbin, 1996).

This section will be twofold; firstly, it will address the family adaptation process, which comprises two levels, namely restructuring and consolidation, and, secondly, it will give an outline of the factors involved in the family adaptation phase. Some of the factors coincide with the factors of the adjustment phase, but on a different level.

The family adaptation process, as described by Van Breda (2001), has a first phase of restructuring, which is when the maladjusted family becomes aware that the family's efforts to adjust to the stressor are inadequate. The family then works towards a shared definition of the situation [C to cCC], which is influenced by both the pile-up [aA] of demands and the extent and availability of the family resources [bB]. This differs from the adjustment phase in that the adjustment changes are minimal, with no change to the family structure, while, with the adaptation restructuring, the family will actively search for new definitions and agree upon and

implement some or other structural change. However, the restructuring change is problem-focused and the family has little cognisance of the broader, long-term implications of the change.

In the second phase, called the consolidation phase, the family firstly works towards consolidating the changes by working in the broader consequences of the primary changes. Secondly, in the consolidation phase the entire family integrates the change, rather than to compartmentalise the change in the system as within the restructuring phase (Van Breda, 2001). Thus, the entire family works towards a shared view, life orientation and meaning, which will support and maintain the changes made in the family system.

The adaptation process is determined by the pile-up of demands [aA], interacting with the family's vulnerabilities [V], resources [bB], appraisal processes [C to cCCC], social support [bBB], patterns of functioning [tT], coping and problem solving [PSC], as well as processes that explain the relational processes involved in family adaptation (McCubbin & McCubbin, 1996).

2.4.2.4.2.1 Family Adaptation [xX]

Family Adaptation [xX] is used to describe the outcome of family efforts to bring about balance and harmony to a crisis situation. Bon-adaptation manifests when the family has integrated the demands of the stressor and acquired a state of harmony and balance with a fit at both the individual-to-family and the family-to-community level of functioning (McCubbin & McCubbin, 1996).

2.4.2.4.2.1.1 Pile-up [AA] of Demands

Families are continuously and regularly confronted by stressors, and seldom deal with one stressor at a time. Families thus have to deal with an accumulated stress effect or pile-up [aA] effect of these stressors. This is a common phenomenon in most families, but of particular importance in family situations involving a prolonged illness (i.e., family member with a psychiatric disorder) (McCubbin & McCubbin, 1996).

Because family adaptation evolves over time in a social context, McCubbin and McCubbin (1996) identified nine broad categories of stressors and strains. These categories contribute to the pile-up effect and the family's vulnerability in connection with the crisis situation. This eventually determines the family's ability to achieve balance and harmony:

1. The Stress and Hardship (McCubbin & McCubbin, 1996)

This category refers to the initial stressors and the associated difficulties, which develop over time. These difficulties may include problems in the marital or sibling relationship, parent-child conflict, community conflict, and decreased community and financial resources.

2. Normative Transitions (McCubbin & McCubbin, 1996)

Families experience predictable transitions and changes as a result of the normal growth and development of each member. These transitions (e.g., a child, in terms of need for nurturance and supervision, or adult development in terms of career changes) may co-occur independently but may also interact in ways that increase the pile-up of family stress.

3. Prior Strains (McCubbin & McCubbin, 1996)

Prior strains involve family strains that have built up over time. These may be residual strains resulting from previous stressors, or they may be carry-over strains inherent in certain roles, such as parenthood. Prior strains might surface or be highlighted in the pressure of new demands and thus contribute to the pile-up of demands.

4. Situational Demands and Contextual Difficulties (McCubbin & McCubbin, 1996)

The society or community within which the family is situated might pose unexpected situational demands or contextual difficulties. This influences the family's ability to deal with already existing stressors. These types of demands include financing of medical needs or threats of job losses.

5. Consequences of Family Efforts to Cope (McCubbin & McCubbin, 1996)

Not only the stressor itself leads to the pile-up effect, but also the consequences of the family's efforts to deal with the stressor, for example increased rigidity or denial of feelings and frustrations. These stressors can emerge from the adjustment phase or from the currently used strategies to deal with the stressor.

6. Intra-family and Social Ambiguity (McCubbin & McCubbin, 1996)

Every crisis situation causes a certain amount of ambiguity and uncertainty. Families might then rely on community guidelines and expectations on how to act in the specific crisis situation. These guidelines are not always impermeable and may be contradictory to the best interests of the family, and this might lead to a greater degree of tension and ambiguity.

7. Newly Instituted Patterns of Functioning Create Additional Stress (McCubbin & McCubbin, 1996)

The healthy new patterns of functioning established by the family during the adaptation phase in reaction to crisis situations may demand changes in the family system, creating additional stress and leading to the pile-up of stressors. Especially in the short run, these patterns bring additional strains to family roles, rules, values and relationships, as changes are demanded to integrate these new patterns of functioning.

8. Newly Instituted Patterns of Functioning Clash with Family Beliefs (McCubbin & McCubbin, 1996)

Newly instituted pattern of functioning might create additional stress, as not all the family members might agree upon the changes implemented and it might clash with the family's belief system.

9. Established Patterns of Functioning (McCubbin & McCubbin, 1996)

Lastly, a pile-up of stressors and tension might occur, as the old patterns of functioning may no longer be compatible with the newly formulated patterns of functioning. These old patterns are, however, crucial in providing harmony and stability to the system while it is adapting.

To a large extent, the last three categories resemble the following element, namely family types of functioning, in the Resilience Model.

2.4.2.4.2.1.2 Family Types and Newly Instituted Patterns of Functioning [T&tT]

The family's typical pattern of functioning influences the adaptability of the family and is represented in the Resilience Model as [T&tT] (McCubbin & McCubbin, 1996; Van Breda, 2001):

1. Inadequate and /or Deterioration in Family Patterns of Functioning [T]

By the end of the adjustment phase, these inadequate patterns of functioning influence the family's degree of maladjustment as it inters the adaptation phase. A significant part of the reason for a family to enter the maladjustment phase can be ascribed to inadequate or deteriorating patterns of functioning. This unsuccessful adjustment process exacerbates the family crisis.

2. Retained Patterns of Functioning [T]

The family usually enters the adaptation phase with previously acquired functional patterns of functioning, which may facilitate the bon-adaptation process. However, some of these patterns might be pathogenic and may clash with the new patterns.

3. Restored Patterns of Functioning [T]

The crisis [X] may reactivate old or restored patterns of functioning that are needed to cope with the presenting situation. The activation particularly occurs in the face of prolonged stress (e.g.,

the death of a spouse might force the surviving spouse to regain patterns of functioning from her/his single days).

4. Newly Instituted Patterns of Functioning [tT]

As discussed in the former section, as well as in relation to the FAAR model, the adaptation phase requires the family to make significant second-order changes in order to adapt. These changes facilitate the development of new typologies.

2.4.2.4.2.1.3 Family Resources [bB]

Family resources comprise family capabilities and strengths or adaptive resources. They can be described as the family's potential to draw upon or create resources to meet the demands of the crisis (McCubbin & McCubbin, 1996). Individual family members, the family unit or the community can serve as potential sources of resources. A resilient resource is a characteristic, trait or competency of one of these systems that facilitates adaptation. Resources vary greatly, from tangible (e.g., money or programmes) to intangible forms (e.g., ethnic identity or self-esteem).

Personal and family system resources are important for family adaptation. Personal resources include the innate intelligence of family members' knowledge and skills, personal traits, physical, spiritual and emotional health, sense of mastery, self-esteem, sense of coherence and ethnic identity, and cultural background. The two most important family resources are cohesion (the bond of unity between the family members) and adaptability of the family members. Other family resources include trust, appreciation, support, integration, respect for individuality, family organisation (agreement, clarity and consistency, shared parental leadership and boundaries), instrumental and effective communication, and family hardiness (sense of control over the outcome of events and stressors) (McCubbin & McCubbin, 1996).

2.4.2.4.2.1.4 Social Support [bBB]

McCubbin and McCubbin (1996) described social support [bBB] as all the persons and institutions that individual members of the family as a unit may utilise to manage a crisis situation. It includes both formal (medical or social services) and informal (family or extended family members) sources. It also includes the broader social structure (government).

McCubbin and McCubbin (1996) combined Cobb's view of social support with their own and conceptualised five categories of social support, namely emotional support, esteem support, network support, appraisal (feedback) support and altruistic support.

2.4.2.4.2.1.5 Family Appraisal Processes [C to cCCCC]

The family appraisal process involves five levels, namely schema [cCCCC], coherence [CCCC], paradigms [CCC], situational appraisal [CC] and stressor appraisal [C] (McCubbin & McCubbin, 1996; McCubbin & Patterson, 1983). The work done by McCubbin and his colleagues on the appraisal process is most unique and a major new contribution to family resilience theory. They also introduced the importance of a family's culture and ethnicity in the appraisal process. These processes assist families in giving meaning to stressful situations and are critical in integrating adaptation for the family unit.

1. Family Appraisal Process Level 5: Family Schema [cCCCC]

Family Schema [cCCCC] is an integral part of the family's attempts to change its existing patterns of functioning. Over time, families compile and adapt their own unique set of values and beliefs by which the family unit can be identified. A family schema is described as "a structure of fundamental convictions, values, beliefs and expectations" (McCubbin & McCubbin, 1996, p. 39). It creates the family's unique characteristics and serves as an overriding backdrop of information against which the family's experiences and behaviours are integrated, processed and evaluated. The family's worldview, including cultural and ethnic beliefs and values, plays an

important role in further sculpting the family's schemas. These schemas are highly resistant to change and have a central function of giving meaning within the family unit.

The family schema promotes the development of meaning through five primary functions (McCubbin & McCubbin, 1996): (a) classification – understanding the crisis in terms of shared values and expectations, (b) spiritualisation – understanding the situation in the context of the family's spiritual belief, (c) temporalisation – understanding the crisis in terms of long view and long-term consequences, but focussing on the positive nature of the present, (d) contextualisation (nature) – understanding the crisis in terms of and in the order of living things, and (e) contextualisation (relationships) – framing the crisis in terms of human relationships, thus a group orientation and not in terms of individual needs.

2. Family Appraisal Level 4: Family Coherence [cCCC]

Family coherence [cCCC] refers to the motivational and appraisal bases for utilising and activating the family's potential resources into actual resources, by facilitating changes, coping, health and well-being in the family system (McCubbin & McCubbin, 1996). Family coherence is optimised if the family manages to view the world/stressor as being comprehensible, manageable and meaningful, which correlates with the previously discussed theory of Antonovsky.

3. Family Appraisal Process Level 3: Family Paradigm [cCC]

Family paradigms [cCC] are shared and adopted rules within the family, which guide the family's development of specific patterns of functioning around explicit domains in life (McCubbin & McCubbin, 1996). Once a paradigm has been settled and shaped regarding a specific issue, family functioning will not occur in the absence of a paradigm (e.g., child rearing, communication, etc.). Family paradigm is a lower order appraisal process than the fifth and fourth levels. Family schema and coherence relate to daily living and consciousness, while family paradigm focuses specifically on family functions, patterns and dimensions.

4. Family Appraisal Process Level 2: Situational Appraisal [cC]

Situational appraisal [cC] refers to the family's ability to evaluate its capabilities and the demands the stressor poses, as well as the demands upon the family, to change some established patterns of functioning (McCubbin & McCubbin, 1996). Situational appraisal focuses on the specific stressor in general, while family paradigm focuses on the family's functioning in general.

5. Family Appraisal Process Level 1: Stressor Appraisal [C]

The stressor appraisal [C] refers to the family's definition of the stressors, as well as of their severity (McCubbin & McCubbin, 1996). Stressor appraisal does not feature in the adaptation phase, because by the time the family enters the adaptation phase this part of appraisal has already been dealt with in the adjustment phase.

A description of the appraisal process is warranted so as to give clarity on how it occurs within a family crisis situation, such as in the case of a member with a treatable injury (McCubbin & McCubbin, 1996). Firstly, the family's appraisal process is activated, with minimal involvement of the family's schema or the family's coherence. However, the family's paradigms [cCC], situational appraisal [cC] and stressor appraisal [C] will be utilised to shape the family's initial response and behaviour.

In contrast to the above, in a more severe crisis situation such as a family member living with depression, the established patterns of functioning might not be sufficient in helping the family through the crisis. Thus the need for changes in the family unit, accompanied by action and adaptation at all levels of family appraisal (family schema, sense of coherence, paradigms and situational appraisal), will be implicated and emphasised. New resources and capabilities are needed, family routines might need change, family roles must be re-established; family paradigms may be challenged and restructured, and newly established patterns of family functioning, along with new roles and expectations, will be developed. All this will lead to a shift

in the family's established patterns of functioning, which will lead to new family paradigms, including new and adopted rules and expectations for the implementation of the newly established patterns of functioning. This, in turn, will activate the family's schema, which is the centre of the family's appraisal process. The appraisal process will assist the family in ascribing new meaning to the stressor, which may help them to view the stressor in a less threatening way than previously. When combined with the three other levels of appraisal (coherence, paradigms and situational appraisal), the family's schema helps them to develop their unique identity and strengthens the family's sense of coherence.

The adaptation phase further involves congruency. New patterns of functioning must be congruent to the family's existing paradigms and schemas. Family bon-adaptation, which is the desired end product of the adaptation phase, is characterised by family harmony, balance, stability and congruity.

2.4.2.4.2.1.6 Family Problem Solving and Coping [PSC]

Family Problem Solving and Coping [PSC] is "the process of acquiring, allocating, and using resources for meeting crisis-induced demands" (McCubbin & McCubbin, 1996, p. 49). It might also aim at the reduction or elimination of stressors, the identification and utilisation of additional resources, as well as the continuous management of the family system tension. It further shapes the appraisal at both the situational and schema level.

Adaptive coping involves four important concepts. Firstly is synergising, in which the family members work together as a unit; second comes interfacing, in which the family promotes family-to-community balance, and, thirdly, compromising, in which the family compromises if new changes do not meet needs that assist the family in the consolidation phase. Lastly, system maintenance is the adaptive coping strategy involved in the restructuring phase (McCubbin & Patterson, 1983; Van Breda, 2001). These adaptive efforts result in adaptation ranging from bon-adaptation to mal-adaptation.

2.4.2.5 Walsh's Family Resilience Framework

Subsequent to McCubbin and McCubbin's model, Walsh (2003b) also contributed to family resilience theory by focussing on key processes in family resilience. These processes aim to reduce stress and vulnerability during crisis situations, and to foster healing, growth and family empowerment. Walsh (2003b) identified three domains of family functioning that influence family resilience, to be discussed below.

The first domain concentrates on family belief systems. The family's belief system assists families to organise and structure family processes as well as their approach to dealing with crises. It involves the family's ability to find meaning and to maintain a positive outlook in the face of adversity. It mainly includes values, convictions, attitudes, biases and assumptions, which form a set framework that triggers emotional responses, informs decisions and guides actions (Walsh, 2003b). In this domain, resilient families are seen managing to normalise and conceptualise a crisis, and to view it as a shared challenge within a trusting environment. Walsh (2003b) argues that a strong sense of coherence will be fostered if a family manages to see a given situation as manageable, meaningful and comprehensible. This will assist and strengthen family resilience (Walsh, 2003b).

The second domain encompasses the organisational patterns of the family, which focuses on flexibility, connectedness and social and economic resources (Walsh, 2003b). Flexibility stands for the opposite of rigidity, and for a family to be resilient the family has to incorporate flexible processes when attending to a new or different stressor, without falling apart. It further focuses on the family's ability to bounce back and adapt to demands. Connectedness has also been found to improve family resilience. Families who find a balance between mutual support, collaboration and commitment, versus boundaries, differences and individuality, tend to function better. Social and economic resources have also been shown to be important contributors to resilience. Extended family support, social networks, friends, community groups and religious organisations are examples of social resources. Organisational patterns of family systems incorporate financial

resources, which appear to be a strong resilience factor, especially in ongoing stressors like a chronic illness.

Lastly, the third domain focuses on the communication process in families (Walsh, 2003b). It is well known that good communication is vital to family functioning. However, good communication tends to be controversial in terms of quantifying the concept. Walsh (2003b) identified three key elements of communication, namely clarity, open emotional expression and collaborative problem solving.

In terms of clarity, value is added if family members communicate clearly with consistent messages that aim to clarify unclear information. Clarity ties in with open emotional communication in the family system, in the sense of openly sharing and expressing underlying emotional responses, and then receiving these responses with the necessary tact and empathy. This supports each family member to take responsibility and ownership of their own feelings, without blaming the others. Collaborative problem solving involves (a) conjoined problem identification, (b) creatively brainstorming resources and (c) shared decision making as a family. This also links to shared conflict resolution, which eventually forms a framework of success from which the family can draw for assisting them with future problems.

Family processes, as described by Walsh (1998), serve as mediating factors for families in the sense that protective processes foster resilience and maladaptive processes increase vulnerability and risks for the family unit.

2.4.2.6 Postulation for a Circular and Salutogenic Adaptation of the Resilience Model

In addition to the above-mentioned theoretical developments, a South African researcher, Smith (2006), emphasised an omission in the current Resilience Model. She studied Xhosa family resilience and found that communication plays a crucial role in these families, an element that was not accounted for in the Resilience Model. She came to the conclusion that communication is a trans-cultural phenomenon on different levels and that its presence warranted an adaptation

of the Resilience Model. This highlights the potential for continuous refinement of the Resilience Model in reaction to the fact that families continuously change and adapt in reaction to demands on a micro-, meso- and macro-level.

2.5 Conclusion

This chapter illustrated the interwoven development of, initially individual resilience as a concept and then the simultaneous evolving of family resilience theory over the past 60 years. In summary: family resilience theory was formulated by Hill in 1949 with the ABCX Model (1949, 1958). Numerous researchers refined this model. After the initial development of the model, three additional developments evolved naturally, namely the Double ABCX Model of McCubbin and Patterson (1982, 1983), the Family Adjustment and Adaptation Response Model (FAAR), and the T-Double ABCX Model of McCubbin and McCubbin (1989). A few years later, McCubbin and McCubbin (1993, 1996) developed the Resilience Model of Family Stress, Adjustment and Adaptation. In addition to this model, Walsh (2003b) published the Family Resilience Framework, which focused on belief systems, organisation patterns and communication processes in families. The Resilience Model (McCubbin & McCubbin, 1993, 1996) and the Family Resilience Framework (Walsh, 2003b) form the basis of the theoretical underpinning of the current study. These developments pointed to the significant amount of research and theoretical development regarding resilience theory, with specific focus on the family as the unit of analysis.

The next chapter provides a literature review of relevant research done within the family resilience paradigm. There will be specific focus on resilience factors and parental depression.

CHAPTER 3

FAMILY RESILIENCE AND DEPRESSION

3.1 Chapter Preview

This chapter begins by defining contemporary families and progressing into a description and outline of major depressive disorder (MDD). The relevance of the current Family Resilience Model (McCubbin & McCubbin, 1993, 1996) is discussed. A literature review on family resilience is given and structured according to the Family Resilience Model (McCubbin & McCubbin, 1993; 1996). There will be specific focus on resilience in families with a member who has been living with a psychiatric disorder.

3.2 Introduction

Defining contemporary families is a complex and multifaceted process (Patterson, 2002; Walsh, 2002). Patterson (2002) defines a family as two or more individuals with a certain pattern and relationship between them. Families are currently characterised by an escalation of stress and transformation. This results in diverse family forms, such as single-parent households, blended family units, interracial marriages, and stepfamily systems (McCubbin, McCubbin, Thompson, Han & Allen, 1997). A substantial amount of pressure is placed on families to perform and deal with changes in social structures, the demands of society and general daily living. It is assumed that families will be competent and resilient in the face of these challenges. The added hardships and the fact that families need a greater amount of resilience and support to deal with these challenges effectively, as in the case of major depressive disorder, is often neglected.

The current study focuses specifically on families affiliated to the South African National Defence Force (SANDF), which necessitate some distinction and description (Maj. V. Dalla Cia, personal communication, senior psychologist at a military hospital, July 14, 2008). These families were all actively involved in the military system, or had been in the military for at least 10 years. The military environment is well known for its strenuous impact on family life. Factors

such as deployments and harsh military environments have an inconsistent and disruptive effect on families. Single parent households often occur when a partner is deployed or sent on detached duty. The military environment necessitates a disciplined, strict and rigid way of being. These principles are often forced on family members by parents who struggle to let go of their military roles and follow harsh black-and-white thinking strategies, with little focus on emotional expression and well-being. However, the military also offers stabilising factors that can benefit families in a positive way. Firstly, the military offers financial security (i.e., housing, pension, uniform allowance and transport) and status. Secondly, these families have access to resources like full medical coverage, which includes social and psychological support for family members. Thirdly, these families have the opportunity for self-development and to further their studies through the military. Despite the risk factors associated with military families, these families have access to protective and recovery factors that can assist with their adaptation process.

With the brief overview and contextualisation of contemporary and military families, the following section will focus on the criteria, features, course, aetiology and treatment of major depressive disorder (MDD). This section is particularly important for an understanding of the specific disorder the families in the current study had to deal with.

3.3 Major Depressive Disorder

In 1990, depression was found to be the fourth leading cause of disease-burden in the world by the Global Burden of Disease Project. By 2020, depression is expected to become the single leading cause of disease-burden worldwide (Ellen, 2005). This trend has raised concern, as the illness often occurs within a family system and the question regarding coping with it remains imminent.

3.3.1 Criteria for Major Depressive Disorder

Major depressive disorder (MDD) is one of the mood disorders classified within the Diagnostic and Statistical Manual of Psychiatric Disorders (DSM-1V-TR) (American Psychiatric Association, 2002). The criteria for depression briefly are as follows:

A. Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (a) depressed mood or (b) loss of interest or pleasure.

1. depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.

2. markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

3. significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weigh in a month), or decrease in appetite nearly every day. Note: in children, consider failure to make expected weigh gains.

4. insomnia or hypersomnia nearly every day

5. psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

6. fatigue or loss of energy nearly every day

7. feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

8. diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

9. recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or either important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than two months or are characterised by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation (p. 356).

3.3.1.1 Associated Features and Disorders

Individuals with an MDD frequently present with tearfulness, irritability, brooding, obsessive rumination, anxiety, phobias, excessive worries over physical health and somatic complaints (American Psychiatric Association, 2002). The DSM-1V-TR (American Psychiatric Association, 2002) states that problems in intimate relationships often occur, characterised by less satisfying social interaction or problems in sexual functioning. This also ties in with marital, occupational and academic problems. One of the most serious consequences of MDD is suicide and the risk of suicide. This can be a major burden on the family, and will call for new and innovative coping and adaptation strategies.

3.3.1.2 Specific Culture, Gender Features and Age

Universal research findings indicate that a two-fold greater prevalence of MDD exists in women than in men (Kaplan & Sadock, 1998). This trend seems to be unrelated to ethnicity, education, income or marital status (American Psychiatric Association, 2002; Kaplan & Sadock, 1998). A recent study conducted in South Africa supports the notion that depression rates are significantly

higher among females than males (Tomlinson, Grimsrud, Stein, Williams & Myer, 2009). Kaplan and Sadock (1998) mentioned that MDD often occurs in people without close interpersonal relationships, or in those who are divorced or separated. However, this notion was contradicted by the study of Tomlinson et al. (2009), who found that depression rates were higher amongst those South Africans with a lower education level. Generally, the mean age for the onset of MDD is in the mid twenties (American Psychiatric Association, 2002). This trend is supported by the findings of Tomlinson et al. (2009), who indicated that the mean age of onset for their sample of South Africans was 25.6 years for the total sample, 26 years for the females and 25.6 for the males.

3.3.1.3 Course

MDD is a common disorder (Ohayon, 2007), with a lifetime prevalence of about 15%, and possibly as high as 25% for women (Kaplan & Sadock, 1998). Tomlinson et al. (2009) revealed that the life-time prevalence of MDD in South Africa is 9.8%. This rate is lower in comparison with data from other countries.

About 60% of individuals with a single episode of MDD can be expected to have a second major depressive episode (Kaplan & Sadock, 1998). These figures increase dramatically to a 90% chance of developing another episode after the third episode (American Psychiatric Association, 2002). This suggests that a parental figure with a first depressive episode has a significant chance of having recurrent depressive episodes. In about two-thirds of cases, depression will end in complete remission, and in the remaining one-third remission will be only partial or not at all. For the remaining 33% there is a greater possibility of developing additional episodes and the individual will probably continue with this pattern of partial inter-episode recovery (American Psychiatric Association, 2002). Early age of onset appears to define a positive familial history of MDD, and is twice more frequent among women than among men (Nierenberg et al., 2007).

3.3.1.4 Aetiology

The aetiological factors contributing to the development of MDD can be divided into three categories, namely biological, genetic and psychological factors (Kaplan & Sadock, 1998). Seen from a biological realm it is consistently found that mood disorders are associated with heterogeneous deregulation of the biogenic amines. Of the biogenic amines, nor-epinephrine and serotonin are the most frequently indicated in the pathophysiology of mood disorders (Kaplan & Sadock, 1998). Kaplan and Sadock (1998) state that research indicates strongly that genetic factors play a significant role in the development of MDD. MDD is about one and a half to three times more common among first-degree biological relatives of individuals with depression than among the general population (American Psychiatric Association, 2002). From a psychological point of view it is suggested that longstanding stressful events often precede first rather than subsequent depressive episodes. Research indicates that recent stressful events are the single most powerful predication of MDD, more so than any specific personality trait (Kaplan & Sadock, 1998). However, it is indicated that there tends to be a strong correlation between the family functioning and the onset and course of mood disorders. Thus, the degree of family pathology influences the course of the illness. It can be interpreted that the family functioning as a whole has a direct impact on the course, rate of recovery, return of symptoms and the severity of the mood disorder.

3.3.1.5 Treatment

Kaplan and Sadock (1998) mention that the treatment plan for individuals with MDD typically includes hospitalisation, pharmacotherapy and psychotherapy. Hospitalisation is indicated when a patient is a suicide or homicide risk, and also if support systems are not optimal. Most researchers are of the opinion that a combination of psychotherapy and pharmacotherapy is indicated to treat depression effectively. It is also suggested, however, that either one alone is also effective, especially with mild depression (Kaplan & Sadock, 1998). Psychotherapy ranges from cognitive therapy, interpersonal therapy, behavioural therapy, psychoanalytical orientated

therapy and family therapy (Kaplan & Sadock, 1998). The outcome of these specific therapies varies and the success rates depend on a multitude of interrelated factors.

The question arose as to the relevance and applicability of the Family Resilience Model, especially in the light of the nature of depression and all the potential risk factors associated with parental depression in families. In the following section the applicability and reason for the implementation of the Family Resilience Model in the current research will be discussed.

3.4 Relevance of the Family Resilience Model

The Family Resilience framework offers several advantages and is used by clinicians and researchers for the following reasons (Walsh, 2002, 2003a). Firstly, by definition the model focuses on family strengths during a crisis rather than on pathology. Secondly, it assumes that no single model fits all families, dynamics or situations. The Resilience Model assesses functioning in the context of family values, resources and life challenges. Thirdly, the processes for optimal functioning and well-being of family members are seen to fluctuate over time as challenges unfold and families mature.

Previously there was substantial critique regarding the conceptualisation and empirical testing within the family research paradigm. However, the Family Resilience Model of McCubbin and McCubbin (1993, 1996) is revolutionary in terms of providing a framework for empirical testing and measurement of the family resilience process (Smith, 2006). Van Breda (2001) adds that the resilience model considers interpersonal and intra-familial factors, and not on intra-psychic ones (which focus on system issues regarding the fit between member and family, and between family and community). This opens the possibility for interventions, because the resilience factors are located in the family and not just individually. There thus is a greater possibility to develop families' support systems, patterns of communication and cohesion, or to develop other resilience factors through a group intervention programme, or therapeutically within the family (Van Breda, 2001).

The Family Resilience Model is very versatile and is applicable to any family situation, as with the current research population. The model suggests that a family's adaptation to a crisis, such as family member living with depression [xX], will be mediated by the pile-up of additional stress and demands (i.e., financial burdens) [aA], which interact with the family's vulnerabilities [V], the family resources subsequently available to the family [bB], the family's perception of the diagnosis and consequent events [C to cCCC], social support [bBB], patterns of functioning [tT], as well as coping and problem solving [PSC] (McCubbin & McCubbin, 1996).

The Family Resilience Model furnishes the current study with a strong theoretical framework for the identification of resilience factors, as well as their development. The work of McCubbin and his colleagues involves three processes, namely (a) theory and model development, which were discussed in Chapter 2, (b) scale development and (c) empirical research (Van Breda, 2001).

The concept of resilience has a short, colourful history in longitudinal research on resilience in children, which predictably evolved in the development of family resilience theory, as discussed in Chapter 2. This evolution was basically shaped by the findings of these studies, which indicated the importance of the family system. Essentially, the Family Resilience Model involves two distinguishable but related family processes, namely adjustment and adaptation, as discussed previously (McCubbin et al., 1997). Thus, family resilience research has subsequently focussed on identifying the protective and risk factors that are critical to assist with family adjustment in the face of risks and stress, as well as on recovery factors, which are vital in the family adaptation process (McCubbin et al., 1997). Developing strengths in response to a stressor highlights the dynamic nature of protective factors (Patterson, 2002). The following section will focus on the empirical research and the integration thereof in the Family Resilience Model. It will focus on the adaptation phase, as it is suggested that families who experience a psychiatric disorder (MDD) would probably be in the adaptation phase due to the crisis and the impact of the illness on the system. The outline and structure of the Family Resilience Model will be used to

structure the empirical research overview (McCubbin & McCubbin, 1996). It will further motivate and illustrate the applicability of the current research paradigm.

Before exploring this section, the following literature review should be mentioned to orientate the reader.

National and international literature on family resilience in families with psychiatric disorders is very limited. Consequently, the researcher included studies that explored family strengths and coping, which expanded the literature searches. Only a few studies addressing psychiatric disorders (Enns et al., 1999; Greeff et al., 2005; Jonker, 2008; Marsh & Lefley, 1996) in the specific Family Resilience Framework (McCubbin & McCubbin, 1996) were identified. Research in the family resilience paradigm commenced in South Africa recently. From 2001, Greeff and colleagues (University of Stellenbosch) researched the specific exploration of family resilience factors in the Family Resilience Framework. These studies focused mainly on identifying resilience factors in a specific familial situation (e.g., single parent families, divorced families). These studies made a valuable contribution to the already existing body of research, which aims to identify resilience factors. Most of these studies were part of the first phase of research in this field, both nationally as well as internationally. International studies addressing family resilience are included, as certain general resilience factors will also be applicable to the current research population.

The following section will integrate the results of these different studies by applying them to the Family Resilience Model.

3.5 Family Resilience: Adaptation Phase

3.5.1 Family Adaptation [xX]

Family adaptation [xX] focuses on the outcome of a family's efforts to bring about balance and harmony in a crisis situation, such as when a parent lives with depression, as described in

Chapter 2 (McCubbin & McCubbin, 1996). The impact of parental MDD tends to be multi-faceted and has an expansive effect on all levels of the family system, including each family member (Beardslee et al., 1997b; Mordoch & Hall, 2002). It is specified that the average age of onset of MDD is several years after the birth of the first child, which suggests that depression often presents within a familial setup (Nicholson & Clayfield, 2004). Disability in one family member affects all the other family members and the system in totality (Hornby & Seligman, 1991). Because MDD often occurs within the family setup, it is important to acknowledge the fact that the family system might find it difficult to cope with the challenges posed, which can lead to maladjustment and cause a crisis situation [X]. The crisis situation will call for an adaptation [xX] process in order to achieve equilibrium, balance and harmony in the family setup.

The study by Enns et al. (1999) illustrates the challenges posed regarding the adaptation [xX] process involved in families living with a member with a psychiatric disorder. These researchers evaluated the family members of patients admitted to a large psychiatric hospital by measuring family adaptation, appraisal, stressors and resources. The Family Resilience Model (McCubbin & McCubbin, 1996) was utilised as the theoretical underpinning for this study. Family members (N = 111) of the inpatients completed questionnaires regarding family adaptation, appraisal, stressors and resources. The results were compared to the general population's replies to these questionnaires. Several interesting discoveries were made. These findings will be discussed under the applicable subsection of the Resilience Model in this chapter. With regard to adaptation [xX], it was found that the respondents indicated statistically significant higher levels of concern on the adaptation measurement of affective expression (i.e., family's awareness of each other's emotional needs and the ability to respond effectively), communication and control (i.e., ability to adjust patterns to changing demands) than the general population. This is indicative of the fact that a psychiatric disorder in families challenges the system in terms of adjustment and adaptation. A specific cohort of stressors that creates a pile-up [Aa] effect and

leaves the family system vulnerable [V] is associated with this specific family group. These factors might potentially complicate the adaptation process [xX]. The following section will address these stressors and vulnerabilities.

3.5.2 Pile-up [Aa] of Demands and Family Vulnerability [V]

Families are continuously dealing with numerous stressors at a given time, and this results in an accumulated stress or pile-up [aA] effect, as described in Chapter 2 (McCubbin & McCubbin, 1996). Numerous risk factors for families with parental depression have been established that contribute to the pile-up of demands. Family Vulnerability [V] is determined by the pile-up of demands [aA] and the family's life cycle stages. The following section explores the stressors associated with a psychiatric disorder that might impact on the pile-up [aA] and vulnerability [V] of the family. The pile-up of stressors associated with a psychiatric disorder, and specifically with depression, challenges the family system in bringing about harmony and stability.

Depression is one of the most prevalent psychiatric disorders and tends to have a chronic course. It is often co-morbid in nature, as mentioned in the previous section (Burke, 2003). It is thus important to view depression within its social context. The rationale is that depression is widely seen as an illness that impacts greatly on a family and, eventually, on a community (Burke, 2003; Johnson, 2000).

Research states clearly that families living with a member with a psychiatric disorder tend to experience chronic levels of strain and burden, which impact greatly on the pile-up [aA] of demands (Carpentier, Lesage, Goulet, Lalonde & Renaud, 1992; Chafetz & Barnes, 1989; Johnson, 1994; Marsh & Lefley, 1996; Noh & Turner, 1978; Solomon & Draine, 1995; Van Wijngaarden, Schene & Koeter, 2004). This can be divided into two categories, namely objective and subjective burdens. Objective burden refers to concrete stressors such as financial problems, limitations on social life and family disruption. Subjective burden indicates the extent to which the patient's presence, behaviour and/or dependency is perceived as an added source of concern

and strain on the family. Van Wijngaarden et al. (2004) specifically suggest that the burden of depression is linked to interpersonal aspects of relationships, such as worrying, feeling burdened, and experiencing stress. Depression affects daily routines and role functioning, which add to the pile-up effect, affecting the family's vulnerability.

Families with a psychiatric disorder are usually characterised by destructive or less effective parenting patterns, greater family discord, lower cohesion, and higher divorce rates than families of non-depressed patients (Beardslee & Wheelock, 1994). Beardslee, Versage and Gladstone (1998) and Whisman (1999) also added to this list by including genetic influences and marital difficulties associated with parental depression.

Several studies revealed that parental depression is a risk factor for a variety of adjustment difficulties in children (Beardslee & Gladstone, 2001). They demonstrated that 50% of children of parents with a mood disorder are expected to experience an episode of depression themselves by the age of 19, or that they are at an elevated risk of developing a psychiatric disorder (Avenevoli & Merikangas, 2006; Beardslee et al., 1993; Beardslee & MacMillan, 1993; Burke, 2003; Devlin & O'Brien, 1999; Grigoroiu-Serbanescu, Christodorescu, Jipescu, Marinescu & Ardelean, 1990; Sarigiane, Heath & Camarena, 2003). Noh and Turner (1987) confirmed this by mentioning that the single most common problem reported by family members is the effect on their own mental health and psychological well-being. This supports a study done by Sarigiane et al. (2003), which found that adolescents in families with parental depression reported higher levels of depressed mood and greater family conflict.

Most research focuses on maternal rather than paternal depression, while there is little evidence that suggest that the impact differs. Kane and Garber (2004) suggest that paternal depression might indirectly increase the effects in children of depressed mothers. Thus, the combined effects of paternal and maternal depression may be linked to worse outcomes (Manning & Gregoire, 2006). However, Peisah, Brodaty, Luscombe and Anstey (2004) found that children tend to

relate to depressed mothers in a complex way, with a fusion of greater responsibility and less regard, while with depressed fathers they simply disengage. They are further at risk for specific psychiatric disorders, such as anxiety and substance disorders, and have problematic relationships with the well spouse, especially if the well spouse is their father. Elgar, McGrath, Waschbusch, Steward and Curtis (2004) mention that depression in mothers and adjustment problems in their children are frequent and tend to co-exist. Peisah et al. (2004) support the above-mentioned by arguing that the children of depressed parents may be at higher risk for developing a psychiatric disorder in general, and depression specifically. These researchers have indicated that the children of depressed mothers might have problematic relationships with their fathers, instead of the anticipated broadly disrupted family relationships. Depression in mothers is more strongly related with increased psychopathology in children than is depression in fathers (Keller et al., 1986). Manning and Gregoire (2006) found that maternal psychiatric disorders can have a significant impact on the social, emotional, behavioural and cognitive development of children, as well as on their safety and wider environment (Avenevoli & Merikangas, 2006). The impact of maternal psychiatric disorders occurs early, even before birth (Manning & Gregoire, 2006); hence, children seem to be most vulnerable to the impact of parental depression from birth to the age of 17 years (Keller et al., 1986). It seems that these researchers are all in agreement that the risk factor posed to children in families with parental depression might potentially affect all aspects of their lives – social, emotional and behavioural. These risk factors impact on the family's vulnerability [V], and are important variables for consideration, regarding the current research population.

In terms of the couple cohort in a family system, the general perception exists that illness in a partner might have a detrimental impact on the couple's relationship. Rolland (2003) argues that when serious illness (i.e., cancer, AIDS, psychiatric disorders) or disability strikes a couple, a number of significant structural (i.e., role changes) and emotional problems are likely to take place. In terms of psychiatric disorders specifically, Whisman (1999) specified that marital

dissatisfaction could be uniquely related to major depression and post-traumatic stress disorder for women and dysthymia for men.

Despite the general assumption that psychiatric disorders pose challenges regarding the accumulation of stressors, the study of Enns et al. (1999) revealed no significant differences regarding the accumulation of stressors [aA] between the total sample and the psychiatric population or gender. This finding is surprising in the light of the high level of family burden associated with psychiatric disorders, as discussed above. However, it might be that the scores were moderated due to the fact that these families had the option of re-admitting the family member, which might have alleviated the family's burden. The study of Noh and Turner (1987) focused on the relationship between level of family burden (chronic strain) and the extent of psychological distress amongst family members of ex-hospitalised psychiatric patients (N = 211). Data for this study was drawn from a larger study of psychiatric disorders. All the patients has been living as functionally psychotic (schizophrenia and other psychoses) and were living with a significant other (i.e., family). Different questionnaires were employed to assess the mental health of the significant others, the subjective and objective family burden, mastery or sense of personal control, social support and stressful life events. It was found that psychiatric health did not appear to be the direct cause of family burden, but rather the social-psychological variables (i.e., mastery, community tenure and social support) associated with psychiatric disorders. The psychological well-being of the family members correlated significantly with the type and severity of the psychiatric disorder of the identified patient. Despite this, Noh and Turner (1987) point out that the impact of living with a psychiatrically ill member in the family is a major source of continuing strain for many significant others and that the strain is related to variations of psychological stresses.

The family burden in families living with a person with a psychiatric disorder cannot be negated. However, according to the above-mentioned two studies (Enns et al., 1999; Noh & Turner, 1987), different factors come into play in terms of the severity of the family burden felt by

family members. It appears that certain factors can alleviate family burden, and this could lessen the severity of accumulated stress or pile-up [aA] and family vulnerability [V] in families living with a member with a psychiatric disorder. Important factors to consider in terms of respite for families are medical support (i.e., access to hospitalisation), the psychological well-being of family members, and community and social support.

In a South African study by Der Kinderen and Greeff (2003), the Family Resilience Model was utilised to explore the resilience factors in families where a parent accepted a voluntary teacher's retrenchment package. The results confirmed that, if not managed well, the pile-up of stressors depletes resources and leads to family tension and stress (McCubbin & McCubbin, 1996).

The research in this section suggests that the accumulated pile-up [aA] of stressors and vulnerabilities [V] associated with parental depression creates risk factors that impact on the adaptation process of the family system, both on an individual level as well as on the systemic level. Future research regarding accumulated pile-up [aA] in families with a member with a psychiatric disorder is highly recommended, as current research tends to provide limited and tentative indications.

The following section will focus on family resources [bB] and social support [bBB], which have been proven to assist families in difficult times.

3.5.3 Family Resources [bB] and Social Support [bBB]

Family resources [bB] are defined by the family's strengths, capabilities and adaptive resources, which vary from personal and family resources to community resources (McCubbin & McCubbin, 1996). Social support [bBB] also collaborates with family resources by including individuals and institutions the family system can utilise to manage a crisis (McCubbin & McCubbin, 1996). These resources vary from tangible to intangible resources, opening up a wide range of possibilities that the family can utilise, and can also be seen in terms of protective, recovery or resilience factors (Hawley & De Haan, 1996; McCubbin et al., 1997; McCubbin &

McCubbin, 1988; Rutter, 1999). Previous research will be discussed in the next three subsections according to the mentioned distinction.

McCubbin et al. (1997) identified two national surveys that contributed to the distinction made between (a) protective factors, (b) recovery factors and (c) generally appearing resilience factors that address family resources. These studies were part of surveys of family stressors and strains over the family life cycle, conducted by or in collaboration with family scientists of the Family Stress, Coping, and Health Project at the Centre for Family Studies and the Institute for the Study of Resiliency in Families at the University of Wisconsin-Madison (Olson et al., 1985; McCubbin, Thompson, Pirner & McCubbin, 1988).

3.5.3.1 Protective Factors

Protective factors assist families to manage developmental transitions and change over time, by continuing to promote harmony and balance. The nature of protective factors can best be assessed in the context of family systems being challenged by specific risk factors, for instance when a family member lives with MDD (McCubbin, 1995; McCubbin & Lavee, 1986). McCubbin et al. (1997) discussed protective factors according to the family life cycle stage, as well as race and ethnicity, and these will be addressed in the following two subsections.

  1. Family Life Cycle Stage

The most prominent protective factors that stood the test of time over all stages of the family life cycle are family celebrations, family hardiness, family time and routine, and family traditions. Family communication, financial management and personality compatibility were significantly prominent in three out of the four categories of family life cycle stages, namely the (a) couple, (b) childbearing/school age, (c) teenage/young adult and (d) empty nest/retirement stages (McCubbin & McCubbin, 1988; McCubbin et al., 1988; Olson et al., 1985). These researchers made some distinctions between the different life cycle stages. Family accord is important at the couple and childbearing/school stages; health becomes apparent at the couple and empty nest and

retirement stages; support network is vital in the childbearing/school-age and teenage/young adult stages of the family cycle; and shared values regarding leisure time appear to be important at the couple stage of the family life cycle. It is further noted by McCubbin (1995) and McCubbin and Lavee (1986) that couples without children employ protective factors such as social and occupational status, problem-solving coping skills, intra-family member support, and work and community support. In contrast, families in the pre-school and school age stage of the life cycle employ the protective factors of religious programmes in the community, community support, and the sense of coherence of fitting into the larger community. On the other hand, families at the adolescent and launching stages of the family cycle incorporate protective factors of status and income, mutual support from family and spouse, family cohesiveness and bonding, and fitting into the community. Lastly, the empty nest stage (i.e., when children leave the parental home) of the family cycle emphasises the protective value of coping skills, family cohesiveness and bonding, support from the community, and work.

2. Race and Ethnicity

Family protective factors vary specifically in their importance in terms of race and ethnicity (McCubbin, 1995; McCubbin & Lavee, 1986). Race and ethnicity have been shown to play a role in the value and importance of protective factors for both Caucasian and African-American families. Caucasian families incorporate a broad and comprehensive range of protective factors in their family system, such as: family cohesiveness, coping skills, coherence, community support, intra-family mutual support, sense of control, employment, involvement in the community, friendship support, neighbourhood support, family time together, spouse commitment to the lifestyle of the work/occupation, and sense of family-to-work/occupational fit. However, African-American families display a different cohort of protective factors, namely: family time together, spouse commitment to lifestyle, neighbourhood support, involvement in the community, spouse employment, sense of control, spouse education, and a sense of fitting into work place (McCubbin & McCubbin, 1988). It is clear that the way in which families deal

with the process of the illness varies significantly among ethnic groups, social-economic categories, gender position of family, and the stage of the illness (Johnson, 2000).

3.5.3.2 Recovery Factors

McCubbin et al. (1997) insist that the search for family recovery factors remains the major challenge for the scientist, as one could argue that once the first line of resilience factors has been studied, namely protective factors, everything has been covered. The fact remains that families do stumble when adversity strikes and experience disharmony and imbalance, which might lead to deterioration and a family crisis. When this occurs, families have to utilise their resources, capabilities and recovery factors to withstand, revive and thrive from a crisis. Hence the interest in quantifying the specific recovery factors used by families in difficult times (McCubbin et al., 1997).

McCubbin et al. (1997) summarised the critical recovery factors identified in a study of families managing the long-term care of a child with cystic fibrosis (McCubbin, Patterson, McCubbin, Wilson & Warwick, 1983; McCubbin, Thompson, Thompson & McCubbin, 1993), namely: (a) family integration, which indicates the parents' efforts to keep the family together; (b) family support and esteem building from the community and friends and; (c) family optimism and mastery, which involves efforts to maintain a sense of order and optimism.

McCubbin et al. (1997) further gave an overview of the recovery factors identified in studies done with families who were exposed to prolonged war-induced separation from a member of the military held captive or missing in action, namely (a) self-reliance and equality, which encompasses the family's efforts to change its worn patterns of functioning, and also the social psychosocial and economical conditions. Central to these changes is the adult member's ability to effectively act independently in the best interests of the family; (b) family advocacy, which is the ability of these families to be involved with and/or support other families in similar situations; (c) to give new and viable meaning to the crisis situation, and (d) family schema, the

collective set of values, beliefs and rules that play a crucial role in promoting balance and harmony in the context of a family crisis. The last two factors are also applicable in the appraisal process, which will be discussed in the section 3.5.3.3

3.5.3.3 Resilience Factors

Several researchers have found and identified prominent and generally appearing resilience factors that could also be seen as either protective or recovery factors. Research regarding these generally appearing resilience factors will be addressed in the following sections, where applicable.

Family resources [bB] and social support [bBB] were found to be fundamental factors used by families in difficult times to facilitate durability (McCubbin et al., 1997). In the case of a crisis, families will not only draw from existing social support, but will also seek additional, unique forms of social support, such as from depression and anxiety support groups. Walsh (1996) indicated the importance of the utilisation of community resources and social networks. The positive aspects of relationships with in-laws, relatives and friends cannot be overemphasised, as they foster an important sense of external support and help that families can utilise (McCubbin & McCubbin, 1988).

An intangible family resource [bB] or resilience factor is the physical and emotional well-being of family members (which are essential family strengths), as this can reduce stress and preserve a healthy home atmosphere (McCubbin & McCubbin, 1988; McCubbin et al., 1997). When illness or disability enters a family system, the entire system becomes vulnerable. The critical position of family resources and social support in families is supported in several studies by Greeff and colleagues (Gillard, 2002; Greeff & Van der Merwe, 2004; Van der Walt, 2006). Van der Walt (2006) researched resilience factors in families with an autistic child. Social support and the mobilisation of community resources were identified as valuable resilience factors. Gillard

(2002) also found social support to be an important resilience factor in families living with a disabled child.

Greeff and Van der Merwe (2004) explored the variables associated with resilience in divorced families. Their results indicated that, amongst others, intra-family support and support of the extended family and friends were important resilience factors in these families. Geldhof (2004) explored and described those resilience factors that assisted Belgian families to adjust and adapt after a child has been living with cancer. Significant results came from the children's data, which suggested that commitment to the family was one of the factors that assisted with family adaptation. In another South African study, Thiel (2005) identified resilience factors in families with a husband with prostate cancer. The qualitative findings also suggested the importance of intra-familial support, professional support and knowledge about the condition. The qualitative results indicated that social support was one of the more important resources. Greeff et al. (2005) identified resilience factors in families with a member with a psychiatric disorder. It was found that, for the children, community support, emotional support and self-worth assisted in the adaptation process. This study by Greeff and his colleagues enhanced the notion that family and social support form an integral part of family adaptation in a diverse range of family setups.

Other studies by Greeff and his colleagues supported other forms of family resources. Der Kinderen and Greeff (2003) highlighted the protective nature and resilience-fostering qualities of good financial management and social support. Work and financial security (Greeff & Van der Merwe, 2004), together with the educational level of the parents, were also recognised as vital tangible resilience factors (Gillard, 2002).

Several international studies that focussed on psychiatric disorders and distinct forms of family resources will be discussed in the following paragraphs. The previously mentioned study by Enns et al. (1999) explored the availability and level of utilisation of resources [bB] by these families following the patient's admission to a psychiatric hospital. It was found that family

members of in-patients were less confident in themselves and their ability to solve problems effectively, which might have impacted on their confidence in terms of utilising resources. These resources included the willingness to utilise extended family support, or the extended family's willingness to offer assistance. It was concluded that this population was less likely than the general population to utilise their extended family and less likely to receive offers of assistance from their extended family. From this study it became evident that family members of people with a psychiatric disorder should be empowered to utilise the available resources, as this is a vital source of resilience in the care of patients with a psychiatric disorder and is beneficial to patient outcomes. However, it was found that both genders were significantly less likely to utilise spiritual support than the general population, but were more likely to acquire social support (Enns et al., 1999). They were more likely to utilise their immediate families, though not extended families, to acquire support (Enns et al., 1999). This gives an indication of the type of support that might appeal to these families, and this should provide some direction for interventions regarding an empowerment strategy for utilising support.

Johnson's study provided more input regarding the specific resources these families might need. In Johnson's (2000) qualitative study, the families of 180 people with serious psychiatric disorders were analysed in an attempt to identify significant areas of concern to families, areas for professional input, and differences among families based on gender, ethic group and socio-economic status. Johnson (2000) found that family members will adapt and cope better if they are included as team members by the professional community. Medication was viewed as an important resource in assisting with the illness. Help and support from extended families and close friends were viewed as important resilience factors in families in which a member has been living with a psychiatric disorder. Johnson also mentioned that greater knowledge of other families struggling with the same problems increased the family's ability to cope.

Tebes et al. (2001) assessed the adaptation of children whose mothers had serious psychiatric disorders (N = 177). They found that family psychosocial processes (i.e., financial resources,

social network constriction, parenting tasks, increased family stress and parent-child bond) are more consistent predictors of child adaptation than parental psychopathology. The authors explained that this suggests that parental psychiatric symptoms and functioning might not directly account for children's difficulties, but rather for the family psycho-social processes that accompany parental psychiatric status. This highlights the familial element of a psychiatric disorder, which indicates the importance of conceptualising it on a systemic familial level. Adaptation was also consistently predicted by parenting performance and, to a lesser extent, by the parent-child bond and familial stress. Disruptions in the parent-child bond were associated with child intelligence, self-esteem and behavioural competence. Problem behaviour, general psychiatric impairment, global functioning and overall adaptation behaviour seemed to be difficult areas for boys. However, the authors found that studies yielded inconsistent findings regarding gender-linked differences. The impact of child age appeared to be less dramatic for a family system, but on two occasions it was found that younger children exhibited better adaptation than older children. Socio-economic status did not appear to be a predictor of adaptation in this study. In conclusion, apart from other interesting gender- and age-related findings in this study, the impact of psychosocial factors on these families seems to be important factors to consider, especially with regard to child adaptation. The impact of psychosocial processes as mentioned by Tebes et al. (2001) also relates to the findings of Noh and Turner (1987). As mentioned in the previous section in the discussion of the pile-up of stressors, the study of Noh and Turner (1987) identified mastery (i.e., sense of personal control) as a significant resilience factor (social-psychological variable) for family members in terms of coping with a family member with a psychiatric disorder. However, Noh and Turner (1987) also support the idea that social support is a very important resource for these families. A third study supporting this notion of psychosocial support is that by Solomon and Draine (1995), who sought to describe factors associated with adaptive coping by interviewing family members (N = 225) of persons with serious psychiatric disorders. The results showed that more extensive

adaptive coping (i.e., resilience) was associated with increased social support, affirming social support, and participation in a support group for families. Better coping was further associated with a greater sense of self-efficacy in dealing with the family member's illness.

Marsh and Lefley (1996) discussed the findings of a national survey in the United States of America that explored the resilience factors among family members of people with psychiatric disorders. The survey examined the following dimensions of family resilience: (a) that most families served as a sanctuary for their members, offering comfort and containment, which highlights family bonds and commitment; (b) that family strengths and resources are utilised by many families to deal with difficulties. These families thus maintained the integrity of the family system by nurturing and supporting each other; (c) family growth and development are the result of family involvement with psychiatric disorders. Families are confronted with adaptation when dealing with psychiatric disorders. They have to acquire essential information, develop coping skills and change accordingly, leading to growth and development; (d) families contribute by taking on different roles by being informal case managers or advocates for the patient; and (e) when families have to deal with these challenges, the system sometimes experiences a sense of meaning and pride. This study summarised the potential for growth and resilience in a system where psychiatric disorders exists.

From the above-mentioned empirical studies, it is clear that socio-psychological support, as expressed through family support [bB] and social support [bBB], is generally accepted as an invaluable link to the family adaptation process and is seen as an important resilience factor.

The next section will explore the empirical findings of the appraisal process [C-cCCC], which forms part of the facilitation process, regarding the identification and utilisation of resources in the family system.

3.5.4 Appraisal Process [C-cCCC]

The family appraisal process involves five levels (McCubbin & McCubbin, 1996). Each of the levels, namely schema [cCCCC], coherence [cCCC], paradigms [CCC], situational appraisal [cC] and stressor appraisal [C], will be discussed separately.

Researchers have confirmed the resilience quality of family schemas [cCCCC]. Finding meaning and justification through spiritual beliefs and practices when a crisis emerges helps families to conceptualise life events that would otherwise not have a logical explanation (McCubbin et al., 1997). Walsh (1996, 2002, 2003a, 2003b) also declared affirmative family belief systems to be an important resilience factor, as families utilise it to construct meaning for specific events, as well as to formulate a family identity and worldview (Patterson, 2002). Families increase their capabilities through the meaning-making process. McCubbin et al. (1997) also identified hope as a resilience factor that assists families in maintaining a confident expectation of outcomes, despite adversity.

Greeff and Human (2004) support the resilient quality of family schemas. They studied resilience in families in which a parent had died. The qualitative data indicated that optimism, perseverance, faith, expression of emotions and self-confidence were prominent individual characteristics that promoted resilience in these families. Greeff and Ritman's (2005) study could not confirm a quantitative relationship between individual resilience qualities associated with the adaptation of single-parent families. However, the qualitative results indicated the same tendency as in Greeff and Human's study, namely that optimism, perseverance, faith, expression of emotions and self-confidence were prominent individual resilience factors that were viewed as promoting resilience in these families. Greeff and Van der Merwe (2004) as well as Thiel (2005) highlighted the importance of spiritual/religious beliefs as a coping resource. Van der Walt (2006) described commitment and an internal locus of control as important resilience factors. A sense of competence and meaning were important contributors to the families' successes in the community (Johnson, 2000). Family members working together, as well as religious faith, was

found to enhance resilience and also supports the findings in the aforementioned studies (Johnson, 2000). All the above-mentioned literature indicate that an affirmative belief system, hope, optimism, perseverance, faith/religion, expression of emotions, self-confidence, internal locus of control, sense of meaning and cohesiveness in the family system are important family schemas [cCCCC].

McCubbin et al. (1997) describe family coherence [cCCC] as an important resilience factor. During difficult times, families often draw on the collective internal strengths in the family system to assist with the challenges. Family coherence is optimised if the family manages to view the world/stressor as being comprehensible, manageable and meaningful. Coherence is often referred to as family hardiness, which focuses on the shared responsibility and commitment of the family to work together in identifying, utilising and activating the family's resources into workable possibilities. In other words, hardiness refers to a family's internal strengths and durability (McCubbin & McCubbin, 1996). Family hardiness was confirmed and identified as an important resilience factor in numerous studies by Greeff and colleagues (Gillard, 2002; Van der Walt, 2006). The qualitative results of Thiel's (2005) study indicated that family adaptation to prostate cancer was also partly fostered by family hardiness. Family hardiness was also shown to be an important resilience factor in Greeff et al.'s (2006) research regarding resilience in families where a member had a psychiatric disorder.

Family paradigm [cCC] represents the family's functions, patterns and dimensions (McCubbin & McCubbin 1996). It refers to the shared and adopted rules in the family that guide family development and patterns of functioning (McCubbin & McCubbin, 1996). However, during a crisis situation, flexibility is needed regarding the family's paradigm in order to respond meaningfully to the crisis at hand. Flexibility has been identified by various researchers as an important resilience factor in the family's effort to maintain stability and recover from adversity in the context of a crisis situation (McCubbin et al, 1997; Walsh, 1996; 2002; 2003a; 2003b). Patterson (2002) says that family flexibility represents the family's ability to find balance and

harmony between change and stability. Flexibility is needed to facilitate this process. Patterson (2002) further suggests that families employ daily routines and rituals in order to maintain stability and a sense of who they are. Some resistance to change might be adaptive and change should not be introduced rapidly in families. However, family flexibility may be necessary to incorporate new needs that will assist the family with the demands experienced during a stressful period.

Situational appraisal [cC] defines the family's ability to evaluate its capabilities and the demand the stressor poses, while the appraisal of the stressor [C] refers to the family's definition of the stressor (McCubbin & McCubbin, 1996). In terms of situational and stressor appraisal, it was found that families need truthfulness to deal effectively with a crisis situation, in terms of changing their social, psychosocial and economic situations (McCubbin et al., 1997). Ambiguity is an inherent element of family crisis and sometimes complicates the clear appraisal of a situation. Getting clear information and truthful facts aids the family in effectively appraising the situation and the stressor in order to help with the decision-making process (i.e., a home care regime for a chronic ill family member) (McCubbin et al., 1997).

Research by Geldhof (2004) regarding the appraisal process revealed that the experience of control over life events, redefinition of the crisis situation and a passive appraisal of the crisis situation were associated with family adaptation. A passive evaluation or the utilisation of avoidance strategies was helpful in dealing with difficulties in families with a psychiatric disorder, according to Greeff et al. (2006). Gillard (2002) mentioned that families living with a child with an intellectual disability coped better with difficult situations if they managed to reframe a stressful situation in a positive way and by defining it as a challenge that was manageable.

The international studies of Peisah et al. (2004) and Enns et al. (1999) provided interesting findings regarding the appraisal process in families in which a member had a psychiatric

disorder. Peisah et al. (2004) studied the long-term effect of parental depression on children (N = 94) after 25 years. These children exhibited significant resilience in comparison with the control group, especially with similar overall psychiatric morbidity rates and quality of intimate relationships. One possible explanation could be that adult children have insight into their parents' relationships and consequently managed themselves and their intimate relationships differently by integrating their appraisal of their childhood experience of living with a depressed parent. In other words, this might have assisted the participants to develop themselves personally and to thrive despite their childhood circumstances. This may be an important resilience factor to take into account when engaging generational families with psychiatric disorders. In terms of gender differences, Enns et al. (1999) identified a significant gender difference regarding the appraisal process as measured by the Family Crisis Orientated Personality Evaluation Scale (F-COPES). This scale measures family problem-solving and behaviour strategies and incorporates the appraisal process followed during a stressful situation. Enns et al. (1999) found that male family members were less likely than female family members to invite spiritual support into their lives as a means of appraising the stressor [C] of living with a family member with a psychiatric disorder.

Patterns of functioning [tT] will be discussed in the following section.

3.5.5 Patterns of Functioning [tT]

A family's pattern of functioning influences the adaptation process, as discussed in Chapter 2. These patterns might range from inadequate/inappropriate, retained or restored patterns of functioning (McCubbin & McCubbin, 1996; Van Breda, 2001).

In the adaptation phase of the Family Resilience Model, the restored patterns of functioning that received attention in the research were family time and routines. These are patterns of behaviour that foster rhythm, which creates predictability and stability, thus creating a setting of balance and harmony (McCubbin et al., 1997). Family meals, chores, togetherness, and other everyday

routines play an important role in creating continuity and stability in the family system (McCubbin & McCubbin, 1988). It is crucial that families aim to hold specific times and routines in place, even in difficult times. Walsh (2002, 2003a, 2003b) also identified these family organisational patterns as vital resilience factors. Geldhof (2004) and Thiel (2005) concurred specifically by indicating the importance of family routines in their studies.

The next section will deal with problem solving and coping [PSC] as the last link in the Family Resilience Model. However, the different links cannot be separated, but are intertwined, forming part of the systemic approach of the model.

3.5.6 Problem Solving and Communication [PSC]

Problem solving and communication is the process of identifying and utilising resources in order to deal with crisis demands, as discussed in Chapter 2 (McCubbin & McCubbin, 1993, 1996). This process is interwoven with the other facets of the adaptation process, and should be seen in relation to the above-mentioned sections. The specific open, clear and constructive family communication style promoted in the Resilience Model is an important tool to assist families in identifying and utilising resources. This process creates a shared sense of meaning in developing coping strategies and in maintaining harmony and balance, which assist with the resilience process (McCubbin & McCubbin, 1988; McCubbin et al., 1997; Patterson, 2002; Walsh, 1996, 2002, 2003a, 2003b). There appear to be two basic communication patterns, namely affirming (conveying support and care) and incendiary (yelling and screaming). A family system that emphasises affirming communication as a primary pattern of communication assists in fostering a functional system. Family communication is very important in the sense that it facilitates shared expectations about cohesiveness and flexibility and the accomplishment of family functions (Patterson, 2002).

Smith (2006) explored resilience factors in Xhosa families. This researcher's qualitative and quantitative results support the above-mentioned. It was found that communication was

considered by most of the Xhosa participants as a foremost factor contributing to their family's resilience. The studies by Greeff and Van der Merwe (2004), Geldhof (2004) and Jonker (2008) also echo the importance of communication. Open communication was identified as an important link in the adaptation process of families with an autistic child (Van der Walt, 2006). Jonker (2008) focused on families living in an underprivileged, semi-rural area caring for a patient using the state-sponsored psychiatric services. It was found that family communication was one of the most significant variables associated with family adaptation in these families.

The study by Birkets (2000) analysed qualitative data from follow-up interviews with families and children regarding the limitation and extension of emotions in children concerning their affectively ill parents (depression). It was found that parents with depression could promote resilience in their children by encouraging them to express and communicate the affect/emotion they experienced as a result of the parental illness. Elaboration and encouragement to express negative affect contributed to the development of resilience in these families. The researcher suggested an approach that parents could follow to foster emotional resilience in children by allowing them to express emotions (especially negative emotions) freely, instead of constricting emotions, which creates a risk factor in terms of dealing with emotions appropriately in order to foster a healthy emotional state. These findings support the notion that problem-solving and communication skills, as described in the Resilience Model (McCubbin & McCubbin, 1993, 1996; Walsh, 2003), are of critical importance in families with parental psychiatric disorders.

Although the literature is limited in terms of information on family resilience and parental depression, the current overview provides a picture of the existing trends regarding the topic, which will be integrated with the current study's findings in Chapter 5.

3.6 Conclusion

This chapter defined contemporary families, and discussed major depressive disorder (MDD) and the relevance and applicability of the current Family Resilience Model in a family setup in

which there is a psychiatric disorder (McCubbin & McCubbin, 1993, 1996). The literature review on family resilience and particularly resilience in families with parental depression was structured according to the Family Resilience Model (McCubbin & McCubbin, 1993, 1996). The literature review had to be expanded to related topics of stress and coping after it became apparent that there is only limited national and international literature on family resilience in families with psychiatric disorders. Despite the overwhelming risk factors associated with parental psychiatric disorders, the literature clearly indicates the possibility of successful adaptation in these families. According to the literature, several resilience factors should be considered and encouraged in these families. The first to consider is individual resilience factors, such as emotional development and well-being, and a sense of mastery and spirituality in the family members. Secondly, a proactive appraisal stance regarding stressors goes hand in hand with the identification and utilisation of resources, such as medical, familial, psychosocial and community resources, which appear to be of significant importance to these families. Thirdly, effective communication and problem solving, with a specific focus on the open emotional expression of negative emotions, are highlighted by various researchers as very important factors to consider for the successful adaptation to psychiatric disorders in families.

The following chapter addresses the research design and methodology of the descriptive phase of this research study.

CHAPTER 4

DESCRIPTIVE PHASE: RESEARCH DESIGN AND METHODOLOGY

4.1 Chapter Preview

The methodology for this research was divided into two phases, namely the descriptive phase and the intervention phase. This chapter provides an explanation of the research design and methodology employed for the descriptive phase of the study. The primary aim of this phase of the research is outlined, as well as the research methods that were utilised. A description of the participants' demographic details and an explanation of the sampling procedures are provided, including an overview of the measures used to gather data. An outline of the procedures and process of the research, as well as a description of the data analysis, is given. Lastly, ethical considerations are discussed.

4.2 Primary Aims of the Research

The primary research question and objective of the first phase (descriptive phase) of the research were as follows:

4.2.1 Primary Research Question

Which qualities of resilience are present in families in which a parent has been living with depression?

4.2.2 Primary Research Objective

The primary objective of the study was to identify and describe qualities of resilience in families in which a parent has been living with depression.

4.3 Research Design and Methodology

4.3.1 Research Design

An explorative-descriptive research design was used in which the participants were asked to complete a biographical questionnaire, quantitative self-report questionnaires and a qualitative open-ended question (Babbie, 1998; Bless & Higson-Smith, 1995; De Vos, 2000; Salkind, 1997). The method of triangulation was used to enhance the validity of the research, by gathering both quantitative and qualitative data from the same unit of analysis, namely the family, via different insider perspectives. Neuman (2003) says that the phenomenon of triangulation is activated by social researchers when something is assessed from different slants. Struwig and Stead (2001) add that triangulation assists researchers to search for patterns in data, and to complement data from quantitative sources with qualitative sources and vice versa.

The aim of the descriptive phase of the research was to accurately identify, explore and describe qualities of resilience in families in which a parent has been living with depression (Babbie, 1998; De Vos, 2000). Various researchers point out that explorative-descriptive research, especially the cross-sectional survey type, is beneficial as it provides a snapshot description of target populations and is representative in nature, allowing the researcher to identify and describe the qualities of resilience in the current population (Bless & Higson-Smith, 1995; Cohen, Manion & Morrison, 2000). The descriptive survey is one of the best methods available to the social scientist interested in collecting original data for describing a population too large to observe directly (Babbie, 1998; Cozby, 1993). It enables researchers to draw comparisons between different groups and to generalise findings (Cohen et al., 2000; Salkind, 1997). The choice of the specific self-report survey type questionnaires (measures) utilised in the study was suggested by previous research and is in accordance with the theoretical model underlying this research (McCubbin et al., 1996).

Additional strengths of the explorative-descriptive design are that it is relatively cost and time effective, and also that it ensures optimal participation due to the once-off nature of the administration (Cohen et al., 2000). Therefore, this design was best suited to meet the aims of the descriptive phase of this study. The most frequently mentioned disadvantages of this method are the lack of control over the environment, unpredictable return dates of questionnaires, unpredictable response rates, an increase in the likelihood of misunderstood items, as well as incomplete responses (Cohen et al., 2000; Dane, 1990; Salkind, 1997). In this study, these disadvantages were controlled by arranging a meeting with each participating family and verbally explaining the procedures. The questionnaires were also completed in the presence of the researcher.

In addition, the study can be described as correlative in nature, since the relationship amongst the variables was investigated (Cozby, 1993). Correlation designs are identified by their ability to demonstrate relationships between variables (Davidshofer & Murphy, 1998). In other words, as explained by Howell (1995), when dealing with the relationship between two variables, the research is concerned with the degree or strength of the relationship between them.

4.3.2 Participants

4.3.2.1 Sampling Procedures

A non-probability purposive sampling procedure was utilised to select the families for the present study (Babbie, 1998; Babbie & Mouton, 2001). This sampling procedure allows the researcher to select the cases to be included in the sample on the basis of their typicality, the inclusion criteria and the purpose of the study (Bless & Higson-Smith, 1995; Cohen et al., 2000). Therefore, the procedure of purposive sampling is directed toward obtaining a certain type of element in the sample (Dane, 1990).

An advantage of non-probability purposive sampling is that the researcher uses his or her research skills and prior knowledge to select respondents appropriately (Cozby, 1993). It is

further relatively practical, uncomplicated and cost effective to implement (Graziano & Raulin, 2000). However, the disadvantages of this sampling procedure are that external validity might be limited and generalisability reduced (Dane, 1990), as this kind of sampling may not produce a very representative sample of the population and the results may therefore be biased. However, these shortcomings did not have a significant effect on this particular study, since the aim of the study was not to generalise the results, but to explore and describe the population.

The participating families had to meet the following three inclusion criteria to obtain homogeneity within the study. Firstly, the couples had to be heterosexual. Secondly, at least one child should still be living with the family. Thirdly, one parent must have been living with depression (identified patient). A study population of 70 families who met the inclusion criteria was identified by the State Information Technology Agency (SITA) through the military's data-capturing system. They were all active patients at the psychology and psychiatry department at a military hospital in South Africa. Both parents, as well as one child in the family, represented these families, and this offered a multi-generational perspective on the family.

4.3.2.2 Description of the Sample

Due to ethical considerations, the researcher was not allowed to contact the participants directly to invite them to participate in the research project. This would have been a breach of privacy and confidentiality. Although it was time-consuming, an ethically appropriate recruitment procedure was implemented. The researcher conducted a meeting with the heads of the psychology and psychiatry departments of the particular institution and briefed them regarding the research. They gave their support to the project and suggested that a formal academic presentation on the research proposal be made to the psychology and psychiatry departments. During this presentation, the researcher outlined the research project and asked for the support and cooperation of the psychologists and psychiatrists during the recruitment phase of the research. They were requested to identify patients from their caseload who fulfilled the inclusion criteria, to contact them, and to introduce the research to the identified patient and to obtain

permission for the researcher to approach them, should they be interested. Two other recruitment strategies were also followed, namely putting up posters (see Addendum A), and distributing flyers (see Addendum A), which advertised the research in the hospital and allowed for prospective participants to contact the researcher. This recruitment phase extended over a year.

A sample of 56 families was identified, most of which were referred by the psychiatrists and psychologists. All of them were contacted, but only 36 families voluntarily completed the questionnaires. Of the remaining 20 families, 17 families were not interested in participating in the research project after the researcher contacted them. Three families did not keep their appointments.

The majority of the identified families in the population were coloured or white, with only three black families, which indicated the use of English and Afrikaans versions of the measuring instruments. The questionnaires regarding qualities of family resilience had to be completed by the parent without the relevant diagnosis (spouse) and a child that was old enough to comprehend and complete the questionnaires. The parent with depression (identified patient) completed both the Beck Depression Inventory II and the Biographical Questionnaire (see Addendum E). The questionnaires were completed as follows: 36 identified patients, 34 spouses and 27 children were old enough to complete their questionnaires successfully. The number discrepancy between the spouses, patients and children is due to the fact that two spouses could not attend the meetings to complete the questionnaires and nine families either did not have a child old enough to complete the questionnaire, or the child could not attend the meeting.

4.3.2.3 Participants' Demographics

The study population was current or ex-South African National Defence Force members who benefited from the military's medical aid. Thus, most of the participants were involved in the military, or had been involved in the military for at least 10 years. The study population encapsulated a diverse group of participants with the dominant denominator being a significant

amount of experience of military family-life. The demographics of the participants were obtained by means of a biographical questionnaire, completed by the identified patient. These demographics will now be presented. The duration of the marriages of the participants is presented in the Table 4.1.

Table 4.1

Length of Marriage of the Participating Couples (N = 36)

Years married	N	Percentage
4-10	6	17
11-18	14	39
19-26	16	44
Total	36	100

As can be seen in Table 4.1, all the participants in the study had been married for between four and 26 years, with an average of 17 years (SD = 6.05).

The distribution of the number of marriages for the identified patients and their spouses is presented in Table 4.2.

Table 4.2

Identified Patients and Spouses: Number of Marriages

Number of marriages	Identified patients	Spouses	Percentage Identified patients	Percentage Spouses
1	31	32	86	89
2	4	3	11	8
3	1	1	3	3
Total	36	36	100	100

Table 4.2 illustrates that the majority of the identified patient participants (n = 31; 86%) and the majority of the spouses (n = 32; 89%) were in their first marriages. All the participating families

had dependent children, ranging from one to three children per family. Two-thirds (n = 24; 67%) of the participating families had two children, while eight (22%) families had three children and four (11%) families had one child.

The age distribution of the participants is presented in Table 4.3.

Table 4.3

Age of Identified Patients and their Spouses

Age in completed years	Identified patients N	Spouses N	Identified patients Percentage	Spouses Percentage
25-35	7	4	20	11
36-45	21	17	58	47
46-55	8	14	22	39
56-65	0	1	0	3
Total	36	36	100	100

The average age of the identified patients was 41 years (SD = 5.20) and ranged between 27 and 49 years, with a gender distribution of 89% females (n = 32) and 11% (n = 4) males. The average age of the spouses of the identified patient population was 43 years (SD = 6.57) and ranged between 28 and 59 years, with 8% females (n = 3) and 92% males (n = 33).

The average age of the first child in these families was 16 years (SD = 5.22), with a range from eight to 25 years. Forty-two percent were female (n = 15) and 58% (n = 21) were male. Thirty-two of the 36 families had a second child. The average age of the second child was 12 years (SD = 5.15), with a range from four to 22 years. Forty-seven percent (n = 15) were female and 53% (n = 17) were male. Eight of the 36 families had a third child. The average age of the third child was 11 years (SD = 4.96), with a range from three to 18 years and 38% (n = 3) females and 63% (n = 5) males.

Six (17%) of the 36 families had a living-in member (e.g., grandparent), while 30 (83%) did not

have a living-in member.

The distribution of the highest level of qualification of the participants is presented in Table 4.4.

Table 4.4

Highest Qualification of Identified Patients and Spouses

Qualification	Identified patients	Spouses	Identified patients	Spouses
	N	N	Percentage	Percentage
Primary school	1	0	3	0
Secondary school	20	26	56	72
Diploma	9	9	25	25
Degree	6	1	17	3
Total	36	36	100	100

The education status of the identified patients and spouses is portrayed by allocation to the same

categories. The majority of both the identified patients (n = 20; 56%) and their spouses (n = 26;

72%) had a secondary education. Only one identified patient fulfilled the criteria of having a

primary school education as highest level of education.

The occupational status of the participants is presented in Table 4.5.

Table 4.5

Occupational Status of the Identified Patients and Spouses

Qualification	Identified patients	Spouses	Identified patients	Spouses
	N	N	Percentage	Percentage
Employed	32	36	89	100
Unemployed	4	0	11	0
Total	36	100	100	100

Table 4.5 presents the occupational status distributions of the identified patient and the spouses. The 100% (n = 36) employment rate of the spouses and the 89% (n = 32) employment rate of the identified patients emphasised the dual-income nature of the participating families. It is also of significance that the spouses' sample had a 0% unemployment rate.

The annual familial income of the families is presented in Table 4.6.

Table 4.6

Income Distribution of the Families

Income	N	Percentage
Less than R 100 000	7	19
R 100 000 to R 120 000	6	17
R 121 000 to R 150 000	2	6
R 151 000 to R 180 000	1	3
R 181 000 to R 200 000	7	19
More than R 200 000	13	36
Total	36	100

The income distribution of the participants illustrated in Table 4.6 shows that a large number of the participating families (n = 13; 36%) had an annual income of more than R 200 000, while seven (19%) participating families had an annual income of less than R 100 000.

The distribution of English and Afrikaans as home language was more or less even, with 58% (n = 21) of the families indicated English and 42% (n = 15) indicated Afrikaans as their home language. All the participants completed the questionnaires in their home language, as the questionnaires were available in both English and Afrikaans. All the participating families were white or coloured, while no black family participated in the research.

The length of diagnosis of the identified patients is presented in Table 4.7.

Table 4.7

Length of Diagnosis of Major Depressive Disorder

Length of diagnosis	N	Percentage
Less than 1 year	1	3
1 to 2 years ago	8	22
3 to 5 years ago	10	28
6 to 10 years ago	8	22
More than 10 years ago	9	25
Total	36	100

Table 4.7 presents a layout of the time since the initial diagnosis of major depressive disorder for each identified patient. The time frames ranged from less than a year to more than 10 years, with a relatively equal distribution among the different time periods.

Treatment options utilised by the identified patient are presented in Table 4.8.

Table 4.8

Treatment Received for Major Depressive Disorder

Treatment	N	Percentage
Medication	15	42
Medication and psychotherapy	15	42
Psychotherapy	3	8
None	3	8
Total	36	100

Table 4.8 gives an outline of the different formal treatments for major depressive disorder utilised for the identified patients at the time of assessment. Three (8%) of the participants were on no current treatment, three (8%) received only psychotherapy, while 15 (42%) received medication and psychotherapy and the same number received only medication (n = 15; 42%).

Only four (11%) of the participants were not interested in the intervention programme that was to follow after the first phase of this research project. Thus, 89% (n = 32) of the participants indicated their initial interest in the intervention programme.

4.3.3 Measures

The following three subsections deal with the different kinds of measures used in the descriptive phase of the research, namely biographical, quantitative and qualitative.

4.3.3.1 Biographical Questionnaire

The identified patient completed a biographical questionnaire with structured questions regarding family composition, marital status, duration of marital relationship, age and gender of family members, level of education, employment, income, home language and information regarding the onset of depression and the treatment received. The biographical questionnaire also gave the participants the opportunity to indicate whether they were interested in the intervention programme.

4.3.3.2 Quantitative Measures

In terms of the Resilience Model (see Figure 2.1), the Family Attachment and Changeability Index 8 (FACI8) was used to measure the dependent variable (family adaptation), while all the followings quantitative measures were used to measure other family variables.

1. The Family Attachment and Changeability Index 8 (FACI8)

The dependent variable in the current study was measured with FACI8 to assess the family's level of attachment (cohesion) and changeability (flexibility), which represents family adaptation according to the Resilience Model. The FACI8 (McCubbin et al., 1996) evolved as an adaptation of the Family Adaptability and Cohesion Evaluation Scales (Olson, Portner & Bell, 1989).

The FACI8 consist of 16 items on a five-point Likert scale of how frequently events occur, ranging from 'never' to 'always'. The scale consists of two subscales, namely Attachment and

Changeability (McCubbin et al., 1996). The Attachment subscale (items 2*, 5*, 7*, 9*, 12*, 13*, 15*, 16*) measures the strength of attachment between family members, for example 'It is easier to discuss problems with people outside the family than with other family members'. The Changeability subscale (items 1, 3, 4, 6, 8, 10, 11, 14) measures the level of flexibility in the relationships between family members, for example 'Our family tries new ways of dealing with problems'. The score on each subscale is obtained by adding the value circled by the respondent (never = 1, sometimes = 2, half the time = 3, more than half the time = 4, always = 5) for each item in the subscale. The Attachment subscale items, marked with an asterisk, must be reverse scored (never = 5, sometimes = 4, half the time = 3, more than half the time = 2, always = 1). A total score is obtained by adding the Attachment and Changeability scores and then dividing by two (McCubbin et al., 1996). The Attachment subscale has an internal reliability (Cronbach's alpha) of .73, and the Changeability subscale has an internal reliability of .80 (McCubbin et al., 1996). Validity was ascertained by determining the FACI8's relationship to a treatment programme's successful outcome (McCubbin et al., 1996). In this study, an internal reliability of .73 was found for the total scale for the adult participants and .60 for the child participants. For the Changeability subscale, an internal reliability of .76 for the adults and .73 for the children was found, and on the Attachment subscale there was an internal reliability of .76 for the adults and .67 for the children.

2. The Family Hardiness Index (FHI)

Internal strengths and durability of the family unit were measured with the Family Hardiness Index (McCubbin et al., 1996). The FHI measures the family's ability to have a sense of control over the outcomes of life, and having an active rather than passive orientation in adjusting to and managing stressful situations (McCubbin et al., 1996).

The scale consists of 20 items which aim to measure the characteristics of hardiness in mitigating the effects of stressors and demands, and facilitating adjustment and adaptation over time (McCubbin et al., 1996). The FHI requires participants to assess, on a five-point Likert rating

scale (False, Mostly False, Mostly True, True, Not Applicable), the degree to which each statement describes their current family situation. The scale consists of three subscales, namely (a) Commitment, which measures the family's sense of internal strengths, dependability and ability to work together; (b) Challenge, which measures the family's effort to be innovative, active, to enjoy new experiences and to learn; and (c) Control, which measures the family's sense of being in control of family life rather than being shaped by outside events and circumstances (McCubbin et al., 1996).

The FHI has a test-retest reliability of .86, a total scale internal reliability of .82, an internal reliability of .81 for the Commitment subscale, an internal reliability of .80 for the Challenge subscale, and an internal reliability of .65 for the Control subscale. The internal reliability (Cronbach's alpha) of the FHI is .82 (McCubbin et al., 1996). The validity coefficient ranges from .20 to .23 regarding family satisfaction, time and routines, and flexibility variables (McCubbin et al., 1996). In this study, an internal reliability for the total scale of .81 was found for the adults and .44 for the children. For the Commitment subscale, an internal reliability of .72 was found for the adults and .65 for the children, with an internal reliability of .79 for the adults and .44 for the children on the Challenge subscale, and an internal reliability of .73 for the adults and .43 for the children on the Control subscale.

3. The Social Support Index (SSI)

The Social Support Index was developed by McCubbin, Patterson and Glynn to evaluate the importance of finding support and the families' integration in the community (McCubbin et al., 1996). The SSI assesses community integration and the family's utilisation of community resources for emotional support, esteem support (affection) and network support (relationship with relatives). This questionnaire consists of 17 items rated on a five-point Likert scale of agreement, ranging from 'strongly disagree' to 'strongly agree'. It has an internal reliability of .82, a test-retest reliability of .83, and a validity coefficient (correlation with family well-being) of .40 (McCubbin et al., 1996). The current study's SSI revealed a Cronbach's alpha of .78 for

the adults and .64 for the children, as well as a Guttman split-half alpha of .83 for the adults and .70 for the children.

4. The Relative and Friend Support Index (RFS)

The Relative and Friend Support Index was developed by McCubbin, Larsen and Olson (McCubbin et al., 1996). It was incorporated in the research as it assesses the family's use of friend and relative support as a coping mechanism. The RFS consists of eight items rated on a five-point Likert scale ranging from 'strongly disagree' to 'strongly agree'. It has an internal reliability of .82 (Cronbach's alpha) and a validity coefficient (correlating with the original F-COPES) of .99 (McCubbin et al., 1996). The internal reliability of the FRS in the current study was .87 for the adults and .50 for the children.

5. The Family Crisis Oriented Evaluation Scales (F-COPES)

The Family Crisis Oriented Evaluation Scales was developed by Olson et al. (1985), and was utilised to assess family problem solving and behaviour strategies in times of crises. The F-COPES consists of 30, five-point Likert-type items (Strongly disagree, Moderately disagree, Neither agree nor disagree, Moderately agree, Strongly agree). The scale consists of five subscales that are divided into two dimensions, namely, (a) internal coping skills – the way individuals manage a crisis and (b) external coping skills – the way in which the family manages crises outside its boundaries (Olson et al., 1985). Internal coping strategies are: (a) redefining and ascribing meaning to the problem (Cronbach's alpha = .79) and (b) passive appreciation, that is passively accepting the problem and doing nothing about it (Cronbach's alpha = .74). External strategies are: (a) social support by friends (Cronbach's alpha = .79), religious support (Cronbach's alpha = .87) and professional help (Cronbach's alpha = .70). The F-COPES total scale has an internal reliability coefficient (Cronbach's alpha) of .77 and a test-retest reliability of .71 (Reis & Heppner, 1993). Table 4.9 gives a layout of the internal reliability coefficients obtained for the subscales of the F-COPES in this study.

Table 4.9

Internal Reliability Coefficients Obtained for Subscales of the Family Crisis Oriented Evaluation

Scales in this Study

F-COPES	Parent	Child
Mobilising family to acquire and accept help	.68	.77
Passive appraisal (passively accepting problem and doing nothing about it)	.56	.64
Reframing (redefining and ascribing meaning to a problem)	.40	.71
Social support	.82	.51
Spiritual support	.87	.71

6. The Family Times and Routines Index (FTRI)

The FTRI measures activities and routines utilised by families, and also the value families place on these practices (McCubbin et al., 1996). The scale consists of 30 items and eight subscales. It has a five-point Likert scale format assessing eight aspects of family time and routines, namely (a) the parent-child togetherness subscale, which measures the family's emphasis on creating predictable communication patterns between parents and offspring, (b) the couple togetherness subscale, which measures the family's emphasis on creating predictable routines to promote communication between couples, (c) the child routines subscale, which measures the family's emphasis on establishing predictable routines to encourage a sense of autonomy and order in the children, (d) the meals together subscale, which measures the family's efforts to enhance family togetherness through predictable family mealtimes, (e) the family togetherness subscale, which measures the family's emphasis on family togetherness by focusing on activities such as special events, caring, quiet time and family time, (f) the family chores subscale, which measures the family's focus on creating predictable routines to promote child and adolescent responsibilities in the home, (g) the relative connection routines subscale, which measures the family's efforts to establish routines to enhance a meaningful connection and relationship with relatives, and (h) the family management routines subscale, which measures the family's attempts to establish

predictable routines to promote a sense of family organisation and accountability so as to maintain family order. Table 4.10 gives a layout of the internal reliability coefficients obtained in the study of McCubbin et al. (1996), as well as the current study's internal reliability coefficients obtained for the FTRI for the adult and child participants.

Table 4.10

The Internal Reliability Coefficients obtained for the Subscales of the Family Times and Routines Index (FTRI) in this Study Compared to those of McCubbin et al. (1996)

FTRI	McCubbin et al. (1996)	Parent	Child
Parent-child togetherness	.27	.47	.57
Couple togetherness	.69	.47	.54
Child routines	.40	.47	.59
Meals together	.55	.48	.76
Family time together	.49	.65	.60
Family chores routines	.56	.68	.84
Relatives' connection spouse	.27	.74	.60
Family management routines	.65	.56	.45
Total: Cronbach's alpha	.88	.75	.87
Total: Guttman split-half alpha		.63	.73
Total: Important		.79	.89
Total: Guttman split-half alpha		.74	.77

7. The Family Problem Solving and Communication Scale (FPSC)

This FPSC was designed by McCubbin et al. (1996) and was utilised to assess family communication patterns. It consists of 10 items with a four-point Likert format, which aims to measure the two dominant family communication patterns. Incendiary communication represents negative communication patterns that tend to exacerbate a stressful situation, and affirming communication represents positive communication patterns, such as support and care, which exert a calming influence. The Incendiary subscale has an alpha reliability of .78 and the

Affirming subscale's alpha reliability is .86. The total scale has an alpha coefficient of .89 and its validity has been confirmed in several studies (McCubbin et al., 1996). In this study, the internal reliability of the total score was .81 for the adults and .71 for the children. In internal reliability for the Incendiary Communication subscale was .71 for the adults and .52 for the children, while it was.75 for the adults and .88 for the children on the Affirming Communication subscale.

8. Beck Depression Inventory (BDI-II)

The Beck Depression Inventory (BDI-II) is one of the most widely used instruments to measure depression (Beck, Steer & Brown, 1996; Hagen, 2007). The first version of the scale was relatively robust in terms of psychometric properties. It thus was replaced with the new, revised BDI-II, which is consistent with the DSM-1V categories of the diagnosis of depression. The BDI-II is a 21-item, four-point ordinal scale (0 to 3) for rating the severity of each item in the questionnaire (Beck et al., 1996; Osman, Barrios, Gutierrez, Willians & Bailey, 2008). The total scale severity score is attained by adding the highest rating for each item (Osman et al., 2008). The total score of BDI-II ranges between 0 and 63, with higher scores reflecting greater depressive pathology. The following cut-off scores are used as guidelines for interpreting specific levels of severity of depressive symptoms: 0 to 13 as minimal, 14 to 19 as mild, 20 to 28 as moderate and 29 to 63 as severe (Osman et al., 2008).

The BDI-II demonstrates high internal consistency, with alpha coefficients of .86 to .81 for psychiatric and non-psychiatric populations (Beck et al., 1996). The study of Coles, Gibb and Heimberg (2001) also reported a good alpha coefficient of .89 for the BDI-II. Consistent with studies in other populations, the BDI-II exhibited a good internal reliability of .95 for the patients identified for this study.

4.3.3.3 Qualitative Measure

The Qualitative measure comprised of one open-ended question. The following question was posed to the identified patients: 'In your own words, what are the most important factors, or strengths, which helped your family lately?'

4.3.4 Procedures

With a view to obtaining permission to conduct the study, the relevant authorities at the military hospital were approached and informed as to the nature of the study. Consent to conduct the study was obtained from the University of Stellenbosch, as well as from the ethics committee of the South African National Defence Force. The descriptive phase was conducted during 2006. The procedures for the descriptive phase were as follows:

After the parent with the diagnosis has been approached by their relevant psychologist or psychiatrist, voluntary permission for the researcher to contact them was obtained from that patient. The patient was also given the option to contact the researcher. The same applied to the families who responded to the poster and flyers (see Addendum A). The next step was to telephonically contact the identified patient in each families and re-inform her/him about the research. If the family was still interested in participating in the research, an information letter (see Addendum B) and a letter as evidence for the workplace (see Addendum C) were mailed or faxed to the family. The parents were requested to discuss the research, the information and their interest in the intervention programme with their family.

Telephonic contact was made for a second time to determine whether or not they remained interested in the research project. If so, a meeting was set for family data capturing at their nearest military health service. Both parents and a child completed the applicable questionnaires, with the researcher being present in the event of any questions arising. Some of the children were too young to comprehend the questionnaires and thus could not complete them. Alternative times were scheduled if the participants were not able to keep the first appointment.

The attendance of these meetings was voluntary. At the meetings, the nature of the study was explained and any questions regarding the study were answered. Following the above, the participants had the opportunity to proceed with, or retire from, further participation.

Each participant (identified patient, spouse and child) received a copy of the consent form (see Addendum D), which confirmed that participation was voluntary. The consent form was explained to the participants and they had the opportunity to read and sign it after all their questions had been answered. The identified patient had to complete both the Biographical Questionnaire and the Beck Depression Inventory after giving consent. He/she also indicated whether they, as a couple, were interested in the intervention programme. The spouse of the identified patient, and a child still living at home, each completed the questionnaires regarding potential resilience factors. The participants took approximately 45 minutes to complete the questionnaires.

4.3.5 Data Analysis

The empirical analyses centred on the concept of triangulation, namely the merging of the quantitative and qualitative data analyses. The family was the unit of analysis, with two quantitative insider perspectives, namely a parent and one child. In addition, the data was also enriched by the analysis of the qualitative open-ended question, which was answered by the identified patient – an insider's perspective of the family. All data analyses were planned and executed in collaboration with a senior statistician, Prof. M. Kidd of the Statistical Consultation Service of the University of Stellenbosch.

The quantitative data was analysed using STATISTICA (V8) (StatSoft Inc., 2008), a data analysis software package. The following section will deal firstly with the quantitative data analysis and, secondly, with the qualitative data analysis.

The quantitative data from the description phase was analysed through Spearman product-moment correlations (Howell, 1995) and regression analysis in order to determine which

independent variables contributed most to the variance in the dependent variable, family adaptation (FACI8 scores), according to the Resilience Model. Various family qualities, as postulated by the literature, were measured through quantitative instruments in the descriptive phase. These instruments, as mentioned earlier, were The Family Hardiness Index (FHI) (McCubbin et al., 1996), The Social Support Index (SSI) (McCubbin et al., 1996), The Relative and Friend Support Index (RFS) (McCubbin et al., 1996), The Family Crisis Orientated Personal Evaluation Scale (F-COPES) (Olson et al., 1985), The Family Time and Routine Index (FTRI) (McCubbin et al., 1996) and The Family Problem Solving and Communication Scale (FPSC) (McCubbin et al., 1996). These variables were regressed (best subsets technique) on the dependent variable, namely that of family adaptation as measured with The Family Attachment and Changeability Index 8 (FACI8) (McCubbin et al., 1996).

Demographic data was obtained from each participant via a biographical questionnaire completed by the identified patient. The biographical questionnaire was included to obtain baseline data of the patient, the spouse and their immediate family members. In addition, the Beck's Depression Inventory was completed by each identified patient to ensure more detail regarding the severity of each patient's depression. The data obtained with the biographical questionnaire, as well as the results of the Beck's Depression Inventory-II, was codified and analysed alongside data obtained through the other measures.

In addition to the quantitative statistical analysis, grounded theory was utilised to analyse the qualitative data of the descriptive phase. Grounded theory analysis was used to categorise the qualitative data obtained from the open-ended question (Glaser & Strauss, 1967). An open-ended question regarding each identified patient's perception of resilience and factors contributing to his or her family's ability to combat and recover from adversity was included.

Charmaz (2006) says that grounded theory coding promotes sensitivity to and encourages researchers to explore and analyse qualitative data. Coding means categorising segments of data

with a short name that simultaneously summarises and accounts for each piece of data (Marshall & Rossman, 1995). According to Charmaz (2006), the grounded theory coding process consists of two phases, namely initial and focused coding. During the initial coding process, the fragments of data, namely words, lines, segments and incidents, are studied closely for their analytical importance and codes are assigned to the data. This process involves line-by-line scrutinising of transcripts and noting in the margins of the text. This, in turn, inspires another set of refined codes that focus on the structure and content of the data (Charmaz, 2006; Strauss, 1987). In the following phase - coding - the relationship between the codes and categories are explored (Charmaz, 2006). Strauss (1987) refers to this process as axial coding. Strauss (1987) suggests that this phase accentuates the commonalities and contradictions of the data. It also allows for an exploration of possible causes and consequences of the participants' views on family resilience, which assists with the exploration. The final step is the identification of central themes. The qualitative data comprised of one open-ended question that was posed to the identified patient, as mentioned previously.

Following the grounded theory coding process, the qualitative data were quantified in terms of the occurrence of each category. These categories will be reported on in the next chapter.

4.3.6 Ethical Considerations

Numerous researchers have argued that ethical considerations should be focused on protecting the rights, dignity and welfare of research participants (Babbie, 1998; Barker, Pistrang & Elliot, 1994; Cohen et al., 2000; Mertens, 1998). In conjunction with the consent obtained from the relevant authorities and the stipulations of the South African National Defence Force Ethics Committee, the following ethical considerations were upheld in the present study in order to adhere to the above-mentioned considerations.

In order to adhere to the principal of the right to self-determination, an information letter was sent to and discussed with each participant. This was followed up by the completion of an

informed consent form by each participant (Babbie, 1998; Barker et al., 1994; De Vos, 2000). The aforementioned information, as well as the verbal procedural explanation by the researcher, which included information regarding possible advantages and disadvantages attached to the study, allowed the participants to make a free, informed decision regarding their participation or not in the study. These procedures were followed to ensure that the participants understood and agreed to their voluntary participation. The children were also allowed to make an informed decision regarding their participation, with their parents as guardians.

These procedures also incorporate adherence to, and emphasis on, accurate and complete information so that the participant fully comprehended the study and consequently was able to make an informed decision about her or his participation (Babbie & Mouton, 2001; De Vos, 2000; Goddard & Melville, 2001).

Research participants also have the right to privacy, anonymity and confidentiality (Babbie, 1998; Barker et al., 1994; De Vos, 2000). In order to adhere to these rights, each prospective participant was initially identified and contacted by his or her psychologist or psychiatrist, and consent was gained for the researcher to contact him or her. The researcher then discussed the research with the identified patient, who then gave verbal consent. The researcher could then send an information letter to them as a family. This protected the identified patients' rights to privacy and confidentiality regarding their illness and also protected them in cases where they did not want their family to be aware of their illness.

Hereafter, the anonymity and confidentiality of all the participants were protected by using pseudonyms at all stages of the research. In addition, no identifying detail was revealed in the dissemination of the results. The right to privacy was protected by scheduling an individual session with each family for data gathering during the description phase. This allowed the researcher to explain the research project to each family member and answer questions in privacy before they made an informed decision about continuing. This phase was entirely

anonymous and confidential and allowed the couple to make a decision on whether or not they would like to participate in the intervention phase of the research, which was in group context with other couples. This entailed a different level of privacy and confidentiality, which will be discussed in Chapter 7. The participants were also given the option of withdrawing from the research at any stage.

4.4 Conclusion

The research design and methodology of the descriptive phase was chosen in order to address the aim of this phase of the research, namely to identify and describe qualities of resilience in families with a parent living with depression. An explorative, descriptive design was utilised in the study. Data was gathered by using a biographical questionnaire, the Beck's Depression Inventory-II, several quantitative instruments that measured different potential resilience factors, and a qualitative open-ended question. A non-probability purposive sampling procedure was utilised to select families in which one parent has been living with depression. The sample, the measures used, the participant's demographics as well as the procedures followed has been discussed in detail. Data analysis encapsulated the following: (a) quantitative data was analysed through Pearson product-moment correlations and a regression analysis, (b) grounded theory analysis was used to categorise the qualitative data obtained from the open-ended question, while (c) the demographics obtained from the biographical questionnaire, as well as the results of the Beck's Depression Inventory, were codified and analysed alongside data obtained from the other measures. Ethical issues in the research, such as the right to informed consent, privacy, anonymity and confidentiality, have been discussed in detail.

The results obtained are reported, discussed and integrated in the following chapter.

CHAPTER 5

DESCRIPTIVE PHASE: RESEARCH RESULTS AND INTEGRATION

5.1 Chapter Preview

This chapter is divided into two sections - firstly, the research results of the descriptive phase (Phase 1) are reported on and, secondly, these results are integrated with the relevant literature. The first section of this chapter reports on the results of the description phase obtained from the qualitative and quantitative data analyses. It also reports on (a) the correlation analyses of the quantified biographical data, (b) the results obtained with the various measures, which were correlated and regressed (best subsets technique) on the dependent variable, namely family adaptation (measured with The Family Attachment Changeability Index 8 (FACI8) (McCubbin et al., 1996), (c) the results of the Beck Depression Inventory (BDI-II), and (d) the different themes and interrelations of the qualitative data. The second section of this chapter provides an overview of the findings and concentrates on the results of the current study in relation to those of previous research on the Family Resilience Model (McCubbin et al., 1996).

5.2 Review of the Aims

Before reporting on and integrating the results, it is important to review the aim of the descriptive phase of the research. The primary research aim posed the following question: 'Which qualities of resilience are present in families in which a parent has been living with depression?' The primary objective of the descriptive phase was to answer this question by identifying and describing the qualities of resilience in families in which a parent had been living with depression.

The following section displays the quantitative correlations and regression analysis, followed by the qualitative results.

5.3 Results

5.3.1 Quantitative Results

The first phase of the statistical analysis was to determine the relationships of the independent variables with the dependent variable (family adaptation). The independent variables were measured with the FHI, SSI, RFS, F-COPES, FTRI and FPSC, while the Family Attachment Changeability Index 8 (FACI8) (McCubbin et al., 1996) was used to measure the dependent variable, namely family adaptation. Quantified biographical data also allowed for correlation analyses.

The relationships between these variables were determined by means of Spearman Correlation Coefficients (Sr), which are used for ranked data where it is not assumed that the data is normally distributed (non-parametric). Harris (1998) says that a p-value of .05 is the standard for most psychological reports in order to assess the significance of correlation coefficients. A second phase of the data analysis entailed the regression (best-subsets technique) of the independent variables on the dependent variable, namely that of family adaptation. This technique explored the combined influence of several independent variables on the dependent variable.

The following subsection reports on (a) the correlations between the biographical data and the dependent variable (FACI8 scores), as well as the one-way ANOVA that was used to compare language and gender with the dependent variable, (b) the correlations between the potential resilience qualities and the dependent variable (FACI8 scores), and (c) the results obtained from the regression analysis.

5.3.1.1 Results of Biographical Data

The participants' biographical information was discussed in the preceding chapter. In this subsection, significant correlations between the biographical variables and family adaptation are

looked at. Spearman's correlation coefficients for ranked data (Sr) were determined. Table 5.1 illustrates the relationships between these variables and family adaptation.

Table 5.1

Spearman Correlations between the Measured Biographical Variables and the Dependent Variable Family Adaptation (FACI8)

Participant	Biographical variable	R	P
Adult	Length of marriage	.14	.44
Child		-.08	.69
Adult	Age (identified patient)	.16	.35
Child		-.03	.90
Adult	Age (spouse)	.04	.82
Child		-.17	.39
Adult	Age (child 1)	.29	.10
Child		-.28	.15
Adult	Age (child 2)	.26	.16
Child		-.22	.26
Adult	Qualification (identified patient)	.18	.30
Child		.15	.46
Adult	Income	.23	.18
Child		.17	.41
Adult	Length of MDD diagnosis	-.01	.97
Child		.24	.23

According to Table 5.1 there was no significant relationship between family adaptation (FACI8) scores) and the quantified biographical data. However, two interesting, significant findings were highlighted by comparing the mean FACI8 score between the subgroups identified by language and gender. Significantly higher scores for family adaptation were obtained by Afrikaans-

speaking spouses and by spouses who had male oldest children. These findings will be elaborated on in the following section. Table 5.2 gives a layout of the unweighted mean scores when comparing the Afrikaans-speaking spouses' family adaptation scores with the English-speaking spouses' results.

Table 5.2

Spouse Language Differences when Comparing Mean Scores for Family Adaptation

	Mean Scores				
Home language	FACI8 Total Spouse	FACI8 Total Spouse	FACI8 Total Spouse		N
	Mean	Standard error	-95.00%	+95.00%	
Afrikaans	30.750	1.1678	28.371	33.129	14
English	27.575	0.9771	25.585	29.565	20

Table 5.2 demonstrates that, when comparing mean scores for family adaptation, adult Afrikaans-speaking spouses achieved a statistically significant higher score ($p = .05$) on the FACI8 ($M = 30.75$) than their English-speaking equivalents ($M = 27.58$). Figure 5.1 illustrates this difference.
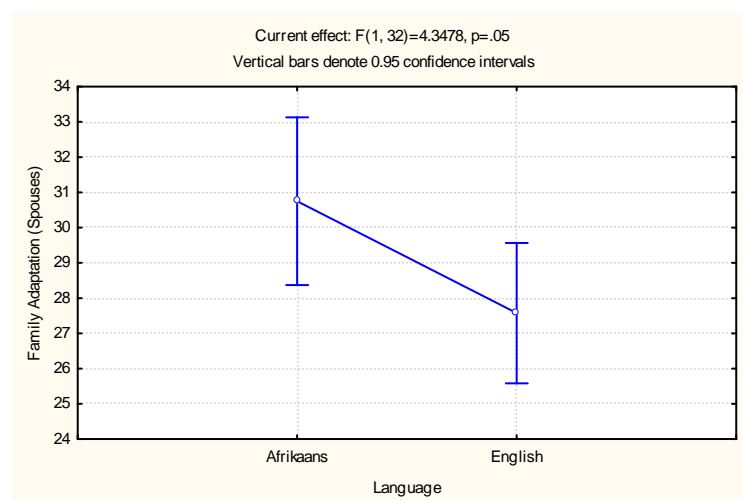
Figure 5.1. Spouse language differences when comparing mean scores for family adaptation.

Figure 5.1 illustrates a slightly broader interval range amongst Afrikaans-speaking spouses than English-speaking spouses, which might be ascribed to the bigger sample size of the English-speaking participants.

Table 5.3 illustrates the statistically significant difference of the mean scores in comparing family adaptation (spouses' scores) for families that have males as the oldest child with families (spouses' scores) that have females as a first child.

Table 5.3

Family Adaptation According to Gender of Oldest Child: Comparing Mean Scores for Family Adaptation

	Mean scores				
Gender	FACI8 Total Spouse	FACI8 Total Spouse	FACI8 Total Spouse		N
	Mean	Standard error	-95.00%	+95.00%	
Male	30.250	0.9708	28.273	32.227	20
Female	26.929	1.1603	24.565	29.292	14

Table 5.3 illustrates that, when comparing mean scores for family adaptation, families with a male oldest child achieved a significantly higher mean score (M = 30.25) than their equivalents (M = 26.93; p = 0.04) with a female as the first child. Figure 5.2 illustrates this difference.

Current effect: F(1, 32)=4.8198, p=.04
Vertical bars denote 0.95 confidence intervals
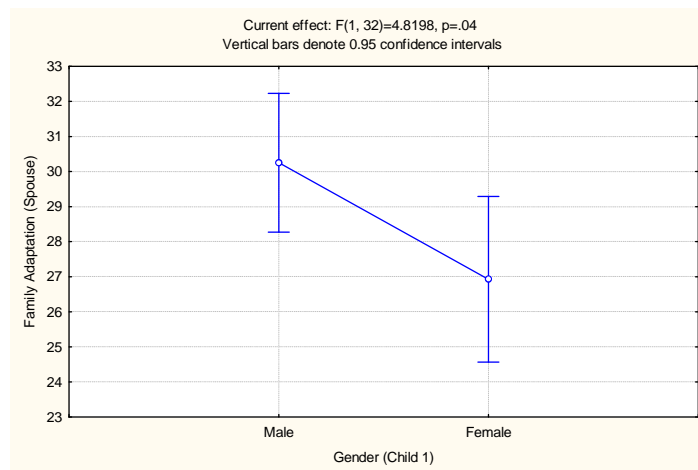
Figure 5.2. Gender Differences when comparing mean scores for family adaptation (Family Attachment Changeability Index 8, McCubbin et al., 1996).

Figure 5.2 illustrates a slightly broader interval range among families with a first-born male child than those with first-born female children. Family adaptation scores for spouses with male oldest children ranged between 28.27 and 32.23, while spouses with female oldest children had a slighter broader, lower spectrum of between 24.57 and 29.29.

5.3.1.2 Results Obtained with Different Family Resilience Measures

To enable comparison and enhance transparency, all quantitative correlations and their probability levels of the adult (spouse) and child participants are reported separately in the following section. Scatter plots of significant correlations are provided thereafter. Table 5.4 reports on the Spearman correlations between the measured independent variables and the dependent variable, family adaptation (FACI8 scores).

Table 5.4

Spearman Correlations between the Measured Independent Variables and the Dependent Variable, Family Adaptation (FACI8)

Participants	Independent variable	Spearman	
		r	p
Spouse	FHI Total	.61	0.00**
Child		.42	0.03*
Spouse	FHI – Commitment	.56	0.00**
Child		.33	0.09
Spouse	FHI – Challenge	.51	0.00**
Child		.43	0.03*
Spouse	FHI – Control	.58	0.00**
Child		.31	0.11
Spouse	SSI	.29	0.09
Child		.27	0.17
Spouse	RFS	.31	0.07
Child		.46	0.02*
	F-COPES	-	-
Spouse	FC: Acquiring social support (SOC)	.30	0.08
Child		.34	0.08
Spouse	FC: Reframing (RE)	.30	0.09
Child		.12	0.54
Spouse	FC: Seeking spiritual support (SPIR)	.13	0.46
Child		.39	0.05*
Spouse	FC: Mobilising family (MO)	.24	0.16
Child		.19	0.35

(table continues)

Table 5.4 (continued)

Spearman Correlations between the Measured Independent Variables and the Dependent Variable, Family Adaptation (FACI8)

Participants	Independent variable	Spearman	
		r	p
Spouse	FC: Passive appraisal (PA)	.38	0.03*
Child		.56	0.00**
Spouse	FTRI Total	.55	0.00**
Child		.48	0.01**
Spouse	FTRI: Important	.11	0.55
Child		.09	0.66
Spouse	FTRI: Child routine	.27	0.13
Child		.26	0.19
Spouse	FTRI: Couple togetherness	.41	.02*
Child		.39	.05*
Spouse	FTRI: Eating meals together	.31	.08
Child		-.01	.97
Spouse	FTRI: Parent-child togetherness	.39	.02*
Child		.39	.04*
Spouse	FTRI: Family time togetherness	.42	.01*
Child		.55	.00**
Spouse	FTRI: Relative's connection	.35	.05*
Child		.30	.13
Spouse	FTRI: Parent chores routines	.42	.02*
Child		.39	.06

(table continues)

Table 5.4 (continued)

Spearman Correlations between the Measured Independent Variables and the Dependent Variable, Family Adaptation (FACI8)

Participants	Independent variable	Spearman	
		r	p
Spouse	FTRI: Family management routines	.45	.01**
Child		.28	.15
Spouse	FPSC Total score	.74	.00**
Child		.64	.00**
Spouse	FPSC: Affirming	.67	.00**
Child		.45	.02*
Spouse	FPSC: Incendiary	-.72	.00**
Child		-.59	.00**

Note. *p < 0.05; ** P < 0.01

Measures

1. The Family Hardiness Index (FHI)

2. The Social Support Index (SSI)

3. The Relative and Friend Support Index (RFS)

4. The Family Crisis Orientated Personal Evaluation Scales (F-COPES)

5. The Family Time and Routine Index (FTRI)

6. The Family Problem Solving and Communication Scale (FPSC)

Table 5.4 clearly depicts 16 variables according to the spouses' data and 12 variables according to the children's data that correlated statistically significantly with the dependent variable, family adaptation. Of these, the strongest cohort of statistically significant correlations was found between family adaptation (as measured by FACI8) and family problem solving and communication, affirming communication and incendiary communication as measured by the FPSC scale. A graphical illustration of these follows below.

Figure 5.3 represents the statistically significant correlative relationship between family adaptation (FACI8 scores) and family problem solving and communication (FPSC) for the spouses.
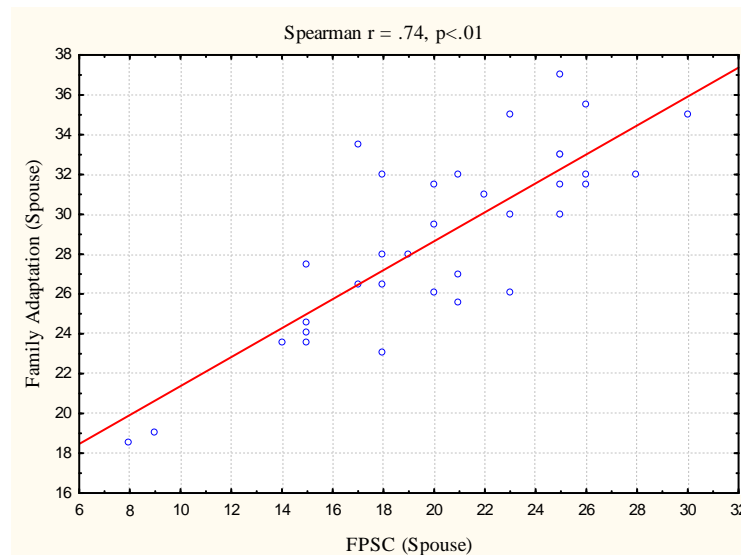
Figure 5.3. Spouses' responses regarding the association between family problem solving and communication (FPSC) and family adaptation (FACI8).

Figure 5.3 clearly shows the strong statistically significant ($r = .74$; $p< .00$) positive relationship between family adaptation (FACI8) and family problem solving communication (FPSC scale) according to the spouses.

In Figure 5.4, the relationship between family adaptation (FACI8) and affirming communication (FPSC subscale) according to the spouses is shown.
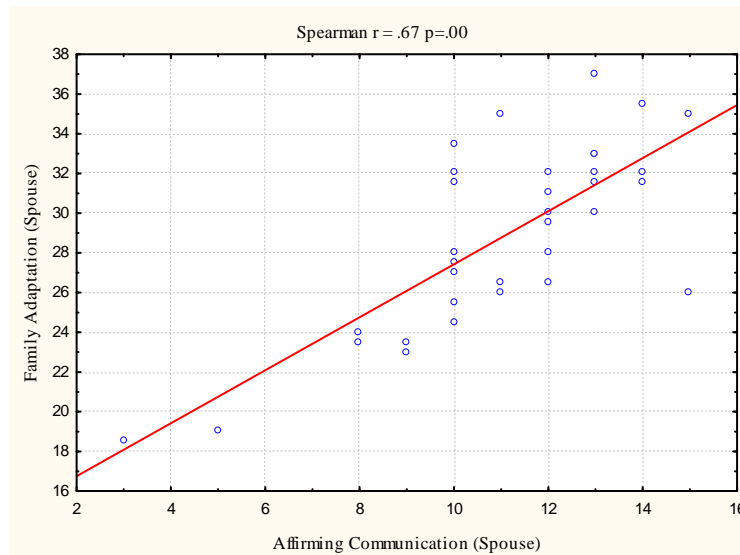
Figure 5.4. The association between affirming communication (FPSC: Affirming subscale) and family adaptation (FACI8), according to the spouses.

Figure 5.4 depicts the strong statistically significant (r = .67; p < .00) positive relationship between family adaptation and affirming communication, according to the spouses.

In Figure 5.5, the relationship between family adaptation (FACI8) and incendiary communication (FPSC subscale) according to the spouses is shown.
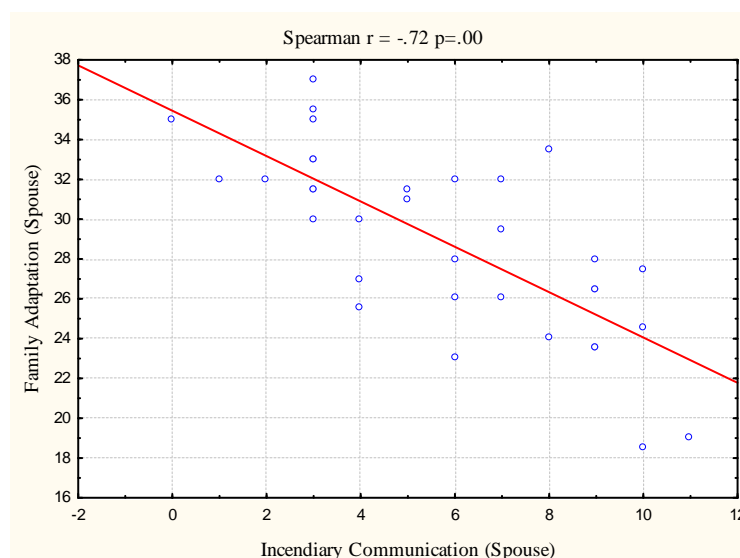
Figure 5.5. Spouse findings regarding the association between incendiary communication (FPSC: Incendiary subscale, McCubbin et al., 1996) and family adaptation (FACI8, McCubbin et al., 1996).

Figure 5.5 illustrates the strong statistically significant (r = -.72; p < .00) negative relationship between family adaptation and incendiary communication, according to the spouses.

5.3.1.3 Results of the Regression Analyses

In this section the possible co-joined influence of several independent variables on the dependent variable is analysed via a regression analysis. The independent variables listed in Table 5.4 were regressed (best subsets technique) on the dependent variable, namely family adaptation (measured with FACI8), for both the spouses' and the children's responses. The significant results of the regression analysis as obtained from the spouses' data are outlined in Table 5.5.

Table 5.5

Summary of Regression Analysis of Independent Variables on Family Adaptation (FACI8) for the Spouses' Data (N = 34)

	Beta	Standard error of Beta	B	Standard error of Beta	t (28)	p-level
Intercept			14.56243	3.83901	3.79328	.00073
FTRI Family Total	.26256	.12423	0.11274	0.05335	2.22348	.04360
FTRI Important Total	-.18413	.11468	-0.12088	0.07529	-1.60558	.11959
FC SOC	.22202	.13457	0.13876	1.08410	1.64986	.11015
FC MO	-.22903	.13378	-0.28757	0.16798	-1.71189	.09797
FPSC Total	.73932	.13694	0.66284	0.12278	5.39879	.00001

(R = .85686, R^2 = .73420, Adjusted R^2 = .68672, F (5, 28) = 15.469, p < .00000, Std. error of estimate: 2.5668)

Table 5.5 illustrates that, according to the spouses' data, family time and routines (FTRI Family total score) as well as family problem solving and communication (FPSC total score) made statistically significant contributions to the prediction of family adaptation (FACI8 scores).

The results of the regression analysis as obtained from the children's data are outlined in Table 5.6.

Table 5.6

Summary of Regression Analysis of Independent Variables on Family Adaptation (FACI8) for the Children's Data (N = 27)

	Beta	Standard error of Beta	B	Standard error of Beta	t (21)	p-level
Intercept			7.61852	5.54033	1.37510	.183594
FTRI Total	.35895	.20562	0.11897	0.06815	1.74567	.095484
FTRI Important	-.19675	.18009	-0.08582	0.07856	-1.09251	.286985
FC SOC	.19939	.16025	0.20315	0.16327	1.24420	.227134
FC PA	.45799	.14215	0.59215	0.18379	3.22182	.0004091
FPSC Total	.24218	.16432	0.17586	0.11932	1.47385	.155356

($R = .78232880$, $R^2 = .61203835$, Adjusted $R^2 = .51966653$, $F (5, 21) = 6.6258$ $p < .00076$. Std. error of estimate: 3.2216)

Table 5.6 indicates that the passive appraisal of a situation (F-COPES subscale PA) was revealed to be a statistically significant contributor to the prediction of family adaptation (FACI8 score).

In addition to the above-mentioned measurements, all the identified patients completed the Beck Depression Inventory (BDI-II) (Beck et al., 1996) in order to measure the severity of their depression. This provided a better understanding of the possible impact of the depression on the family's adaptation. Table 5.7 gives the scores obtained.

Table 5.7

Results of the Beck Depression Inventory (BDI-II)

Severity category	Score	N	Percentage
Minimal	00 to 13	13	36
Mild	14 to 19	07	19
Moderate	20 to 28	02	06
Severe	29 to 63	14	39
Total		36	100

The results of the descriptive statistical analysis of the data obtained with the BDI-II indicated that the participants scored within a broad range, with a mean of 21.64 (SD = 14.93). Thirteen (36%) of the 36 participants had a minimal score, seven participants (19%) were mildly depressed, two (6%) were moderately depressed, while fourteen (39%) were severely depressed. The mean indicates that the average level of depression for the identified patient population was within the moderate category.

The relationship between depression rates and the dependent variable, family adaptation (FACI8), is portrayed in Table 5.8.

Table 5.8

Spearman Correlations between Depression Rates (BDI-II) and the Dependent Variable, Family Adaptation (FACI8)

Participant	Independent Variable	Spearman r	Probability Level (p)
Id Patient	BDI-II	-.45	.01**

Note. $*p < .05$; ** $P < .01$

The correlation coefficients clearly indicate a significant negative correlation ($r = -.5$; $p = .01$) between measured depression (BDI-II) and the dependent variable, family adaptation (FACI8),

which means that a higher depression score is a possible indicator of a lower family adaptation score. This relationship is further highlighted in Figure 5.6.
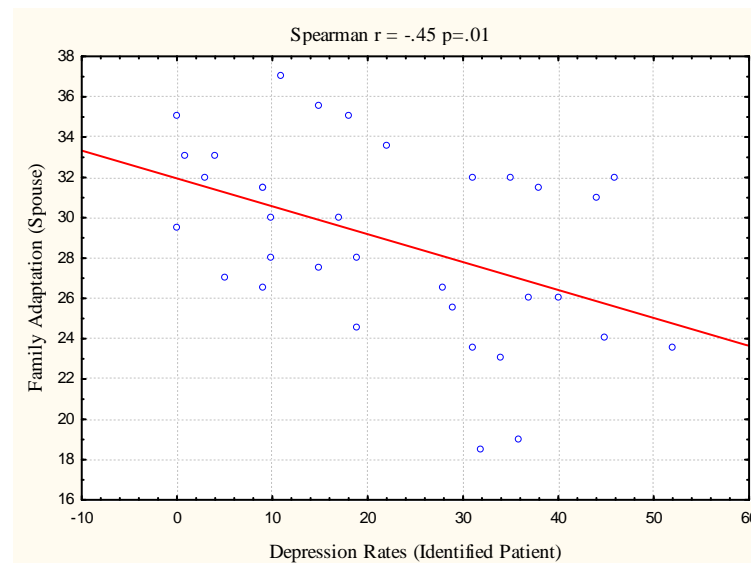
Figure 5.6. Findings regarding the association between measured depression (Beck Depression Inventory II) and family adaptation (FACI8 scores).

Figure 5.6 gives a visual representation of the statistically significant negative relationship between family adaptation (FACI8) and severity of depression as measured by the Beck Depression Inventory-II.

This section gave a representation of the correlative quantitative findings of the descriptive phase (Phase 1). It provided a layout of the correlation between the dependent variable, family adaptation, and (a) the quantified biographical data, (b) the resilience qualities and (c) the measured level of depression. The following subsection reports on the qualitative results of the descriptive phase.

5.3.2 Qualitative Results

The qualitative data comprised one open-ended question that was posed to the identified patient, namely: 'In your own words, what are the most important factors, or strengths, which helped your family lately?' All the participants replied to the question, expect for one, who replied by

mentioning that she could not recall any factors that had recently helped them as a family. Grounded theory analysis provided the method to categorise the qualitative data obtained from the open-ended question. This process was explained in the previous chapter. Table 5.9 gives a layout of the participants' responses to the question regarding family resilience.

Table 5.9

Themes Associated with Family Resilience according to the Identified Patients (n = 36)

Primary themes and associations with family resilience	Frequency (n = 36)	Percentage
1. Medical Attributes	(Total no = 14)	39
Individual psychotherapy/counselling (implementing)	10	
Couples counselling and spouse support	21	
Pharmacotherapy	4	
Workshops (motivation; stress)	2	
Normalise: talk to other people with same problem	2	
Accept illness and help	2	
2. Situational Attributes		
Spiritual Support Total	(Total no = 13)	36
Spirituality and Religion	13	
Community Support Total	(Total no = 3)	8
Implement community advise: old people	1	
Less friends/support from close circle of friends	2	
Extended Family Support Total	(Total no = 9)	25
Extended family support, i.e., grandparents	9	
Intra-family Support Total	(Total no = 20)	56
Spouse support/supportive family relationships and encouragement	17	
Family structural support (housekeeper)	5	

(table continues)

Table 5.9 (continued)

Themes Associated with Family Resilience according to the Identified Patients (n = 36)

Primary themes and associations with family resilience	Frequency (n = 36)	Percentage
3. Interpersonal/Family Attributes		
Communication and Problem Solving	(Total no = 20)	56
Communication: Open to spouse and children	17	
Communication: Honest	2	
Communication: Listen	2	
Communication: Share feelings (verbal or letters)	3	
Communication: Timing and can boundary setting	2	
Problems: assessment, work together, understanding shared decision making, objective view	7	
Conflict Management: Control our tempers/not before child	2	
Values	(Total no = 20)	56
Code of conduct (showing affection, respect, love, praise)	13	
Existential view (ask for help, accept, standing together)	4	
Family structure (gender roles, good discipline)	8	
Family Time and Routines	(Total no = 10)	28
Doing things together and spend time together	9	
Routines (meals together, meetings, life style, friends visit)	4	

Table 5.9 (continued)

Themes Associated with Family Resilience according to the Identified Patients (n = 36)

Primary themes and associations with family resilience	Frequency (n = 36)	Percentage
4. Personal Attributes		
Spouse	(Total no = 2)	6
Personality traits (calm, practical)	2	
Identified Patient	(Total no = 14)	39
Life orientation (day by day)	5	
Sense of responsibility (keep things together, organisation)	5	
Personality traits (friendliness, trust, open mind, positive)	4	
Patients with family/Aware of impact on family	2	
Self investment (study, patients, listen to own needs)	5	
Children	(Total no = 1)	3
Obedient	1	
5. No Contributing Attributes	(Total no = 1)	3

The themes associated with better family adaptation are displayed in Table 5.9. The analysis shows that the following factors are linked to family resilience for these families.

1. Medical Attributes

2. Situational Attributes

    (a) Spiritual Support

    (b) Community Support

    (c) Extended Family Support

    (d) Intra-family Support

3. Interpersonal/Family Attributes

    (a) Communication and Problem Solving

    (b) Values

4. Personal Attributes

    (a) Spouse

    (b) Identified Patient

    (c) Children

5. No Contributing Attributes

Table 5.9 gives a detailed analysis of the findings, because all factors are considered valid and important within the explorative frame of the text. However, certain categories and trends emerged when considering the frequency distribution of the data. The identified patient population listed, in order of reported frequency, the following factors as contributing to their family's resilience.

1. Interpersonal Attributes: *Communication and Problem Solving* (56%)

2. Interpersonal Attributes: *Values* (56%)

3. Situational Attributes: *Intra-family Support* (56%)

4. Personal Attributes: *Identified Patient* (39%)

5. Medical Attributes (39%)

6. Situational Attributes: *Spiritual Support* (36%)

7. Interpersonal Attributes: *Family Time and Routines* (28%)

8. Situational Attributes: *Extended Family Support* (25%)

9. Situational Attributes: *Community Support* (8%)

10. Personal Attributes: *Spouse* (6%)

11. Personal Attributes: *Children* (3%)

12. No Contributing Attributes: *No (3%)*

In view of the above-mentioned list, the three dominating resilience factors indicated by the participants were (a) communication and problem solving, (b) values and (c) family support (Table 5.9). These three factors were mentioned by over 50% of the participants, which gives an

indication of the value these families placed on these resilience factors. The category regarding the identified patient (i.e., life orientation, sense of responsibility) was reported as an important resilience factor by more than a third of the participants. This might be an indication of the importance of individual resilience in the family setup. Furthermore, medical attributes, together with spiritual support (spirituality and religion), are also shown to be significant resilience factors and were mentioned by more than a third of the participants. Family time and routines, as well as extended family support, also appeared to be significant resilience factors, as they were mentioned by a quarter of the participants.

Following the description of the biographical, quantitative and qualitative research results of Descriptive Phase (Phase 1) of the research, the following section will focus on the integration of these findings with previous research.

5.4 Overview and Integration of Findings

Firstly, an overview of the statistical findings of the descriptive phase of the current research will be given. This subsection is divided into three parts, namely the discussion of the biographical, quantitative and the qualitative findings. Secondly, the current research findings will be integrated with previous research in the field. This section will be structured according to the Family Resilience Model.

5.4.1 Overview

5.4.1.1 Biographical Findings

The biographical findings made an important contribution to the study by providing a context for the findings in relation to the measures utilised. A description of the participants' demographical details is provided in Chapter 4. The biographical findings shed light on the following variables: marital status, length of marriage, distribution of marriages, number of children, age and gender of family members, living-in members, highest qualifications, occupational status, income, language, length of MDD diagnosis and treatment options utilised.

In summary, the biographical findings described the research sample as follows. The participants had been married for between four and 26 years, with an average length of marriage of 16 years. The majority of the participants (spouses and identified patients) were in their first marriage. The average number of children per family unit was two children, with a minimum of one and a maximum of three children. The average age of the identified patients was 41 years, with an age distribution of between 27 and 49 years, while the average age of the spouses was 43 years, with an age distribution between 28 and 59 years. The majority (89%) of the identified patients were female. The age of the first child ranged between eight and 25 years, with an average of 16 years. The age distribution of the second child ranged between four and 22 years, with an average age of 12, while the third child's age distribution ranged between three and 18, with an average age of 11. Six of the 36 families had a living-in member (i.e., domestic helper, etc). The participants' home languages were English (58%) and Afrikaans (42%). Secondary school education was the most common level of education for both the identified patients and their spouses, while a quarter of both groups held diplomas and a small portion had tertiary degrees. All the spouses and 89% of the identified patients were employed, which shed light on the fact that only 19% of the participants received an annual income less than R100 000. The biographical findings also gave an indication of the duration of the major depressive disorder of the identified patients. Only one participant had been living with depression for less than a year previously, while the rest were fairly equally distributed between one to two years, three to five years, six to 10 years and more than 10 years previously. Treatment options utilised by the identified patients were as follows: medication (42%), medication and psychotherapy (42%), psychotherapy (8%) and no longer any treatment (8%).

None of the above-mentioned biographical variables correlated significantly with the dependent variable, family adaptation (see Table 5.1). However, by comparing the unweighted mean scores for family adaptation it was found that adult Afrikaans-speaking spouses rated their families higher on the FACI8 than did their English-speaking counterparts, and that those spouses with

male firstborns also rated their families higher on the FACI8 than spouses with female firstborns. It could be speculated that cultural and gender differences played a role in the participants' perceptions regarding their family's adaptation.

5.4.1.2 Quantitative Measurement Findings

According to the quantitative data analysis, the following variables could be acknowledged as being statistically significantly associated with the dependent variable, family adaptation, as measured by The Family Attachment Changeability Index 8 (FACI8) (McCubbin et al., 1996):

1. Family hardiness, which could also be seen as a measure of family resilience. The FHI (McCubbin et al., 1996) was included to validate the FACI8 measure. Family hardiness according to both spouses (r = .61; p < .00) and the children (r = .42; p < .01) indicated a statistically significant correlation with family adaptation. The variables, measured with the subscales of the FHI, had the following correlations with family adaptation: commitment - spouses r = .56 (p < .00), children r = .33 (p = .01); challenge - spouses r = 0.51 (p < .00), children r = .43 (p = .03) and control - spouses r = 0.58 (p < .00).

2. Relative and friend support, according to the children (r = 0.46; p = 0.02), showed a statistically significant correlation with family adaptation. Relative and family support did not appear to significantly correlate with family adaptation for the spouse population.

3. A statistically significant relationship was found between redefining and ascribing meaning to a crisis situation, as measured by the Family Crisis Oriented Personal Evaluation Scales (F-COPES, Olson et al., 1985), and the dependent variable, family adaptation (FACI8), for both the spouse and child populations. The probability levels were accentuated by the subscale, passive appraisal (PA) of the F-COPES, and correlated significantly with the spouses' data r = .38 (p = .03) and children's data – r = .56 (p < .00) data. Furthermore, the child (r = .39; p = .05) population also revealed a significant probability level between family adaptation and seeking spiritual support (SPIR).

4. A strong and positive statistically significant correlation between family adaptation (FACI8) and family time and routines was found on the basis of the measurements of the Family Time and Routine Index (FTRI) (McCubbin et al., 1996) from both the spouse $r = .55$ ($r < .00$) and child $r = 0.48$ ($p = .01$) perspectives. Some of the variables measured by the subscales also echoed this trend: couple togetherness - spouse $r = .41$ ($p = .02$), child $r = .39$ ($p = .05$), parent child togetherness - spouse $r = .39$ ($p = .02$), child $r = .39$ ($p = .04$), and family time together - spouse $r = .42$ ($p = .01$), child $r = .55$ ($p = .00$). However, relative's connection $r = .35$ ($p = .05$), parent chores routines $r = .42$ ($p = .02$) and family management routines $r = .45$ ($p = .01$) correlated statistically significantly with family adaptation from a spouse perspective, but not from a child perspective (FACI8, McCubbin et al., 1996).

5. The strongest correlation found with the probability analysis of the data was the statistically significant relationship between family problem solving and communication (FPSC, McCubbin et al., 1996) and family adaptation (FACI8, McCubbin et al., 1996)) for both the spouse $r = .74$ ($p < .00$) and child $r = 0.64$ ($p < .00$) populations. This variable, measured by the subscales of the FPSC, revealed the following statistically significant correlations with family adaptation (FACI8): affirming communication - spouse $r = .67$ ($p < .00$), child $r = .45$ ($p = .02$), incendiary communication - spouse, $r = -0.72$; $p < .00$, child $r = -.59$ ($p < .00$).

6. The results of the correlation analysis between depression levels (BDI-II, Beck et al., 1996) and family adaptation (FACI8, McCubbin et al., 1996) signified a statistically significant strong negative relationship between these variables. The average level of depression of the identified patient population was within the moderate category.

From the above-mentioned summary it seems evident that a level of overlap, in terms of significant probability levels, does exist between what the spouse and child populations viewed as important independent variables associated with the dependent variable, family adaptation. This overlap accentuates the correlative findings between the dependent variable and the

independent variables due to the process of triangulation. The only independent variable that did not have a significant probability level with family adaptation (FACI8) was social support (SSI, McCubbin, et al., 1996). It is important to note that the regression analysis also revealed interesting findings, which correlated with the correlation analysis. The regression analysis of the spouses' data identified family time and routine (FTRI) and family problem solving and communication (FPSC) as statistically significant indicators and predictors of family adaptation (FACI8). The regression analysis of the child data revealed that passive appraisal (PA, F-COPES) of a stressor contributed statistically significantly to the prediction of the dependent variable, family adaptation, as measured by the FACI8.

5.4.1.3 Overview: Qualitative Findings

The qualitative data on family resilience was obtained by one open-ended question posed to the identified patients. The data was analysed by implementing the procedures provided by grounded theory. Table 5.9 provides a detailed depiction of the composition of each category found in the analysis of the qualitative data. The results were divided into four broad categories, namely Medical, Situational, Interpersonal and Personal attributes, with the last three categories also being subdivided into smaller, detailed categories. Communication and problem solving, values and family support were revealed to be the dominating resilience factors indicated by the participants.

5.4.2 Integration of Findings

This section will focus on the integration of the research findings of the first phase of the current research study. With the results in mind, it is important to revisit the previously mentioned literature to obtain a better understanding of the results. It was decided to structure the integration of the findings according to the Resilience Model of Family Stress, Adjustment and Adaptation (McCubbin & McCubbin., 1996) (see Figure 5.33), which is the theoretical underpinning of the current study and also coincides with the structural layout of Chapter 3.
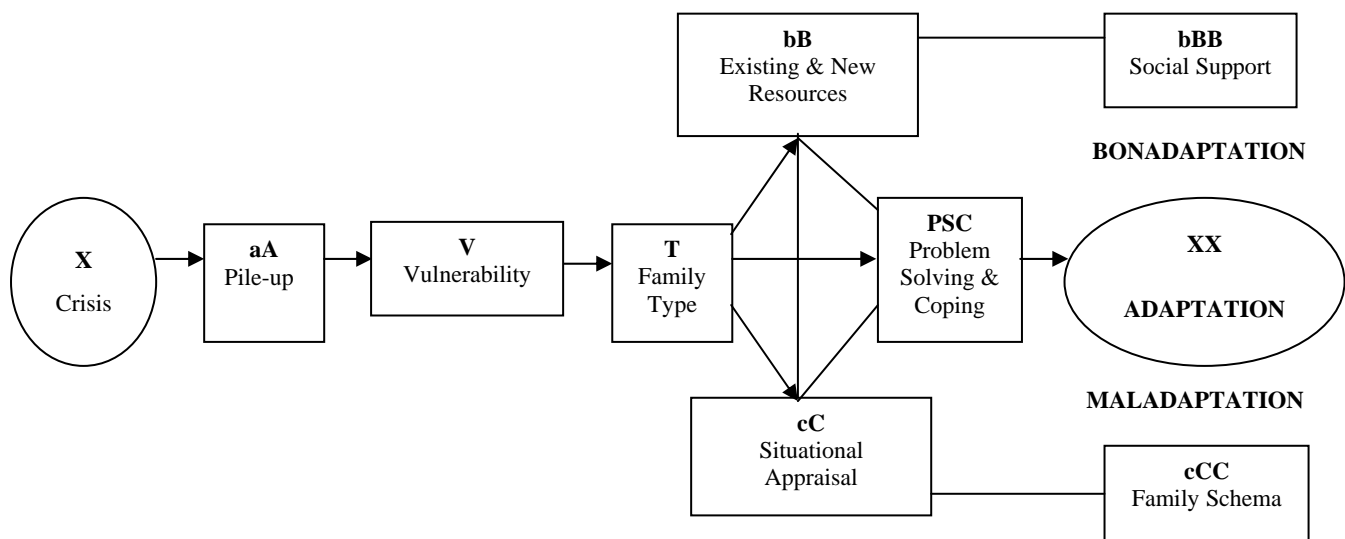
Figure 5.7. The resilience model of family stress, adjustment and adaptation (McCubbin and McCubbin, 1996).

5.4.2.1 Family Resilience: Adaptation Phase

Family Adaptation [xX]

The denominating crisis [X] in the current research population was that these families were all classified as families in which one parent had been living with depression. Psychiatric disorders pose a significant crisis to a family unit (Enns et al., 1999). This specific crisis challenged these families in terms of adapting to a previous state of equilibrium and harmony (McCubbin & McCubbin., 1996). The current study highlighted a significant negative relationship between family adaptation [xX] and the severity of depression as measured by the Beck Depression Inventory-II (Beck et al., 1996). This means that the severity of the depression in the current family setup posed specific challenges to family adaptation in these families.

The following subsections will further elaborate on the resilience factors in the current study that correlated most significantly with family adaptation [xX]. In other words, these resilience factors assisted in the adaptation of the families that took part in this study.

Pile-up [aA] of Demands and Family Vulnerability [V]

The risk factors associated with parental depression are many and contribute to the pile-up [aA] effect and accumulation of stress, which pose significant challenges in terms of family vulnerability [V]. As mentioned in Chapter 3, family vulnerability [V] is determined by the pile-up of demands [aA] and the family's life cycle stages. The biographical findings of the current study provided some useful information regarding the possible contributors to this population's pile-up effect [aA] and family vulnerability [V].

Firstly, the life cycle stages of these families provided functional information regarding the possible accumulation of stressors in the families. The average age of the adult participants was 41 years for the identified patients and 43 years for the spouses. The average age of the children varied from 16 years for the first child to 12 years for the second child and 11 years for the third child. According to Erikson's theory of life span development, the majority of the adult participants were in middle adulthood (Graig, 1996). During this stage, men and women who have resolved earlier conflicts are free to direct their attention more fully to the assistance of others (i.e., their family and children). However, failure to resolve earlier conflicts often leads to preoccupation with oneself, and with one's own health, psychological needs and comfort, and may subsequently result in psychological stressors that may add to the accumulation of stressors (Graig, 1996). Masten and Coatsworth (1998, cited in Mash & Wolfe, 2002) mentions that the same tendency is present in the adolescent children in these families, whose major developmental tasks are the transition into secondary schooling, including academic and extramural achievements, while forming close friendship within and across gender. However, the major task of an adolescent is to form a cohesive sense of self-identity (Graig, 1996). Apart from the fact that the adolescent years are usually challenging and stormy, this phase can be even more detrimental in terms of the family's accumulation of stressors if adolescents do not integrate these life tasks. This could amount to rebellion, conflict and discipline problems within

the family unit. These life cycle tasks become increasingly complex in a family setup that has to deal with a parental psychiatric disorder (Burke, 2003; Johnson, 2000).

Secondly, the pile-up of stressors associated with a major depression disorder (MDD) challenges these families to bring about stability and harmony, as discussed in Chapter 3. According to the results obtained from the identified patients in this study, their average estimated level of depression was within the moderate category. It is well researched that MDD, especially at this level of severity, in a family set-up causes a constant level of strain and burden, which results in adverse circumstances for the amount of pile-up of demands [aA] (Beardslee & Wheelock, 1994; Beardslee et al., 1998). Less affective parenting patterns, family discord, marital difficulties and lower family cohesion are just some of the destructive familial characteristics associated with parental depression. Apart from these familial problems, numerous researchers have found that parental depression is a risk factor for a variety of adjustment difficulties in children, ranging from being predisposed to develop a mood disorder themselves (Noh & Turner, 1987; Peisah et al., 2004) to having adjustment problems (Elgar et al., 2004).

The children of the families that participated in this study were even more at risk for developing a psychiatric disorder due to the fact that the majority (89%) of the identified patients were female (Keller et al., 1986; Manning & Gregoire, 2006). This risk factor is further highlighted in terms of the impact of maternal depression that can occur before the birth of a child (Manning & Gregoire, 2006). However, Keller et al. (1986) mention that children seem to be most vulnerable to the impact of maternal depression from birth to the age of 17 years. The onset of depression for the majority of the participants (identified patients) was between two and more than ten years previously, which allows for the assumption that some of these children were at risk before birth and would be at risk for the majority of their lives. These factors contribute to risk factors associated with the mastering of life-cycle stages, as mentioned in the previous section.

The impact of depression on the marital cohort should not be underestimated in the light of the accumulation of stressors. The majority of the couples were in their first marriage and had been married for an average of 16 years. Whisman (1999) found that marital discord could specifically be related to psychopathology, depression and post-traumatic stress for females, and to dysthymia for men.

Thirdly, the dual income situation is another possible contributor to the accumulation of stress for these families, given the fact that 89% of the sample comprised dual-income households. These families might be experiencing the effects of dual-career situations and this could be another contributor to the pile-up [aA] effect for these families if the situation is not well managed (Burke, 1996; Crossfield, Kinman & Jones, 2005; Haddock, 2002; Rice, 1999). Rice (1999) says that the dual-income situation can become increasingly stressful when it interferes with the quality of home life. It is suggested that this option can be healthy and viable if the family successfully manage the balance between work and family (Haddock, 2002).

The aforementioned section discussed the impact of the following factors, (a) life cycle stages, (b) parental depression and (c) dual income families, as possible contributors to the pileup of demands [aA] and family vulnerability [V] in the current study. The next section integrates the current study's results with previous research regarding family resources [bB] and social support [bBB].

Family Resources [bB] and Social Support [bBB]

As mentioned in Chapter 3, family resources include strengths, capabilities and resources that families utilise to adapt to a stressor. They include different forms and levels of resources, namely on an individual, family and community level. These resources can be arranged in terms of protective, recovery and resilience factors (Hawley & De Haan, 1996; McCubbin et al., 1997; McCubbin & McCubbin, 1988; Rutter, 1999). The following section elaborates on possible protective and resilience factors that were highlighted by the data analysis of this study.

The life cycle stage of the research population appears to be the teenage/young adult stage, as indicated by Olson et al. (1985) and McCubbin and McCubbin (1988). These researchers indicate that social support is a vital protective factor for families in this life cycle stage. They further suggest that these families usually incorporate protective factors of status and income, mutual support from the family and spouse, family cohesiveness and bonding and community support. The current study's qualitative results support the above-mentioned findings (see Table 5.9). It was found that 56% of the families mentioned intra-family support (i.e., supportive family relationships), 36% mentioned spiritual support (i.e., religion), 25% mentioned extended family support (i.e., grandparents) and 8% mentioned community support (i.e., friends) as significant contributors to and protective factors of their family's ability to adapt to their current situation. Another contributing assumption drawn from the biographical findings is that the majority of these families are educated, dual-income families with an annual income of more than R100 000, which might be a protective factor in terms of intellectual and financial resources. This finding is supported by the findings of Greeff and Van der Merwe (2004) and Der Kinderen and Greeff (2003), which highlight the importance of work and financial security, while Gillard (2002) found that parental education was closely related to family resilience. This links to an important factor, namely the availability of and access to job security and medical services via the S.A. National Defence Force. A third of these families acknowledged medical attributes (39%) as a significant resilience factor. Johnson (2000) says that medication, and utilising all family members in the management of the patient, are important resilience factors for families with a member with a serious psychiatric disorder. Thiel (2005) also reiterates the importance of medical support in terms of assisting with family adaptation.

In the current study, personal attributes (see Table 5.9) were mentioned often by the families as a contributing factor in terms of coping. The qualitative findings showed that 39% of the identified patients mentioned their own individual resilience (i.e., life orientation, positive personality traits) as a contributing factor. This is in keeping with the fact that familial resources could also

be on an individual level (Hawley & De Haan, 1996; McCubbin et al., 1997; McCubbin & McCubbin, 1988; Rutter, 1999). The identified patients mentioned that individual resilience centred particularly around individual personality traits, cognitive schemas, characteristics and interpersonal processes (i.e., in the family) (Bandura, 1982; Kobasa, 1982; Strümpfer, 1990; Van Breda, 2001).

Through the quantitative data analysis of this study it became apparent that relative and family support and the family's ability to redefine and ascribe meaning to a situation are two significantly contributing resilience factors for family adaptation. According to the children, family and relative support (RFS) correlated significantly with family adaptation. However, this notion was not supported by the adults' (spouse) results. This significant association was also found in families with a husband with prostate cancer and in divorced family setups (Thiel, 2005; Greeff & Van der Merwe, 2004). Seeking social support, as a coping style (F-COPES subscale SOC), was identified by both the adults and the children as being significantly associated with family adaptation. However, this was not supported by their utilisation or experience of social support (SSI), as these did not exhibit a significant correlation with family adaptation. The importance of social and familial support is well supported by numerous previous studies in different family setups (Greeff & Van der Merwe, 2004; Thiel, 2005; Van der Walt, 2006).

Seeking spiritual support (F-COPES subscale SPIR) was a significant indicator of family adaptation, as shown by the children's results (see Table 5.4). This coincides with the qualitative findings, in which 36% of the participants mentioned spiritual support (i.e., religion, support from church community) as an important resilience factor. A host of other researchers have reported similar findings, as discussed in Chapter 3 (Enns et al., 1999; Johnson, 2000; Leung, Chen, Lue & Hsu, 2007; Noh & Turner, 1987; Solomon & Draine, 1995; Tebes et al., 2001). These studies were done mainly in family systems where a parental psychiatric disorder was present.

Appraisal Process [C-cCCC]

Family coherence [cCCC] describes the strengths families draw on during trying times. It forms part of the appraisal process and could also be referred to as family hardiness (McCubbin et al., 1997). A significantly positive correlation between family adaptation and the family's ability to be innovative and proactive in terms of new experiences (Challenge subscale, FHI) was found, according to the data of both the adults (spouse) and the children. The spouses also positioned the family's sense of internal strengths, dependability and ability to work together (Commitment subscale, FHI) and the family's sense of being in control (Control subscale, FHI) as important resilience factors. These findings were also supported by the qualitative findings, where values (i.e., code of conduct, existential view) were mentioned by 56% of the identified patients as important resilience factors. The participants mentioned 'standing together' in difficult times, accepting each other, and family members asking for help as some of the strengths they could draw from. This could be seen as part of the appraisal process.

However, on the basic stressor [C] and situational appraisal [cC] levels, the opposite seems to be true for these families. Passive appraisal of and accepting the problem (F-COPES subscale PA) were indicated by both the adults (spouse) and the children in this study as a coping style to assist with family adaptation. This finding is in keeping with those of other studies, especially in family setups where an illness is present. For example, Geldhof (2004) found that passive appraisal of the crisis situation assisted families who had to deal with cancer, while Greeff et al. (2005) described the same trend in families with a member with a psychiatric disorder. It appears that the acceptance or passive appraisal of the initial problem might be important as an initial building block of the adaptation process. Seeing it together with the importance of family hardiness, the families might then, at a later stage, draw from more proactive appraisal processes (i.e., innovative; internal strength) to assist them with family adaptation.

Patterns of Functioning [tT]

McCubbin et al. (1997) point out that patterns of functioning in the adaptation phase centre around family time and routines, which foster rhythm and enhances balance and harmony.

The important connection between family adaptation and patterns of functioning [tT] was emphasised by the results obtained with the Family Time and Routine Index (FTRI) (McCubbin et al., 1996) in this study. It is further supported by the qualitative results (see Table 5.9), which show that 28% of the participants mentioned the importance of family time and routines (i.e., meals together) as a resilience factor. For both the adults (spouses) and the children, family time and routines (FTRI total score) was correlated significantly with family adaptation. Similar results were obtained for couple togetherness, parent-child togetherness and family time together (see Table 5.9). Relative's connections, parent chores routines, and the family's management of routines were also significantly correlated with family adaptation, but only according to the adults' responses. The regression analysis indicated that family time and routine was a significant contributor to the prediction of family adaptation for the adult population (see Table 5.4).

The importance of family organisational patterns as well as time and routines is supported by numerous researchers, as mentioned in Chapter 3 (Geldhof, 2004; Thiel, 2005; Walsh, 2002, 2003a, 2003b).

Problem Solving and Communication [PSC]

Problem solving and communication has been identified as an imperative resilience factor associated with family adaptation. It is supported by numerous previous studies in various family setups (Greeff & van der Merwe, 2004; Smith, 2006; Van der Walt, 2006). In the studies by Jonker (2008) and Geldhof (2004), this trend seems to be repeated in family settings where psychiatric disorders are present.

This study's findings strongly support the above-mentioned findings. Both the quantitative (see Table 5.4) and qualitative (see Table 5.9) data analyses revealed that family problem solving and communication are strongly related to family adaptation. The relationship is confirmed by the qualitative data of both the adults (spouse) and the children, as well as by the identified patients' qualitative data. Family adaptation further correlated positively with affirming communication patterns and negatively with incendiary communication patterns, according to both the adults and the children. This trend was further connoted by the qualitative finding that 56% of the participants indicated that family communication and problem solving (i.e., open, honest communication) served as an important resilience factor in their family.

The significant correlation between family adaptation and family problem solving and communication was further highlighted by the regression analysis. The analysis indicated that this variable was a statistically significant contributor to the prediction of family adaptation for the adult population (see Table 5.5). This strong correlation set the scene for the decision to compile an intervention programme aimed at enhancing family resilience for this study population. Due to the strong evidence found in this study for the importance of communication in family adaptation, it was decided to develop a family communication workshop in the intervention phase of this research.

5.5   Conclusion

This chapter dealt with the qualitative and quantitative data analyses in relation to the aim of the description phase of the research. The results were discussed, integrated and, where possible, linked to previous studies and literature cited in earlier chapters. Various interesting, important and study-specific correlations were found between the independent variables and the dependent variable, family adaptation. However, the most significant correlation was between family problem solving and communication and family adaptation. According to the statistical findings (correlation and regression analyses), family problem solving and communication is a very significant predictor of family resilience for the current population. Because of this finding it was

decided to develop an intervention programme - a Family Communication Workshop - aimed at enhancing family problem solving and communication in order to enhance family resilience.

The following chapter describes the second phase of this study, namely the intervention phase, which encapsulates the theoretical framework and the development, implementation and evaluation of the intervention programme.

CHAPTER 6

INTERVENTION PHASE: THEORETICAL FRAMEWORK, AND INTERVENTION PROGRAMME DEVELOPMENT, IMPLEMENTATION AND EVALUATION

6.1 Introduction

The purpose of this chapter is to review and integrate family resilience interventions, psycho-education and adult-education, which allowed for the practical development of a family resilience intervention programme. It consists of two main components, namely to motivate the rationale behind the chosen theoretical framework for the development of the current intervention programme, and to guide the reader through the practical steps regarding the development, implementation and evaluation of the programme.

6.2 Primary Aims of the Research

The first research question of the descriptive phase, namely 'Which qualities of resilience are present in families with a parent living with depression?', was answered in previous chapters. Family problem solving and communication was found to be a significant predictor of family resilience. The secondary research question and objective address the Intervention Phase of the research, as set out below.

6.2.1 Secondary Research Question

1. What should an intervention programme entail that had been designed to enhance a certain identified quality of resilience in families in which a parent has been living with depression?

6.2.2 Secondary Research Objective

1. The secondary objective was to develop a family intervention programme for parents to strengthen and enhance a certain identified quality of resilience in families in which a parent has been living with depression.

This research question guided the development of a Family Communication Workshop in order to address the enhancement of a quality (family problem solving and communication) of family resilience. This workshop will be referred to as the intervention programme.

6.3 Theoretical Framework Guiding the Programme Development

The theoretical framework for the development of the family resilience intervention programme merged three interwoven theoretical domains, i.e. family resilience, psycho-education and adult education. The rationale behind the merging of different theoretical domains was supported by the notion that a solitary theory might limit the effectiveness of programme development (Reeves & Bednar, 1995; Wood, Brendtro, Fecser & Nichols, 1999).

6.3.1 Family Resilience

This section will shed light on the potential of intervention programmes in the family resilience paradigm, which provided the main philosophical framework for the development of the current programme. This paradigm was specifically set in place to direct clinical practice and intervention (Walsh, 1996, 1998, 2002). Walsh (2002) identified the family resilience framework as an important theoretical layout for practical interventions (i.e., programme development). This theory takes cognisance of the potential of individuals and families to transform and develop through adversity, hardship and stressors. Walsh (1996) says that the family resilience framework is established in family systems theory and directed by a bio-psychosocial system orientation, with focuses on the developmental pathways of families. Thus, problems and solutions are viewed in the light of various influences involving individual, family and societal patterns. Finding solutions to problems involves adaptation over time, from ongoing interactions between family life cycles to multigenerational developments. Building family resilience entails an ongoing constructive stance of family difficulties and responses over time, rather than a once-off cross-sectional view at a given time (Walsh, 1998).

Family resilience interventions aim to foster family resources in order to deal more effectively with stress and to rebound from adversity (Walsh, 1998). They provide a positive and pragmatic frame that guides interventions (Walsh, 1996). Various authors have identified key processes of this framework, which guide assessment and intervention in the family resilience framework.

Walsh (1996) published extensively on this topic. She states that each family has the potential to be resilient and that there are many pathways to resilience. Clinicians should focus on a gentle awareness of life challenges and search to identify unrecognised resilience factors. This approach offers a positive and pragmatic intervention framework.

Walsh (2002) argues that resilience-based therapeutic interventions should be future directed and proactive. Thus, interventions should focus on coping and adaptation in the face of adversity by activating a collaborative approach to reduce vulnerability and master family challenges. Sharing stories assists to foster a climate of mutual support and empathy (Walsh, 2002, 2003a, 2003b). Normalising family distress, identifying, affirming and building family strengths, and adopting a positive future-orientated focus have been mentioned as important guidelines for clinical practice (Walsh, 1998).

Walsh (1998, 2002) offered a summary of practical guiding principals for intervention. She formulated it in terms of the following three key resilience categories: family belief systems (making meaning of adversity, positive outlook, transcendence and spirituality), organisational patterns (flexibility, connectedness, mutual support, social and economic resources) and communication processes (clarity, open emotional expression and collaborative problem solving) (discussed in Chapter 2).

Walsh (2003a) says that this approach engages families with respect and compassion, while assisting them in discovering new possibilities to their stagnated problems. It affirms their reparative potential, and discovers and highlights their strengths. Family resilience interventions focus on improving family and individual functioning. Silberberg (2001) confirmed this by

suggesting that therapists should facilitate a process for families to identify their own strengths, and by focusing on families' strengths and normalising processes instead of labelling them. Other authors who recognised these thought patterns were Hawley (2000) and Hawley and DeHaan (1996), who suggest that interventions should (a) focus on strengths, (b) recognise resilience as a developmental pathway (Hawley, 2000, Hawley & DeHaan, 1996), (c) search for key coping processes in families (Hawley, 2000), (d) assist families in identifying and developing useful family schemas (belief systems) (Hawley, 2000), and (e) positively reframe difficulties (Hawley & DeHaan, 1996).

Rutter also identified several key processes, namely (a) aiming to decrease risk factors and analyse the interaction of risk factors (Rutter, 1987, 1999), (b) reducing negative chain reactions (Rutter, 1987, 1999), (c) strengthening protective family processes and reducing vulnerabilities (Rutter, 1987), (d) boosting self esteem through successful problem solving (Rutter, 1987), (e) focussing on social interaction inside and outside the family (Rutter, 1999) and (f) focussing on the individuals' processes regarding their life and familial experiences (Rutter, 1999).

Patterson (2002) suggests that a resilience approach to family interventions assists with the adaptation process. This researcher highlighted the importance of believing in families' inherent abilities to heal themselves and recognising their successes.

Rolland (2003) conceptualised a psycho-educational preventative model within the resilience framework. He recommended the acknowledgment of loss and focussing on sustaining hope. It is important to build on flexibility and the rituals of celebration and inclusion.

Marsh (1996) initiated competency-based models as part of a resilience intervention model that focuses on the acknowledgment of the resilience and positive qualities of families. It is also suggested that professionals should join forces when working with families. Interventions should be informative and acknowledge and address the needs of individuals and families.

Robinson (2000) suggests that a resilience-based framework should focus on the realistic and positive appraisal of situations, effective problem solving, flexible gender roles and a sense of direction within an empathic environment. Principles such as self-determination, freedom of choice, effective communication and integrated spirituality were also mentioned as important intervention focuses.

The suggestions of the above-mentioned authors regarding interventions within the family resilience paradigm are presented in Table 6.1. Walsh's (1998, 2002) three key processes, which are supported and have been elaborated on by many other authors, were used as the framework.

Table 6.1

Intervention Framework According to the Family Resilience Paradigm

Family Belief System	Organisational Patterns	Communication Processes
Making meaning of adversity (Walsh, 1998, 2002)	Flexibility (Robinson, 2000; Rolland, 2003; Walsh, 1998, 2002) and rituals (Rolland, 2003)	Clarity (Walsh, 1998, 2002)
Positive, pragmatic and realistic outlook (Marsh, 1996; Robinson, 2000; Walsh, 1996, 1998, 2002) and sustaining hope (Rolland, 2003), normalising and positive reframing of difficulties (Hawley & DeHaan, 1996; Silberberg, 2001; Walsh, 1998)	Connectedness (Walsh, 1998, 2002)	Open emotional expression (Walsh, 1998, 2002) and effective communication (Robinson, 2000)
Proactive stance (Walsh, 2002)		

<div align="right">(table continues)</div>

Table 6.1 (continued)

Intervention Framework According to the Family Resilience Paradigm

Family Belief System	Organisational Patterns	Communication Processes
Search for unrecognised resilience factors (Hawley, 2000; Marsh, 1996; Patterson, 2002; Walsh, 1996, 2003), strengths (Hawley, 2000; Silberberg, 2001; Walsh, 1998, 2003a) and protective family processes (Rutter, 1987)	Mutual support (Walsh, 1998, 2002, 2003a), respect, compassion and empathy (Robinson, 2000; Walsh, 2003a)	Collaborative problem solving (Marsh, 1996; Walsh, 1998, 2002) Effective problem solving (Robinson, 2000). Boost self-esteem through successful problem solving (Rutter, 1987)
Transcendence and spirituality (Robinson, 2000; Walsh, 1998, 2002)	Activate and analyse social and economic resources (Rutter, 1999; Walsh, 1998, 2002) Reduce risk factors and negative chain reactions (Rutter, 1987, 1999)	Sharing stories (Walsh, 2002, 2003a)

Table 6.1 gives a clear framework of current patterns in the development of intervention programmes in the family resilience paradigm. Walsh's (1998, 2002) theoretical underpinning of communication processes in families will be utilised as the main guiding principal for the development of the intervention programme.

Resilience-based family intervention lends itself to a variety of formats and techniques (Robinson, 2000; Tebes et al., 2001). The couple is seen as the centre of the family unit and an effective focus point of intervention (Robinson, 2000). Psycho-education familial group modalities are particularly well suited to enhance family resilience (Rolland, 2003; Walsh, 1996, 2002). Psycho-education is described as evidence-based practice that combines different intervention strategies, like the family resilience paradigm (Brendtro & Long, 2005), and includes psychological assessment and programme development (Wood et al., 1999). During the development phase of the current programme, it was decided to add the psycho-education

modality as the second theoretical leg in combination with family resilience. The following section will elaborate on this decision.

6.3.2 Psycho-educational Model

Psycho-education is described as the methodology of psychological intervention regarding the prevention and recovery of psychological problems. It focuses on the development and training of human potential, which includes coping with, accepting and/or preventing illness (Authier, 1977; Colom & Lam, 2005; Schoeman, 1983; Swanson, Dibble & Chapman, 1999). As a result, the process of the training, prevention and development of human potential forms a vital component of psycho-education (Schoeman, 1983). It includes the training of individual and group skills and competencies by methods of direct training, consultation and psycho-technology to enable people to live a more meaningful and goal-directed life (Schoeman, 1983). Psycho-education's theoretical perspective can be described as integrated, holistic, multicultural, functional, systemic, comprehensive and functional, which allows for diverse forms of applicability (Wood et al., 1999). It combines multiple strategies of intervention and is described as a well-planned blending of methods for meeting the needs of individuals or groups (Brendtro & Long, 2005).

Fouche (1995) suggests that psycho-education is embedded in three core elements, namely (a) the therapist is viewed as a teacher rather than a specialist, (b) the client's problems are viewed as skills/competency deficiencies rather than pathology, and (c) the clients are seen as resilient and capable of guiding their own learning processes rather than passively receiving treatment. Other authors also support the latter by mentioning that the effectiveness of psycho-educational programmes is embedded in the idea of increasing individual and family resilience to stressors (Hayes & Grantt, 1992; Landsverk & Kane, 1998). In practice it means that psycho-education focuses on a recurring framework based on prevention rather than cure, which develops human potential instead of removing psychopathology (Fouche, 1995).

The aims (prevention, development and training) of psycho-educational programmes should be accomplished to warrant successful and effective implementation (Fouche, 1995). Three forms of prevention have been identified, namely primary, secondary and tertiary. Thus, psycho-education aims at skills training to enable individuals to either prevent the development of a psychiatric disorder, to reduce the suffering, or to reduce the effects of the problem. The current programme will focus on secondary prevention, which entails the identification and treatment of existing problems at the earliest possible moment and reduce the duration and severity of suffering. The second aim, development, sets out to facilitate human development and psychological competencies, which will also be addressed in the present intervention programme. The last aim, training, education and consultation, includes the training of clients by means of psycho-technology (technologically-based psychological training, e.g., training manuals, audio and video models, workshops, etc.). The current programme's training will be facilitated by a one-day workshop. Psycho-educators seek to establish collaborative partnerships with families so that the family members feel empathised with, supported and empowered to deal with life's challenges (Nichols & Schwartz, 1991). The facilitators look at the family's strengths, rather than at their deficits, which concurs with the family resilience view.

Wood et al. (1999) highlighted that the successful application of the psycho-educational approach depends on the professional's ability to merge different theoretical frameworks by translating inter-theoretical connectedness into multiple intervention practices. This idea of Wood et al. (1999) would then support the merging of adult education with psycho-education in the family resilience paradigm. The inter-theoretical merging was supported by the need for a specific framework in order to develop and design the current programme. Adult education provides a rich, colourful and well-researched instrument for this requirement. Most research on programme development has been conducted in the field of adult education (Caffarella, 2002; Houle, 1996; Knowles, 1984; Sork, 2000; Tyler, 1949). Caffarella's (2002) interactive model,

particularly, impresses with its applicability for programme development in the psychological field due to its versatility, which will be discussed in the following section.

6.3.3 Adult Education

Caffarella's model highlights the link between adult education and psycho-education, which is also reflected in words, as well as the link between psychology and education (Wood et al., 1999). Adults display a particular mode of learning or education, whether on a practical or a psychological level.

Knowles (1984) identified key assumptions about adult learning. The author suggests that adults are motivated to learn if they experience needs and interests that learning will address. These are important starting points for adult education. Life situations and experience (i.e., experiential learning) seem to be the richest resources for adults to learn from. It is important to focus on the analysis of the experience. Adults have a need to be self-directing, therefore the role of the facilitator is to engage in dialogue of mutual inquiry. Merriam and Caffarella (1999) added to this by stating that adult learning does not occur in a vacuum, which means that societal and cultural influences cannot be underestimated.

Sork and Caffarella (1989) suggested six steps for the systematic planning of effective educational programmes for adults. These steps are all interwoven and form part of an interrelated process, which also highlights the link between adult and psycho-education. Loops in the sequencing of the process will occur in practice, which will allow the researcher to work on several tasks simultaneously. The steps comprise: (1) analysing and planning context and client system, (2) assessing needs, (3) developing programme objectives, (4) formulating an instructional plan, (5) formulating an administrative plan and (6) designing programme evaluation. However, Caffarella (2002) recently expanded these six steps and formulated the interactive model of programme planning (12 components), which provides detailed guidelines for programme development. This model will further guide the current programme's

development and will be incorporated in the following section on programme development. The steps encompass: (1) discerning the context, (2) building a solid base of support, (3) identifying programme ideas, (4) sorting and prioritising programme ideas, (5) developing programme objectives, (6) designing the instructional programme, (7) devising transfer-of-learning plans, (8) formulating evaluation plans, (9) making recommendations and communicating results, (10) selecting formats, schedules and staff needs, (11) preparing budgets and marketing plans, and (12) coordinating facilities and on-site events. The practical aspects of these steps will be discussed later in this chapter to indicate how they guided the current programme development and implementation.

Caffarella's (2002) model is embedded in seven major ideas, which form an important guideline for the practical understanding of programme development that is discussed in the following section:

1. The focus is on learning and how this learning results in change.

2. Recognition of the non-sequential nature of programme planning.

3. Discernment of the magnitude of context and negotiation.

4. Attendance to preplanning and last-minute changes.

5. Heeding and honouring diversity and cultural differences.

6. Acceptance of different ways of working when programmes are planned.

7. Understanding that programme planners are learners too; reflection and evaluation will strengthen individual abilities.

The above-mentioned main theoretical underpinnings (i.e., family resilience, psycho-education and adult education) provided the programme developer with a clear framework with which the programme development, implementation and evaluation should comply.

6.4 Development, Implementation and Evaluation of a Family Resilience Programme

It was the aim of this study to develop a family resilience intervention programme for adults that would impact positively on the families' adaptation to their current situation (i.e., having a parent who has been living with depression).

The researcher wanted to ensure that the workshop was well planned, provided participants with the necessary information and learning experience at an appropriate level with valuable learning objectives, and had an effective evaluation strategy. Munson (1989) suggests that a sound and proven adult learning and programme planning processes should be utilised in order to achieve these goals.

After reviewing and analysing the literature it was decided to utilise Caffarella's 12-step interactive model of programme planning as the main guide for the development and implementation of the workshop (Caffarella, 2002) (see Figure 6.1).
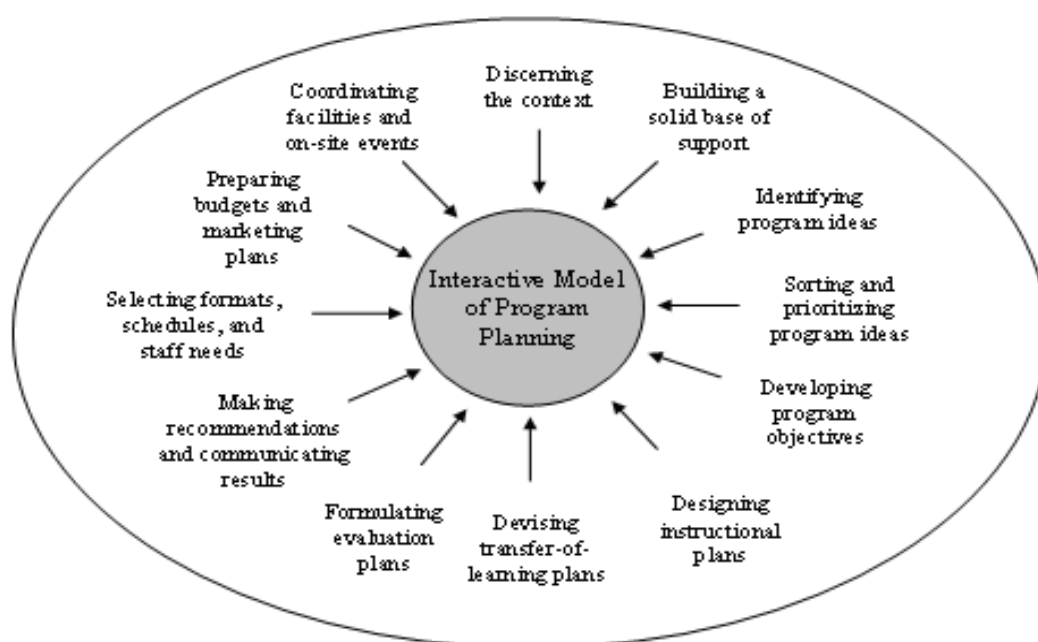

Figure 6.1. Interactive model of programme planning (12 components) (Caffarella, 2002).

The following section utilises the interactive model's (12 components) programme planning and implementation steps as a framework for the development of the current intervention programme (Caffarella, 2002).

6.4.1. Discerning the Context

This step focuses on analysing the internal and external factors related to the client system. The internal factors concern the organisational dynamics in which the client system finds itself (i.e., mission, resources and procedures of the organisation) (Sork & Caffarella, 1989). External factors encompass the organisation's relationships with the external world and the impact thereof (Sork & Caffarella, 1989).

This suggests an analysis of the present situation in South Africa and specifically in the SANDF. The current client system finds itself primarily as part of the South African National Defence Force (SANDF). There are specific organisational dynamics, which were discussed in Chapter 3. The researcher was familiar with the specific target group and context (Caffarella, 2002), as she had been employed by the SANDF for the preceding four years as a Clinical Psychologist in the Department of Psychology. This department works closely with the Department of Psychiatry. These two departments were involved in identifying families who met the criteria for the current study. This also assisted with the second component of the model in terms of building support (Caffarella, 2002) with the key groups and stakeholders (i.e., heads of departments) of the SANDF in order to support the research as well as the implementation of the workshops.

It is clear that no single programme could address the complexities of these families. The current intervention programme is therefore part of a process and should not be regarded as complete.

6.4.2. Building a Solid Base of Support

This step involves networking with key groups and stakeholders (Caffarella, 2002). As mentioned in the previous step, the first base of support was the psychology and psychiatry departments. The research proposal also had to be accepted by the Officer Commanding of the hospital. The support of all above-mentioned parties was gained and the proposal was then submitted for acceptance to the SANDF's security intelligence and ethics committee. Both these

research bodies accepted the proposal and allowed for the implementation thereof. The University of Stellenbosch also accepted the proposal.

6.4.3. Identifying Programme Ideas

The needs assessment was guided by national and international literature surveys (Cilliers, 1993). Needs assessment involves the identification and establishment of the inequalities between the present and the desired capabilities and knowledge of the client system. It further focuses on finding solutions to or means of altering the situation of the client. Assessing the needs is based on data acquired by different means of measuring the levels of capability (i.e., observations, questionnaires, self-assessment instrument, record review). If more needs are identified than can be dealt with, needs prioritising should follow (Sork & Caffarella, 1989).

In the present study, the needs assessment was conducted by analysing the data in Phase 1 of the research (Chapter 5). The assessment was done via the completion of the questionnaires mentioned in Chapter 5. The specific focus of the workshop was determined by the findings. As previously discussed, the FACI8 questionnaire was used to measure the dependent variable (family adaptation), and the other questionnaires were correlated. It was found that both family hardiness (FHI) and family problem solving and communication (FPSC) had a significant positive correlation with family adaptation. Needs prioritising took place (Caffarella, 2002; Sork & Caffarella, 1989) and it was decided to develop a Family Communication Workshop. This decision was further endorsed by the notion that this concept seemed to be prevalent in this population, an aspect that will be discussed in the next step under the review of previous programmes.

6.4.4. Sorting and Prioritising Programme Ideas

The broad idea of family problem solving and communication was identified in section 6.4.3 Sorting and prioritising of programme ideas allowed for the fine-tuning of ideas with the intention to develop a specific programme aim and objectives in the following step.

Several theoretical underpinnings guided the sorting and prioritising of the programme ideas, which was started with a literature review of related programmes. The literature review, which looked at psycho-educational programmes for families in which one parent has been living with a psychiatric disorder, revealed two basic trends. Firstly, most research focussed on intervention programmes to prevent the development of a psychiatric disorder in the children of families in which a parental psychiatric disorder exists (Beardslee & MacMillan, 1993; Beardslee, Salt, Versage, Gladstone, Wright and Rothberg., 1997a; Beardslee et al., 1997b). The second trend aimed to assist families in adjusting and coping with a psychiatric disorder in the family (Dowrick et al., 2000; Klausner et al., 1998; Mullen & Murray, 2000). This literature trends, relates to family resilience, and provided valuable guidance in terms of future direction, and also steered the current study. The next section summarises related previous programmes.

Beardslee and MacMillan (1993) discussed the rationale for preventative interventions and suggested an intervention for families in which a parent had a mood disorder. The intervention utilised clinical methods in an attempt to prevent the development of mood disorders. This notion was crystallised in two later articles by Beardslee et al. (1997a) and Beardslee et al. (1997b), in which they discussed two psycho-educational programmes.

The above-mentioned researchers assigned 37 families with a child between the ages of 8 and 15 who had at least one parent with a recent depressive episode to one of two psycho-educational interventions. These interventions were designed mainly to prevent childhood depression by decreasing the impact of related risk factors and encouraging resilience-promoting factors. The interventions were either facilitated clinically or presented in a lecturing style.

The clinically facilitated intervention consisted of six to ten psycho-educational sessions, which focused on the direct integration of information to relevant personal life experience. The core elements of the interventions were the establishment of a therapeutic relationship, increased familial understanding of the parent's disorder, the child's risks and resilience, clinical

evaluation of the child's strengths and weaknesses, validation of the child's experience, emphasis on unique experiences of each family, and the provision of long-term clinical availability to enforce early intervention, if needed.

The lecture-based intervention consisted of two one-hour presentations, presented over two consecutive weeks. It focussed on the discussion of information, but no integration took place. Information about affective disorders (depression) and the potential impact of affective disorders on children were included in the first lecture. The second session aimed at increasing the parents' understanding of their family's experience, or of the affective disorder. It further focussed on the recognition of early warning signs of depression, being aware of children's strengths, and on increased knowledge about children's protective factors.

The four areas of family functioning and parenting that were hypothesised to be affected by these interventions were: (a) changes in attention to/focus on the children, (b) family problem solving, (c) communication, and (d) spousal perceptions.

The parent participants in both groups reported being satisfied with the intervention. However, the participants in the clinically facilitated group reported a significantly larger number of overall changes, change in terms of communication regarding the illness with their children, as well as better understanding by the children in comparison to the lecture-based intervention. These findings suggest that interactive, workshop-style interventions have better outcomes than one-way teaching-style workshops. Other authors support this notion. For instance, Birkets (2000) mentions that the family's ability to expand and communicate affect and feelings encourages relational resilience. Beardslee, Wright, Rothberg, Salt and Versage (1996) mention the importance of linking cognitive information to a family's life experience for long-term changes. This suggests that the efficacy of a programme might be heightened when the intervention focuses on interactive participation and the personal integration of information.

Mullen and Murray's (2000) paper presents a multi-family psycho-education programme for the families of clients with a recently diagnosed psychiatric disorder. The programme consists of four two-hour sessions. Definitions, causes, risk factors and treatments of psychiatric disorders, as well as looking at the role of stress and preventative strategies, were covered in these sessions. The programme evaluation indicated that the programme tended to improve the families' overall knowledge.

The objective of Dowrick et al.'s (2000) study was to evaluate two psychological interventions for depressed adults. The evaluation took place between (a) an individual problem-solving treatment, (b) a group psycho-education session and (c) a control group. The six individual problem-solving treatment sessions (n = 128) comprised three steps, namely linking the patients' symptoms with their problems, defining and clarifying the problems and attempting to solve them in a structured way. The eight group psycho-education sessions (n = 108) focused on the prevention of depression. These sessions focused on instruction, not on therapy, and promoted relaxation, positive thinking, pleasant activities and social skills. They found that both these interventions reduced the severity and duration of depressive disorders and improved subjective mental and social functioning. However, the individual problem-solving treatment was found by the participants to be a more acceptable way of dealing with their problems.

Research to date indicates that psycho-education is highly recommended as part of the treatment plan for bipolar affective disorder. Rouget and Aubry (2007) evaluated the impact of psycho-education on the treatment of bipolar affective disorder. Specific therapeutic targets were given to evaluate the effectiveness of psycho-education, such as treatment compliance, patients' and families' knowledge of the illness and treatment, relapse prevention, symptomatic phases of the illness, or social and occupational functioning. The results suggested that psycho-education alone or in conjunction with other treatment options makes it possible to improve the course of illness, increase familial awareness, decrease the risk of relapses and improve treatment compliance.

The psycho-education programme of Michalak, Yatham, Wan and Lam (2005, cited in Griffiths, 2006) also focused on bipolar affective disorder. The programme had five aims, namely identifying signs and symptoms of bipolar disorder, establishing the impact on different levels (i.e., cognitive, emotional, social, etc.) of bipolar disorder, acquiring knowledge of treatment modalities and side effects, providing guidelines for treatment effectiveness and safety and providing cognitive strategies for coping. It was found that the programme significantly improved the quality of life of the participants in terms of psychical functioning and general life satisfaction.

Klausner et al. (1998) implemented a successful psycho-educational intervention programme for depressed patients, who experienced a reduction in symptoms after attending the programme. It was based on a goal-focused model of hope, which focused on goal formulation, education and skills training (i.e., anxiety management, cognitive restructuring, behavioural assignment and utilisation of past success to guide achievement). Schwartz (2002) suggests that a priority of these types of programmes should be to augment family communication and to engage in problem solving with their children.

MacFarlane (2002, cited in McDonell & Dyck, 2004) compiled a two-year intervention programme with four phases for the treatment of severe psychiatric disorders. These phases were (a) an initial meeting with each patient and family, (b) a one-day psycho-educational workshop for the families without the patient (i.e., information regarding psychiatric disorders, relapse warning signs and information regarding medications), (c) relapse prevention (i.e., family guidelines) and (d) skills building (i.e., problem solving). Bi-monthly 90-minute meetings were conducted during the first year and monthly meetings during the second year. Education began structurally with the one-day psycho-educational workshop and thereafter informally with the problem-solving phases. This model seems to be successful, as it has been modified for use as a treatment option for diverse groups of psychiatric disorders.

Family programmes are well known to be most effective in the long term for creating ongoing change in family dynamics and environment (Hawkins, Catalano & Miller, 1992; Kumpher, 1996 in Kumpher & Alvarado, 1998). The long-term impact of these programmes can further be enhanced by encouraging families to hold weekly family meetings. An ongoing parental support group is another suggestion for addressing the need in terms of programme continuation.

Considering the literature review important trends stood out with regard to programme development for families with a member with a psychiatric disorder. Firstly, it is clear that the psycho-education group modality appears to be a very useful framework for programme development, which also links with and supports the decision to use psycho- and adult education as theoretical modalities for the current programme development (Beardslee et al., 1997a; Beardslee et al., 1997b; Dowrick et al., 2000; Klausner et al., 1998; Rouget & Aubry 2007). Secondly, the needs assessment (Phase 1) of this study corresponds with the information in the literature in terms of the importance of augmenting family communication (focus on open affective communication) (Birkets, 2000; Schwartz, 2000) and problem solving in these families (Dowrick et al., 2000; Schwartz, 2002). Thirdly, the integration of personal experience (i.e., discussion and integration of personal life situations) through experiential learning, which is an adult educational concept, appears to be equally important (Beardslee et al., 1996).

The following two considerations also steered the current programme's prioritising of ideas: (a) Walsh's (2003) theory on and key processes of family communication and (b) the Problem Solving Communication Questionnaire (FPSC), which was used to identify the focus of the current programme. Walsh's (2003) key processes of optimal family communication, namely clarity, open emotional expression and collaborative problem solving, were utilised as the core information given to the participants, and experiential exercises that consolidated these concepts were implemented. The FPSC was the main quantitative evaluative questionnaire for the pre-test, post-test as well as the three-month follow-up post-test. Therefore, concepts/styles of affirming and incendiary communication, which are assessed by the FSPC, had to be addressed directly or

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indirectly via the programme. Walsh's work on effective communication also supported and addressed the communication styles assessed (specific questions) by the FPSC. Based on all these considerations, the following objectives (and aims) for the one-day Family Communication Workshop were compiled.

6.4.5. Developing Programme Objectives

Objectives should be established at the beginning of the programme planning so that it can facilitate all programme content and methods of presentation (Simerly, 1990). Simerly (1990) suggests that a guideline for the establishment of objectives should contain an inspirational quality fostered in professional expertise. This will allow for each session to be evaluated against these objectives.

In keeping with the principles of family resilience, psycho-education and adult education, as discussed in the previous steps, the following programme aim and objectives were specified.

6.4.5.1 Aim of the Family Communication Workshop

The One-day Family Communication Workshop has a two-fold aim. Firstly, it aims to raise awareness of and increase insight and knowledge regarding communication in families where one parent has been living with depression, and the second part of the aim is to focus on experiential learning exercises for effective familial communication that could be implemented by and integrated into the family system. This will result in improved communication and the fostering of growth in terms of family resilience. The Aim and Objectives of each Session of the Family Communication Workshop are also presented in Addendum G.

Session 1: Introduction

Aim of the Session

The first session aims to brief the participants regarding the workshop, to evaluate their family communication, to introduce participants to each other and to establish workshop rules.

Objectives of the Session

1. Briefing participants and introducing participants to the one-day workshop on family communication.

2. Allowing participants to complete the evaluation questionnaires for research purposes.

3. Providing a brief introduction regarding family resilience and communication.

4. Introducing the themes of group work and the group communication process.

5. Facilitating a process in which participants decide on group rules. These will allow for a safe workshop space with an atmosphere of warmth, acceptance, humour and enjoyment, which is essential for learning, participation, extension and the exploration of personal and family growth.

6. Facilitating an 'icebreaker' exercise to introduce participants to each other, setting them at ease in the new situation, and allowing for active involvement in all sessions of the workshop.

7. Introducing the function of the participant's workbook, as it will be used by the participants throughout the workshop and thereafter.

Session 2: Communication

Aim of the Session

The aim of the second session is to deconstruct the concept of communication and to use it as a tool to analyse and discuss an example of family communication.

Objectives of the Session

1. Introducing communication building blocks by way of an experiential learning activity and group discussion, in order to raise awareness of and increase insight into the types and components of communication.

2. Introducing participants to an example of family communication, namely a video clip from the film *Little Miss Sunshine*, in order to stimulate a group discussion regarding family communication.

Session 3: A Climate for Positive Family Communication

Aim of the Session

The aim of the third session is to introduce and raise awareness and insight regarding the concept of a 'positive family communication climate' that will enhance clear, direct and open communication.

Objectives of the Session

1. Providing a brief overview of the subject of creating 'a climate for positive family communication' and to introduce the basic aspects of the concept to participants.

2. Discussing and introducing the rules to create a positive family communication climate and creating an awareness regarding the general guidelines for effective communication in the family.

3. Increasing the implementation and integration of these positive communication rules and positive responses in the family by means of a group discussion.

Session 4: Effective Communication

Aim of the Session

The aim of the fourth session is to introduce and raise awareness of and insight into 'effective communication' within the family setup, as well as to practise several active listening techniques to enhance open emotional expression.

Objectives of the Session

1. Providing a brief overview of the topic of 'effective communication' in the family and to introduce the basic communication concepts to the participants.

2. Introducing an experiential learning exercise on sharing a wide range of feelings in order to increase the identification of emotions by using 'I feel' statements, which will assist participants in taking responsibility for own feelings and behaviour.

3. Discussing and introducing active listening in the family so as to create awareness and insight regarding this concept.

4. Identifying and practising positive communication skills to identify ineffective parental communication skills and assist participants to recognise and practise effective means of communicating with their children, which will allow the parents to be emotional coaches of their children.

Session 5: Effective Problem Solving Through Communication

Aim of the Session

The aim of the fifth session is to introduce and practise a 'problem-solving plan' for the family in order to enhance collaborative problem-solving skills.

Objectives of the Session

1. Providing a brief overview of the topic of 'problem solving' in the family in order to introduce the basic concepts of collaborative problem solving in families.

2. Discussing the importance of dealing with conflict in the family, in order to create awareness regarding the concept and to focus on goals and take concrete steps to resolve conflict.

3. Discussing and introducing the problem-solving plan so as to increase knowledge and awareness of, and insight into, proper problem solving and conflict resolution, which incorporate active listening, as well as identifying problems, stressors, options and constraints, leading to shared decision making, negotiation, fairness, creative brainstorming and resourcefulness within the family.

4. Introducing an experiential learning exercise of the problem-solving plan in order to give participants an opportunity to experience the plan directly and to work from a proactive stance in their day-to-day living as a family by building on successes, learning from failures and preparing for future challenges.

Session 6: Goal Setting and Closure

Aim of the Session

The aim of the sixth session is to set goals for future family communication and to evaluate and reflect on the workshop.

Objectives of the Session

1. Creating an activity in which the participants can work on goal setting in terms of their family's communication habits in order to continuously work on family communication.

2. Group discussion to reflect on and close the workshop.

3. Evaluating the participants as part of the research process.

6.4.6. Designing an Instructional Plan

Sork and Caffarella (1989) state that the process of designing the instructional plan involves both systemic and creative approaches. Developing this plan entails the development of instructional objectives, formulating content, designing the process, selecting resources and determining the evaluation process. Three learning outcomes can be identified, namely knowledge acquisition, skills building and a change in the attitudes or values of people. Sork and Caffarella (1989) postulated the following guidelines for instructors: (a) provide a structured framework in order to assist learners to organise their learning, (b) commence with learning material that may be well known or at least recognisable to the client system, and (c) provide integration into practice after each learning phase. It is important to keep the capability of the facilitator and the background and experience of the learner in mind when formulating an instructional plan. Time constraints, space, equipment and materials required should also be considered.

Caffarella (2002) and Knowles (1984) point out that the most suitable training formats for small groups, as in the present study, are: course/class, seminar, workshop, clinic or trip/tour. The specific format for small groups is determined by the following six factors, namely (1) participants, (2) availability of staff, (3) cost, (4) types of facilities and equipment, (5)

programme content and (6) intervention outcomes. Programme implementation is optimised when it centres around the participants by focussing on their perspectives and needs, which direct the decision regarding the format of the programme (Marshall, 1990).

Given the above-mentioned, as well as the overview and integration of psycho-education, adult education and family resilience paradigms, the workshop format proves the most suitable for the present study. The one-day workshop format was also highlighted as an effective format in the review of the current programme's theoretical underpinning and aims (MacFarlane 2000, as cited in McDonell & Dyck, 2004). The question arises as to the efficacy of a one-day workshop. In terms of practical considerations, follow-up sessions would not have been feasible in terms of participant availability due to the nature of military work (i.e., deployments and detached duties). It was decided that this study would make use of a one-day workshop with a three-month group follow-up evaluation. Despite limited evidence supporting once-off interventions, Munson (1989) indicates that a narrowly focused programme, such as the current programme, can be effectively performed in a one-day workshop. The possible limitations of a once-off workshop were also addressed by several researchers, who suggested that family meetings or family support meetings (Hawkins et al., 1992; Kumpher, 1996 in Kumpher & Alvarado, 1998) might assist with the long-term impact and carry-over effect of learned material. The suggestion of having family meetings was incorporated in the current programme.

Workshops are ideal in a small group format, and can be defined as an intensive group activity that emphasises the development of skills and competencies in a defined content area (Caffarella, 2002). The current workshop aimed at achieving exactly this, namely the development of a skill in family problem solving and communication, in the content area of family resilience, and to provide the participants with an opportunity to learn in an interactive, spontaneous way.

When deciding on the outline and material to be learned, it is important to incorporate ways of learning preferred by adults. Simerly (1990) suggests that a balanced learning style is most

applicable for adult learners, as they do not prefer a single learning style. Therefore, a combination of passive learning (lectures and formal presentations), active and concrete learning (simulations, exercises, group discussions and role playing), as well as scientific experimentation learning (emphasis on cognitive knowledge), will appeal to most adult learners.

Knowles, Holton and Swanson (1998) refer to Lindeman's theory regarding core assumptions about adult learning. Adults are motivated to learn if they experience that their needs and interests will be satisfied by the learning process. Learning should be life-centred, which emphasises the fact that experience is the richest resource for adult learning. It is also imperative to bear in mind that the individual differences amongst people increase with age, which means that adult learning programmes should be diverse and well planned to address individual differences within a group.

The above-mentioned theory of adult education guided the decision regarding the material for the current programme. The one-day workshop format allowed for the incorporation of different styles of learning in order to cater for the different learning styles of the participants: (a) passive learning, which means that each session was started with a short presentation built around Walsh's concepts of family communication; (b) active and concrete learning, which were incorporated in the sessions by including group discussions and role plays; and (c) the inclusion of diverse experiential learning exercises.

The following section will focus on the details regarding the format and content of each session of the workshop.

1. Format, structure and content of the sessions

Munson (1989) structured a one-day workshop as follows: starting time, breaks (limit each session to roughly an hour, with two 10-minute breaks in the morning and two in the afternoon), lunch (one hour), adjournment (should be at least six and no more than seven solid hours of lecturing (exclusive of breaks and lunches), and homework. Simerly (1990) says that it is

important to allow enough time in the programme for adults to collaborate and share information about what does work and what does not work for them. Important needs are met through these social activities. The Family Communication Workshop was planned accordingly, and an outline of the programme is given in Table 6.2.

Table 6.2

Programme Outline

Time	Programme Outline
8:00-9:00	Arrival and Registration
	• Refreshments
9:00-10:00	Session 1:
	Introduction
	• General Overview
	• Evaluation: Pre-test
	• Introduction: Family Resilience and Communication
	• Establish Group Rules
	• Icebreaker: *Positive Labels*
	• Introduction of the Workbook
10:00-10:15	Refreshments
10:15-11:15	Session 2:
	Communication
	• Experiential Learning Exercise: Communication Building Blocks
	• Video: *Little Miss Sunshine*
	• Group Discussion re Video and Application

(table continues)

Table 6.2 (continued)

Programme Outline

Time	Programme Outline
11:15-11:30	Refreshments
11:30-12:30	Session 3:
	A Climate for Positive Family Communication
	• Lecture: Creating a Climate for Positive Family Communication
	• Group Discussion: Topic
	• Group brainstorming: Ways of Creating a Climate for Positive Family Communication
	• Introduce Rules for a Climate of Positive Family Communication
	• Introduce Positive and Negative Responses
12:30-13:30	Lunch
13:30-14:30	Session 4:
	Effective Communication
	• Lecture: Effective Communication
	• Experiential Learning Exercise: I-feel Statements
	• Lecture: Active Listening
	• Group Discussion: Topic
	• Activity: Parenting Skills (Role play)
14:30-14:45	Refreshments
14:45-15:45	Session 5:
	• Effective Problem Solving Through Communication
	• Lecture: Effective Problem Solving Through Communication
	• Introduce the Problem Solving Plan Worksheet
	• Activity: Problem Solving
15:45-16:00	Refreshments
16:00-17:00	Session 6:
	Goal Setting and Closure
	• Activity: Goal Setting
	• Evaluation: Post-test
	• Activity: Group Feedback

2. Techniques

It is advisable to incorporate a combination of techniques when designing a programme (Henderson, 2006; Marshall, 1990) to facilitate the experiential learning process imperative to adult education. Experiential learning (learning from experience) forms an integral part of adult education (Boud, Cohen & Walker, 1993; Knowles, 1984; Merriam & Caffarella, 1999; Mulligan, 1993). Mulligan (1993) suggests a seven-category model to assist with experiential learning in order to activate internal processes in experiential learning. The categories are reasoning, feeling, sensing, intuition, remembering, imagining and willingness. It is suggested that one should activate these categories for optimal experiential learning (Caffarella, 2002; Knowles, 1970) The programme developer should select techniques based on (a) the level of active group participation allowed (Knowles, 1970), (b) evaluation regarding the balance between the participant's psychosocial background and technique applicability (Caffarella, 2002; Knowles, 1997) and (c) whether the techniques complements the programme's objectives (Caffarella, 2002; Knowles, 1997).

The following techniques were selected for the current programme according to the above-mentioned guidelines, and a detailed description is given in the facilitator's manual (see programme outline, Table 6.2). These techniques were selected carefully to activate the internal processes through experiential learning, allowing for greater learning potential and to complement the programme's objectives.

Session 1: Icebreaker

Session 2: Communication building blocks exercise; video

Session 3: Brainstorming

Session 4: I-feel exercise; parenting skills exercises and role play

Session 5: Problem-solving activity and worksheet

Session 6: Goal-setting worksheet

3. Facilitator

Munson (1989) indicates that a formal, detailed facilitator's guide is necessary and that it should include a pre-workshop check list, an overview and plan for each session of the workshop, a suggested time schedule, audio/visual material cues, suggested questions and anticipated responses for the facilitator, as well as suggested solutions for the application exercises and cases. A facilitator's manual was compiled for the Family Communication Workshop (see Addendum G), which directed the programme implementation. The manual is a comprehensive, independent, step-by-step guide for the facilitator. It begins by orientating the facilitator to the workshop, and providing the aim and objective of the workshop, the theoretical underpinning, the workshop outline/programme, the material needed and the facilitator's style. The manual gives a verbatim account of each session, which includes the lectures, and explains each experiential exercise and technique in detail, including the purpose of the activities. It also provides an implementation guideline for the facilitator, as well as information on the material needed for each session.

Although the manual provides the format if and information for the workshop, the individual style and characteristics of the facilitator are more open and flexible. Wayne (2005) points out that there is no set of ideal characteristics for a facilitator. Still, some general traits seem to be very important for optimal growth in a group setting. These traits include respect for the participants, genuineness (i.e., sincerity, honesty, enthusiasm, openness, consistency and trustworthiness), empathy, acceptance and understanding. Important skills are the ability to listen and attend to the group, to take the lead, to use silences productively, and to apply paraphrasing, clarification, reflection, summarising and questioning. These traits and skills were of great importance for the facilitator of the current workshop.

4. Participants

One of the aims of programme development should be to encourage participants to be actively involved and share ideas and experiences during the workshop. This provides higher levels of

interest and commitment (Munson, 1989). Munson (1989) suggests that this can be ensured by using ice-breakers, and encouraging smaller group discussions, games and role plays (assist with developing specific skills in participants). A very useful learning aid for participants is a workshop workbook, manual or handouts (Munson, 1989). The current programme aimed at employing all these strategies for active participant involvement. The programme outline (see Table 6.2) provides an indication of the strategies used, namely ice-breakers, games, role plays, lectures and group discussions. Each participant also received a personal workbook (see Addendum H), which encouraged participation and allowed for revision and implementation of the learning material after the workshop.

5. Ethical Considerations

In order to address ethical dilemmas thoroughly, several safety nets were implemented. Three central ethical principles, namely informed consent, the right to privacy (Oppenheim, 1992) and confidentiality (Owen & Rogers, 1999) were adhered to. Firstly, the research proposal was accepted by the University of Stellenbosch and by the SAMHS Ethics Committee. The principles of informed consent and right to privacy were adhered to. These principles were implemented by making use of volunteers as participants in the research, and giving them the choice to withdraw at any given point should they feel the need to. Potential participants were also thoroughly briefed about the nature of the research. The participants who decided to enrol in the research signed an informed consent form, which stipulated the procedures regarding the research (see Addendum D).

All questionnaires and tasks were completed anonymously to ensure the privacy of all the participants. Each questionnaire was allocated a random number, which was further used in the process of random assignment of participants into the experimental and control groups.

The facilitator of the workshop addressed the issue of confidentiality by mentioning it at the beginning of the workshop. It was further enforced by asking the participants to verbally agree

that each group member would commit to protecting the others by not discussing group content beyond the group.

The following ethical guidelines were adhered to. Firstly, Owen and Rogers (1999) suggest several applicable ethical issues regarding programme evaluation, which were taken into account in the present study. They focused on the systematic planning of the evaluation process, ensuring the honesty and integrity of the entire process and respecting the security, dignity and self-worth of the participants. Secondly, in adult education theory, Merriam and Caffarella (1999) suggest that there is no single answer for ethical dilemmas, but rather posed that one should always be aware and open in choosing alternatives (i.e., awareness of why we do things the way we do them).

6.4.7 Devising Transfer of Learning Plans

This step involves the selection of transfer strategies that will be the most beneficial in transferring learning objectives and plans to the participants (Caffarella, 2002). The selection of transfer strategies that assist with the application of learned material is closely linked to the previous step. Conversely, the current programme's main transfer strategies centred around the following resources:

1. Facilitator's Manual

The facilitator's manual gives a structured account of the implementation of the workshop (see Addendum G). All the previously mentioned theoretical underpinnings of steps were implemented and merged to compile the manual.

2. Workbook

Each participant received a workbook (see Addendum H), which was divided into six sessions. The workbook provided the participants the opportunity to make notes during the workshop. It included the important learning material of each session for future reference and for a possible carry-over effect.

3. Worksheet

Some of the exercises (i.e., problem-solving worksheet and goal-setting worksheet) were done in conjunction with worksheets that were included in each participant's workbook. Blank worksheets were included, and the participants were encouraged to use them in future.

4. PowerPoint

The programme was also presented in conjunction with a PowerPoint presentation (see Compact Disc). The PowerPoint presentation was designed as an added visual medium to the learning material.

6.4.8 Formulating Evaluation Plans

Programme evaluation assists in keeping the programme on track (Owen & Rogers, 1999). According to Caffarella (2002) and Wickham (1998), programme evaluation should occur at the onset of the programme, at the end, and at a later stage following some time lapse since the implementation of the programme. This supports the pre-test, post-test research methodological design of the present study, which will be discussed in depth in the following chapter.

Houle (1996) states that programme evaluation should determine what occurs in the participants' cognition, emotions and behaviour, and how these differ from before. Several authors agree on the usefulness of programme evaluation, which aids in: (1) the execution of goal-directed programmes, (2) providing a guide for decision making, (3) indicating weaknesses and strengths of programmes, (4) allowing for programme accountability, (5) emphasising the accomplishments of the programme and (6) providing guidance for future research directions (Houle, 1996; Owen & Rogers, 1999; Wickham, 1998).

Caffarella (2002) mentions different processes for conducting evaluation, although participant evaluation is usually used. There are different effective methods of collecting evaluation evidence, of which written questionnaires, tests or interviews are well known (Caffarella, 2002; Sork & Caffarella, 1989). Important considerations are the inclusion of quantitative and/or

qualitative evidence, as well as deciding whether to perform formative and/or summative assessments (Sork & Caffarella, 1989; Warren, 2000). These authors point out that formative programme evaluation focuses on improving programmes while they are still in process, while summative evaluation focuses on measuring the outcome of the programme and whether it has achieved its intended goal. The current programme's evaluation was summative in nature, and focused primarily on measuring whether the programme achieved its aims and objectives (Warren, 2000).

In short, the above-mentioned directions in terms of the evaluation of the current programme were achieved by setting clear aims and objectives in an attempt to improve family communication. Apart from the quantitative evaluation method (FPSC scale), a qualitative programme evaluation was also designed that comprised of open-ended questions in a questionnaire format, which each participant had to complete at the end of the workshop and again after three months. These questions (see Addendums I and J) were compiled to firstly evaluate each participant's suggestions and general and personal experience of the workshop; secondly, to provide richer and supplementary data regarding the workshop; and, thirdly, to guide the participants through an experiential learning exercise. In addition, an independent evaluator/observer observed and evaluated the workshop to ensure that the facilitator adhered to the manual.

6.4.9 Making Recommendations and Communicating Results

This step of the development and implementation of the current programme is discussed thoroughly in the next chapter.

6.4.10 Selecting Formats, Schedules, and Staff Needs

This step entails an administrative checklist, which assists with the smooth execution of the programme. The administrative plan can be divided into three important, logistical tasks inherent

to programme planning, namely budget preparation, obtaining facilities and equipment, and programme marketing (Caffarella, 2002).

This step tied in with the previous steps and stood in combination with the next step (Preparing budgets and marketing plans). Most of this step's planning went into the compilation of the programme for the day, which was also the schedule for the day (see Table 6.2). A conference facility was booked for the programme, and an in-house catering company did catering on the day. The catering included tea, coffee and refreshments with each break, as well as a lunch. The conference facility provided a comfortable, warm space for the workshop. It further succeeded in fulfilling all the basic ergonomic needs for a successful workshop, namely neat restrooms, air-conditioning, U-shaped table with comfortable chairs, data projector, laptop, flip board and comfortable couches for breaks. These factors were very important and played a major part in the programme's effectiveness (Marshall, 1990).

In term of staff needs, the minimum was required because the workshop was compiled in such a way that only one facilitator was needed. This decision was supported by the notion that the workshop should be practical in terms of resources and realistic in terms of the South African context so as to ensure uncomplicated duplication of the programme for future research.

6.4.11 Preparing Budgets and Marketing Plans

Advertising, publicity and programme financing had to be attended to during this step (Sork & Caffarella, 1989). Caffarella (2002) mentions expense items like intervention materials, facilities, equipment, travel, food, promotional materials, and general overheads (e.g., administrative, utilities) that should be taken into account in terms of the budget. The marketing of a programme ensures sufficient participation, informs potential participants and communicates the usefulness of the programme topic (Birkenholz, 1999). Caffarella (2002) suggests that different promotional material, namely flyers, posters, personal contacts, postcards, newspapers and so forth, be used. The current programme addressed the budget and marketing as follows:

1. Budget

A conference facility was booked for the workshop, and it could be hired at no expense due to the fact that the programme was designed for members of the SANDF. Table 6.3 gives a layout of the costs involved.

Table 6.3

Workshop Budget

Item	Budget
Catering	R 3 000
Workbooks and manual	R 390
Design and printing of posters and flyers	R 700
Gifts	R 500
Total	R 4 590

2. Marketing

The marketing of the current programme started with the recruitment of participants for the research study in the first phase. Marketing included the following: the research was verbally advertised by a formal academic presentation to the staff of the psychology and psychiatry departments of the military hospital. They had to refer their clients who met the research criteria to the researcher, who then contacted the possible participants telephonically. Following the telephonic contact the researcher posted an information letter (see Addendum B) to the potential participants. Hereafter, the participants were invited to meet the researcher and complete the questionnaires for the first phase of the project. This meeting was also utilised as a marketing opportunity for the coming intervention programme. Flyers and posters (see Addendum A) were also distributed. After the first phase of this project had been completed, the researcher contacted the participants and invited them telephonically to attend the intervention programme. This contact was followed up with a written invitation (see Addendum F). A week before the programme started, each participant was again contacted telephonically to confirm their

attendance. Each participant also received a certificate (see Addendum K) and a gift as a gesture of appreciation for attending the workshop.

6.4.12. Coordinating Facilities and On-site Events

For the current intervention programme, this step did not pose major challenges due to the fact that the SANDF's existing conference facilities could be utilised. This gave the researcher access to a smooth-operating, existing resource for the programme implementation.

Given the overview and implementation of the 12 steps of Caffarella's (2002) interactive model, it is clear that none of these steps stands in isolation and that each step forms part of the entire programme development process.

6.5 Conclusion

This chapter on the theoretical framework, programme development, implementation and evaluation of the current intervention programme (Family Communication Workshop) gives a comprehensive outline of the relevant theory, as well as the practical design and implementation of the programme. The main focus of this chapter was to guide the reader through the different developmental phases of the intervention programme. Firstly, the theoretical underpinning, namely the family resilience domain, psycho-education and adult education, were discussed. This was followed by a discussion of Caffarella's (2002) 12-step interactive model, which guided the programme development and implementation. The evaluation of the intervention programme will be based on an experimental design (pre-test/post-test (wait-list) control group design), which will be discussed in the next chapter.

CHAPTER 7

INTERVENTION PHASE: RESEARCH DESIGN AND METHODOLOGY

7.1 Chapter Preview

This chapter describes the research methodology of the second phase of the research, namely the intervention phase. It provides a description of the pre-test/post-test (wait-list) control experimental group design utilised for the research design and methodology employed for the intervention phase of this study. The primary aim and hypotheses of this research phase are outlined, as are the research methods used to address these. A description of the participants' demographical details is given, with an outline of the measures used. The evaluation goals are addressed by the qualitative as well as quantitative measures utilised in this phase. The sampling procedure is discussed and a description of the sample is given. An outline of the procedures and details regarding the data analysis are also given.

7.2 Primary Aims and Hypotheses of the Research

The first research question was addressed in the descriptive phase of the research, namely: 'Which qualities of resilience are present in families in which a parent has been living with depression?' The second aim of the research was addressed in the previous chapter on the development of the programme: 'What should an intervention programme entail that has been designed to enhance a certain identified quality of resilience in families in which a parent has been living with depression?' The following two chapters will address the third research aim of this study, namely:

7.2.1 Third Research Question

1. Does the designed intervention programme succeed in reaching its objective, namely to develop a certain identified quality of resilience (problem solving and communication) in families in which a parent has been living with depression?

7.2.2 Third Research Objective

  1. Following its implementation, the tertiary objective is to evaluate the impact of the

  intervention programme on the identified quality of resilience (problem solving and

  communication) in families with a parent has been living with depression.

7.2.3 Hypotheses

Figure 7.1 provides a visual illustration of the implementation of the pre-test/post-test wait-list

control experimental group design in the current study. It was decided to present this illustration

of the timeline of the study early in this chapter for the purposes of clarification and explanation,

as regular reference is made to the design throughout the chapter.

Group 1&2 Pre-test	**Group 1&2** Post-test	**Group 3** Pre-test **Group 1& 2** 3-month follow-up	**Group 3** Post-test	**Group 3** 3-month follow-up
↓	↓	↓	↓	↓
		Experimental Group		
Time 1 *August 2007*	*Time 2* *August 2007*	*Time 3* *November 2007* **Control Group**	*Time 4* *November 2007*	*Time 5* *February 2008*
↑	↑	↑	↑	↑
Control Pre-test	**Control** No testing	**Control** 3-month follow-up Serves as pre-test	**Control** Post-test	**Control** 3-month follow-up

Figure 7.1. Timeline of the pre-test/post-test wait-list control experimental group design.

The timeline presented in Figure 7.1 is complemented by Tables 7.1 and 7.2, which provide a

visual representation of Analysis 1 (Within- and between-group effects) and Analysis 2 (Within-

group effects), which were conducted in order to address the third research objective. A layout of

the main hypotheses of the Intervention Phase (Phase 2) follows after each table. Table 7.1

presents a representation of Analysis 1 as measured by the within- and between-group effects in

the experimental and wait-list control groups.

Table 7.1

Representation of Analysis 1: Within- and Between-group Effects

Analysis 1	Pre-test	Intervention	Three-month follow-up test
Experimental groups 1&2	Time 1	Intervention	Time 3
Experimental group 3	Time 3	Intervention	Time 5
Wait-list control group	Time 1	No intervention	Time 3

Expected outcome after the intervention: Improvement in the experimental group from pre-test (Time 1) to three-month follow-up (Time 3). No improvement in the control group.

Null hypothesis: No time/group interaction, implying that any change from pre-test to three-month follow-up is the same for both groups.

Table 7.2 presents Analysis 2 as measured by the within-group effects found for the experimental and wait-list control groups.

Table 7.2

Representation of Analysis 2: Within-group Effects

Analysis 2	Pre-test	Intervention	Post-test	Three-month follow-up test
Experimental groups 1&2	Time 1	Intervention	Time 2	Time 3
Experimental group 3	Time 3	Intervention	Time 4	Time 5
Wait-list control group	Time 3	Intervention	Time 4	Time 5

Expected outcome: Improvement in the experimental and control groups from pre-test (Time 1) to three-month follow-up (Time 3).

Null hypothesis: No time/group interaction and no time-main effect interaction, implying no change over time for the control and experimental groups treated as one group.

In order to address the hypotheses of Analysis one and Analysis two, a pre-test/post-test wait-list control experimental group design was implemented as the research design and method of investigation. This will be discussed in the following section.

7.3 Intervention Phase: Research Design and Methodology

The research methodology employed to address the third aim of this research focused on the evaluation of the impact of the Family Communication Workshop as the designed intervention programme. Family problem solving and communication (measured with the Family Problem Solving and Communication Scale (McCubbin et al., 1996) was found to be the most prominent quality of family resilience for families in which a parent had been living with depression, as indicated in the descriptive phase of this study. Thus, the results of the descriptive phase, as well as further literature that was consulted, were used to design and compile a programme for parents to enhance family problem solving and communication, as described in Chapter 6.

The two main hypotheses borne in mind while conducting the intervention phase of this research were the null hypothesis (H_0) and the research hypothesis (H_1). The null hypothesis (H_0) was that 'the independent variable, the Family Communication Workshop, did not have a significant impact on the dependent variable, family problem solving and communication', while the research hypothesis (H_1) was that the 'independent variable, the Family Communication Workshop, did have a significant impact on the dependent variable, family problem solving and communication'.

Given the hypothesis, a pre-test/post-test wait-list control experimental group design was implemented to evaluate the impact of the Family Communication Workshop, which proved to be the best suited research method to address the third aim of the research (Babbie, 1998; Bless & Higson-Smith, 1995; Cohen et al., 2000). It involved two groups that were compiled, by randomly assigning participants into the experimental or control group (Cohen et al., 2000). The experimental design allows for the evaluation of an intervention programme by determining the programme's effectiveness by comparing the experimental group with the control group. Groups are randomly assigned and employed in this design. The experimental group receives the

treatment, while the control group is involved in a neutral activity (Tuckman, 1999). A pre-test and a post-test are administered to both groups (Tuckman, 1999).

Programme evaluation also assists with monitoring and keeping the programme on track, as discussed in Chapter 6 (Owen & Rogers, 1999). Wickham (1998) highlights the complexities of programme evaluation and mentions that it is very difficult to evaluate all the different dimensions of a programme simultaneously. These complexities call for prioritisation in terms of directing the evaluation plan to meet the research objective of this phase of the current study (Owen & Rogers, 1999; Wickham, 1998). The experimental design provided a vehicle that directed the current evaluation plan to address the third research objective.

Programme evaluation through an experimental design does not come without major methodological issues and considerations, as mentioned earlier, and proved itself to be the most difficult part of this research study. Cohen et al. (2000) suggest the following methodological considerations in order to optimise the validity of experimental research outcomes: (a) adequate resources to undertake the research, (b) selecting an appropriate methodology, (c) using an appropriate sample and (d) demonstrating internal and external validity. These considerations will be addressed in this chapter. The following section will elaborate on the considerations regarding internal and external validity for the programme evaluation, as it is an important key to effective experimental research (Cohen et al., 2000).

Programme outcome might be influenced by these validity threats if not controlled. Shadish, Cook and Campbell (2002) mention that the experimental design assists with minimising threats to internal validity, but hampers external validity, which will be discussed in more detail. The following section will briefly mention the threats and also discuss the ways in which the current programme considered the factors in order to restrict possible validity issues in the programme implementation and evaluation.

1. Internal Validity

An experiment is internally valid when it allows the researcher to conclude that there either was or was not a relationship between the independent and dependent variables, without extraneous variables influencing the results (Benjafield, 1994). In Table 7.3 it is shown how the researcher addressed possible, relevant internal validity threats that posed the greatest risk in terms of internal validity in the current research design (Bless & Higson-Smith, 1995; Cohen et al., 2000; Krauth, 2000; Tuckman, 1999).

Table 7.3

Control for Threats to Internal Validity

Threat	Description	Controlled
History	History becomes a threat if events other than the programme have an impact on the participants.	Control for by random allocation to experimental and control groups.
Maturation	Naturally-occurring biological and psychological changes in the person during the study.	Control for by random allocation to experimental and control groups. Families were in the same developmental stages.
Testing	This threat refers to participants who become test-wise if the pre- and post-tests are the same.	Use the same tests for all participants in the pre- and post-test.
Instrumentation	This refers to the effect of having different pre- and post- test questionnaires.	Use the same tests for all participants in the pre- and post-test.
Statistical regression	It occurs if extremity exists between the participants.	Control for by random allocation to experimental and control groups.
Differential selection	Refers to the impact on the results of people with different characteristics.	Control for by random allocation to experimental and control groups.

(table continues)

Table 7.3 (continued)

Control for Threats to Internal Validity

Threat	Description	Controlled
Experimental treatment diffusion	This refers to the effect if participants in the control group becomes aware of the treatment and apply it themselves.	Control by exposing the control group to an unrelated activity.
Compensatory rivalry by the control group	This comes in play when control group participants compensate for not being in the experimental group.	Control by exposing the control group to a neutral activity. Aim at having a blind control group (not aware that they are the control group).

In summary, Table 7.3 illustrates that the majority of the internal validity threats in the current study were controlled by random allocation to the experimental and control groups and the utilisation of the same questionnaires for the pre- and post-tests evaluations. The exposure of the control group to an unrelated activity also addressed and nullified important threats to validity.

2. External Validity

External validity encapsulates the ability to generalise between situations (Benjafield, 1994). Table 7.4 provides a layout of and solutions to possible external validity threats, which were considered during the current programme evaluation (Bless & Higson-Smith, 1995; Cohen et al., 2000; Krauth, 2000).

Table 7.4

Control for Threats to External Validity

Threat	Description	Controlled
Explicit description of the experimental treatment	The independent variable must be described in a clear, measurable way to ensure reproduction.	Compiled a step-by-step facilitator's manual.
Failure to describe independent variables explicitly	Reference to future replications of the study is impossible unless the experimental conditions are clearly described.	In-depth description of experimental conditions.
Inadequate operationalisation of the dependent variable.	Operationalisation of the dependent variable must have validity in the non-experimental setting (i.e., settings to which researcher wants to generalise).	Replication of study before generalisation.
Multiple treatment interference	This threat refers to the reality that people are exposed to different treatment options and not just that of the programme (i.e., medication, psychotherapy etc.).	Controlled by random allocation to the experimental and control groups.
Hawthorne effect	This threat refers to the notion that getting special attention will increase motivation to improve.	Controlled for by random allocation to the experimental and control groups, and by exposing the control group to a neutral activity.
Invalidity or unreliably of questionnaires	This threat refers to the utilisation of unreliable instruments.	Controlled for by using well-researched questionnaires in the family resilience field. The programme was also designed in accordance with the specific questionnaire and theoretical underpinning in mind.

(table continues)

Table 7.4 (continued)

Control for Threats to External Validity

Threat	Description	Controlled
Reaction to experimental conditions	This threat refers to the impact the pre-test might have on the participants, which may cause changes.	Controlled for by random allocation to the experimental and control groups.
Interaction between history and treatment effect	This refers to whether the same interaction effect would have been found 10 years previously or be found in the future.	Recommendation: replication of study in different settings.
Interaction between setting and treatment	This refers to the fact that a specific interaction might be due to the specific setting and treatment, and that it might not be the same in a different setting.	Recommendation: replication of study in different settings.
Interaction between selection (sample) and treatment	Refers to the notion that if certain interactions have been found in a specific population, the question arises as to whether the same results will be found in other populations.	Recommendation: replication of study in different settings.

The majority of the threats to external validity in the experimental design, as shown in Table 7.4, were addressed by random allocation and by recommending replication of the study in different settings before generalising between settings. The researcher also explicitly described the experiment and allowed for replication by compiling the step-by-step facilitator's manual. The dependent variable, family problem solving and communication (measured with the FPSC scale) (McCubbin et al., 1996), and the independent variable, the Family Communication Workshop, were also clearly described. The following subsection describes the participants in the second phase by addressing the sampling procedures, the sample and the demographics of the participants.

7.3.1 Participants

7.3.1.1 Sampling Procedures

A non-probability sampling procedure was utilised to select the initial families for the descriptive phase, as explained in Chapter 4. These families thus fulfilled the research criteria, and also formed the sample for the descriptive phase. The only added criterion was that they had to indicate their interest in attending the programme in the intervention phase. From the 36 recruited families in the descriptive phase, 32 families indicated their interest in attending the intervention programme.

The previous section addressed the current study's methodological considerations, especially regarding internal and external validity. It became evident that the most important method in conducting a valid study was the random allocation of participants to experimental and control groups (Shadish et al., 2002). Single-setting experimental studies provide high internal validity because the participants serve as their own controls. Experimental and control groups are formed randomly, which means that any initial group difference in terms of threats to validity should be experienced equally over conditions within the limits of chance (Shadish et al., 2002). However, these studies have extremely low external validity and cannot be generalised confidently to other settings without replication (Shadish et al., 2002). Thus, the current study aimed at conducting an experiment for a specific setting with no intention to generalise it to different settings and without recommending replication of the experiment.

7.3.1.2 Description of the Sample

From the 36 families in the descriptive phase, 32 families indicated their interest in attending the intervention programme. All the families who indicated their interest in the Biographical Questionnaire (descriptive phase) were contacted during the intervention phase, when 30 families of the original 36 indicated that they would be available and interested in attending the workshop.

These families were randomly allocated to an experimental group of 20 couples and a control group of 10 couples. The random allocation was done by a senior statistician (Prof. M. Kidd) at the Statistical Consultation Service of the University of Stellenbosch. The allocation was done independently of the pre-test scores obtained in the descriptive phase.

Only five couples of the original ten couples on the wait-list control group attended the first contact session. Two of the wait-list control group couples withdrew before the first contact session, and three couples did not attend the session. Of the original 20 families allocated to the experimental group, 12 couples attended (either Group 1 or 2, Figure 7.1), and two of the identified patients attended without their spouses being present. Four of the original 20 couples included in the experimental group could not attend either one of the two initial workshop days, but indicated that they were still interested in attending a workshop. They were included in the workshop presented for the wait-list control group and are referred to as Group 3. Four of the five wait-list control group couples attended the three-month follow-up assessment, and attended the workshop after the control phase passed. In total, the workshop was presented to 20 couples (Group 1, Group 2, Group 3 and the wait-list control group), with an additional two identified patients who attended without their spouses.

Most of the participants attended the three-month follow-up session. However, some of the participants could not attend and their questionnaires were faxed or posted to them. Despite this extra measure, some did not return their questionnaires.

7.3.1.3 Participants' Demographics

The participants selected for the intervention phase were from the same sample as described in the description phase (see Chapter 4). However, all the participants of the first phase did not participate in the second phase; therefore it was decided to give a brief summary of the main demographics of the participants in the second phase.

According to the biographical data, the participants had been married for between six and 26 years. The average length of marriage was 17 years (SD = 5.6). The identified patients had an average age of 42 years (SD = 4.7), ranging from 29 to 49 years, while the spouses' ages ranged from 34 to 59 years, with an average of 43 years (SD = 5.3),. The distribution of the number of marriages the participants had been involved in is presented in Table 7.5.

Table 7.5

Number of Marriages of Identified Patients and Spouses

Number of marriages	Identified patients n	Spouses n	Percentage
1	19	19	86
2	3	3	14
Total	22	22	100

Table 7.5 illustrates that 19 (86%) identified patients and spouses were in their first marriage, while three (14%) identified patients and spouses were in their second marriage. The gender distribution of the identified patients and spouses is shown in Table 7.6.

Table 7.6

The Gender of Identified Patients and Spouses that attended the Workshop

Gender distribution	Identified patients	Spouses	Identified patients	Spouses
	n	n	Percentage	Percentage
Male	3	19	14	86
Female	19	3	86	14
Total	22	22	100	100

Table 7.6 indicates that three (14%) identified patients were male and 19 (86%) were female, while 19 (86%) spouses were male and three (14%) were female. All the couples had two children, except one couple who had only one child. The average age of the first child was 16

years, ranging from eight to 25 years, with 59% (n = 13) being male and 41% (n = 9) being female. The average age of the second child was 12 years, ranging from 4 to 22 years, with 48% (n = 10) children being male and 52% (n = 11) being female.

Table 7.7 indicates the time since the identified patients had been diagnosed with depression.

Table 7.7

Time since Diagnosed with Major Depressive Disorder

Timeline	n	Percentage
Less than 1 year	1	5
1-2 years	5	23
3-5 years	6	27
6-10 years	4	18
More than 10 years	6	27
Total	22	100

Table 7.7 illustrates that that there was a fairly equal distribution of patients who had been formally living with depression between one to two years (23%), three to five years (27%), six to ten years (18%) and more than ten years (27%), while only five percent had been formally living with depression for less than a year.

To address the evaluation goals of the intervention phase, specific measures were chosen, and these are discussed in the next section.

7.3.2 Measures

Owen and Rogers (1999) say that the translation of programme goals or objectives into valid measures of outcome might pose methodological concerns. They suggest that the problem could be addressed by utilising previously developed measurements (i.e., questionnaires). However, Owen and Rogers (1999) also point out that programme planning and evaluation is not set in stone and that several factors (i.e., participants, facilitator) could lead to changes with regard to

implementation and evaluation. It therefore is very important to be clear and specific regarding the goals and outcomes of the evaluation. In order to address these difficulties relating to programme evaluation, the following specific goals were formulated, which will be discussed in the following section.

Quantitative goal:

1. Addressing the hypotheses pertaining to the within- and between-group effects, namely to quantitatively evaluate the intervention programme through an experimental design.

Qualitative goals:

1. To determine whether the programme content was appropriate for the participants.

2. To determine whether the programme increased the knowledge of the participants with regard to themselves, their family and life in general.

3. To determine whether the programme information could be applied and remembered for future reference.

4. To elicit any suggestions for future workshops and for the facilitator.

5. To determine the long-term effect of the workshop on family communication and family functioning in general.

With the purpose of addressing these goals of the evaluation, the concept of triangulation was applied in the intervention phase by using both quantitative as well as qualitative measures with the pre-test, post-test and three-month follow-up tests.

The Family Problem Solving and Communication Scale (FPSC) (McCubbin et al., 1996) was employed as the quantitative measure for measuring the impact of the Family Communication Workshop in the pre-test, post-test and three-month follow-up assessments. The intervention programme was designed according to the underlying theoretical aspects measured with the scale, as discussed in Chapter 6. The FPSC Scale will be reviewed briefly, as it was discussed in more detail in Chapter 4 as part of the descriptive phase.

The FPSC Scale evaluates positive and negative communication patterns during crisis situations in families. It consists of ten items on a four-point Likert scale, ranging from false to true. The scale has two subscales, 'Affirming communication' and 'Incendiary communication'. The Affirming Communication subscale (positive communication) refers to the type of communication that diffuses a situation by conveying caring and understanding. The Incendiary Communication subscale (negative communication) centres around communication that exacerbates and intensifies a conflict situation. The scale was developed by McCubbin, McCubbin and Thomson (1988), and has a total internal reliability (Cronbach's alpha) of .89. The Affirming Communication subscale has an internal reliability of .86 and the Incendiary Communication subscale has a reliability of .78 (McCubbin, Thompson & McCubbin, 1996). For Analysis 1 of the current study, the following internal reliabilities (Cronbach's alpha) were found for the FPSC Scale: Time 1: (Total scale = .78; Affirming subscale = .84; Incendiary subscale = .74) and Time 3: (Total scale = .93; Affirming subscale = .96; Incendiary subscale = .85). Analysis 2 revealed the following reliabilities of the FPSC scale: Time 1: (Total scale = .86; Affirming subscale = .89; Incendiary subscale = .79), Time 2: (Total scale = .73; Affirming subscale = .89; Incendiary subscale = .58) and Time 3 (Total scale = .91; Affirming subscale = .89; Incendiary subscale = .83).

In addition, the Beck Depression Inventory (BDI-II) (Beck et al., 1996), as discussed in Chapter 4, was employed to monitor the depression levels of the identified patients. For Analysis 1 of the current study, the following internal reliabilities (Cronbach's alpha) were found for the BDI-II: Time 1 = .95 and Time 3 = .94. Analysis 2 had the following internal reliability: Time 1 = .94 and Time 2 = .95.

The qualitative measure included two questionnaires with open-ended questions. One questionnaire was used to evaluate the programme on the day of presentation (post-test), and the other was used to evaluate the long-term effect of the programme after a three-month follow-up period on post-evaluation. These questions were formulated according to experimental learning

principles in order to optimise the integration of the learning material of the workshop, as discussed in Chapter 6. The first questionnaire, completed directly after the workshop, included the following open-ended questions (see Addendum I):

1. How did you experience the workshop?

2. How might it have been different?

3. What did you learn about yourself, your family or life in general?

4. Will you be able to apply what you have learned to your family situation?

5. How could you remember the topics we have discussed in the workshop?

6. Are there suggestions for future workshops about the information, the format of the workshop or the exercises?

7. Are there any suggestions for the facilitator?

The three-month follow-up evaluation questionnaire included the following open-ended questions (see Addendum J):

1. Did the family communication workshop impact on the communication in your family? If so, please indicate in what way. If not, please indicate why not.

2. Did the workshop on family communication contribute to improving your family functioning? If so, please indicate in what way. If not, please indicate why not.

These measures were utilised during the implementation of the experimental design. The subsequent section addresses the specific procedures followed during the rollout of the evaluation by means of these measurements.

7.3.3 Procedure

7.3.3.1 Administrative Procedure

The intervention phase procedures followed after the procedures of the descriptive phase described in Chapter 4. The data analysis of the descriptive phase was used as basis for the intervention phase to develop the Family Communication Workshop, as described in Chapters 5 and 6.

The programme was designed to be attended by couples. After the development of the intervention programme, the identified patients who had indicated an interest in attending the intervention programme during the descriptive phase were contacted telephonically to ascertain whether they were still interested in attending the workshop. After all the interested couples were recruited, they were randomly assigned to the experimental and control groups.

Following this, each couple was contacted and invited to attend the workshop. During this phone call, procedures were explained and the fact that the intervention was going to be in a workshop format was highlighted. This assisted with transparency and informed consent to ensure that the participants could make an informed decision regarding their participation in group format. The invitations that contained the necessary information about the workshop (see Addendum F) were posted or faxed to each couple. All the participants received a time schedule for two contact sessions. These procedures ensured that the participants were not aware whether they were in the wait-list control group or in the experimental group. This minimised internal validity threats, such as experimental treatment diffusion and compensatory rivalry by the control group, as discussed in the methodology section.

The following section addresses the timeline of the intervention phase.

7.3.3.2 Timeline

The procedures of this phase of the study coincide with the timeline as presented in Figure 7.1 at the beginning of the chapter. A brief summary of the timeline follows. Each time point will be discussed in detail.

Time 1: Pre-intervention assessment of the experimental group (Group 1 and Group 2)

: Pre-intervention assessment for the wait-list control group

Time 2: Post-intervention assessment of the experimental group (Group 1 and Group 2)

Time 3: Three-month post-intervention assessment of the experimental group (Group 1 and Group 2)

: Three-month post-intervention assessment of the wait-list control group (serves as pre-test)

: Pre-intervention assessment of the experimental group (Group 3)

Time 4: Post-intervention assessment of the experimental Group 3 and the wait-list control group

Time 5: Three-month post-intervention assessment of the experimental Group 3 and the wait-list control group

Testing procedures: Time 1

Following the above-mentioned administrative procedures, this phase of the research commenced by determining the family problem solving and communication and depression status of the members of both the experimental and the wait-list control groups using the Family Problem Solving and Communication scale (FPSC) (McCubbin et al., 1996) and the Beck Depression Inventory (BDI-II) (Beck et al., 1996). Experimental Groups 1 and 2 were invited to attend one of two workshop days, while the wait-list control group was invited to attend an initial contact session. Experimental Groups 1 and 2 completed the questionnaires at the beginning of the workshop. Both spouses completed the FPSC, while the identified patient also completed the BDI-II. During the same week, the wait-list control group also completed both questionnaires

(FPSC and BDI-II). These groups were not aware of each other. The participants were encouraged to be honest and to complete their questionnaires independently from their spouses. These values, of honesty and independence, were highlighted during the testing procedures for all the groups. During the testing procedure, the facilitator (researcher) was present to address any uncertainties. An independent observer (registered psychologist) was present on the workshop days for experimental Groups 1 and 2 to ensure that the facilitator adhered to the manual.

Intervention: Family Communication Workshop

The Family Communication Workshop (see Chapter 6) commenced after the Time 1 assessment of experimental Groups 1 and 2. A brief, unrelated situation analysis session followed the Time 1 assessment for the wait-list control group. The one-hour contact session of the wait-list control group was concluded by sharing refreshments.

Testing procedures: Time 2

After the Family Communication Workshop was completed with the experimental Groups 1 and 2, the family problem solving and communication status was reassessed (FPSC scale) at the end of the workshop day. In addition, these participants also completed the open-ended evaluation questions on the workshop (see Addendum I). The wait-list control group did not complete a Time 2 (a) assessment, as their contact session lasted only an hour and it would have been senseless to re-evaluate them on the FPSC scale after an hour. After the assessment, the participants were reminded of the contact session three months later.

Administrative procedures

Some of the experimental group participants (Group 3) could not attend the above-mentioned procedures and an alternative date was scheduled in August 2007. However, this date was not convenient for the participants and it was decided to invite them to the workshop that was

presented for the wait-list control group. After three months all the participants were contacted telephonically to remind them of the coming contact sessions.

Testing procedures: Time 3

Experimental Groups 1 and 2 attended a joint contact session. This session started with the three-month follow-up assessment. Both partners completed the FPSC scale, while the identified patients also completed the BDI-II. In addition, the open-ended question on the long-term effect of the workshop (see Addendum J) was also completed. Each participant received a certificate (see Addendum K) and a small gift of appreciation. This session was concluded with tea and other refreshments.

In the same week, the wait-list control group, as well as the remaining experimental group participants (Group 3), attended the workshop. The workshop started with the pre-assessment of the wait-list control group as well as of Group 3 of the experimental group. The assessment included the same measures, namely the FPSC scale for both spouses and the BDI-II for the identified patients. The Time 3 assessment of the wait-list control group provided a three-month follow-up measure and was used as a baseline (pre-intervention assessment) score before the workshop commenced.

Intervention with wait-list control group and experimental Group 3

The Family Communication Workshop (see Chapter 6) followed after the Time 1 assessment for experimental Group 3 and the wait-list control group.

Testing procedures: Time 4

After the Family Communication Workshop (see Chapter 6) was completed with experimental Group 3 and the wait-list control group, the family's problem-solving and communication (FPSC scale) status was re-assessed. In addition, these participants also completed the open-ended

question regarding the workshop (see Addendum I), and they were reminded of the contact session three months later.

Administrative procedures

After three months, all the participants were contacted telephonically to be reminded of the additional contact session. Some of the participants (from both the experimental and control group) could not attend the three-month follow-up session and their post-intervention questionnaires were posted or faxed to them. Hence, a full return rate was not achieved. The exact numbers will be discussed in the following chapter.

Testing procedures: Time 5

Experimental Group 3 and the wait-list control group attended the session. This session started with a three-month follow-up assessment. Both partners completed the FPSC scale, while the identified patients also completed the BDI-II. The open-ended question regarding the long-term effects of the workshop (see Addendum J) was also completed by all the participants. Each participant received a certificate (see Addendum K) and a small gift of appreciation. This session was concluded with tea and other refreshments.

7.3.4 Data Analysis

The quantitative and qualitative data analyses were conducted to address the research aim of this phase of the study, as well as the measurement goals mentioned above. The quantitative data analysis was done by Prof. M. Kidd of the Statistical Consultation Service at the University of Stellenbosch. Decisions in terms of appropriate techniques were made in consultation with him. The data was analysed using STATISTICA (V8) (StatSoft Inc., 2008), a data analysis software package.

The scores obtained in the pre-test, post-test and three-month follow-up assessments on the FPSC scale (McCubbin et al., 1996) were codified and analysed, as well as the scores from the pre-test and three-month follow-up assessments of the BDI-II (Beck et al., 1996). Descriptive

data analysis was computed to determine the means, standard deviations and reliability of the measures, as well as of the biographical data. The distribution normality of the data was explored by inspecting the normal probability plots.

Analysis 1 addressed between- and within-group effects amongst the wait-list control and experimental groups during the pre-test and three-month follow-up assessments, while Analysis 2 addressed the within-group effects during the pre-test, post-test and three-month follow-up assessments for both the experimental and control groups. Both analyses were conducted by using a two-way repeated measures analysis of variance (ANOVA) to determine the change across time separately for each group.

Threats to statistical conclusion validity were considered with the data analysis of the current study (Benjafield, 1994; Krauth, 2000; Shadish et al., 2002). An important threat was low statistical power, which refers to the probability of detecting a relationship by means of a statistical test if this effect exists in the population in reality. When a study has insufficient power, effect size estimations might be inaccurate (have wider confidence levels) and researchers may incorrectly conclude that cause and effect do not co-vary (Shadish et al., 2002).

Benjafield (1994) explains that statistical power increases as the probability of making Type 1 errors increases, which means that the null hypothesis will be rejected when it actually is true. Low statistical power might be due to stringent criteria for rejecting the null hypothesis (i.e., by allowing less than 5% risk of making a Type 1 error). Power is further increased if the hypothesised effect size increases and if the sample size increases (Benjafield, 1994). This means that the intervention programme should be designed in such a way as to optimise the hypothesised effect (H^1) with an optimal sample size so that the statistical power of the experiment is increased. The current study controls for this threat by making a Fisher least significant difference adjustment. This adjustment controls for the possibility of making a Type 1

error with the performance of the two-way ANOVA at each testing, in order to explore the difference between the experimental and wait-list control group.

The qualitative data analysis of the intervention phase was also undertaken according to the principles of grounded theory, as explained in Chapter 4 (Glaser & Strauss, 1967). The grounded theory coding process guided the analysis and coding of the two sets of open-ended questions for the post-test as well as the three-month follow-up evaluations. The identification of the themes and categories allowed for statistical analysis and will be discussed in the next chapter.

7.4 Conclusion

The pre-test/post-test (wait-list) control experimental group design, as the research design of the intervention phase of the research, presented important methodological considerations. These considerations were addressed by careful analysis and description of the method at hand and by addressing the internal and external validity threats to the current design. The primary aim and hypotheses of this phase provided specific research objectives, which had to be addressed in an attempt to evaluate the intervention programme. Thorough planning of the goals of the evaluation guided the specific qualitative and quantitative measures used during the intervention phase. The procedures followed are discussed in detail according to a timeline (see Figure 7.1). Specific sampling procedures and the data analysis were also discussed.

The following chapter firstly gives a layout of the research results of the intervention phase, and secondly provides a discussion and integration of the findings.

CHAPTER 8

INTERVENTION PHASE: RESULTS, DISCUSSION AND INTEGRATION

8.1 Chapter Preview

This chapter reports on the findings of the intervention phase by commencing with a review of the tertiary aim of the study. The chapter comprises two main components. The first is an outline of the intervention phase that is presented with the focus on the sample and biographical data, quantitative results (Analyses 1 and 2) and qualitative results. The second component discusses and integrates the biographical, quantitative and qualitative results of the intervention phase with existing research.

8.2 Review of the Aims

As mentioned in Chapter 7, the tertiary objective was to evaluate the impact of the intervention programme on the identified quality (problem solving and communication) in families with a parent who has been living with depression.

The tertiary aim has been addressed through the implementation of an experimental research design. Tables 8.1 and 8.2 give a visual representation of Analysis 1 (within- and between-group effects) and Analysis 2 (within-group effects), which was conducted in order to address the third research objective. A layout of the main hypotheses of the intervention phase (Phase 2) follows after each table.

Table 8.1

Representation of Analysis 1: Within- and Between-group Effects

Analysis 1	Pre-test	Intervention	Three-month follow-up test
Experimental groups 1&2	Time 1	Intervention	Time 3
Experimental group 3	Time 3	Intervention	Time 5
Wait-list control group	Time 1	No intervention	Time 3

Expected outcome:

1. Improvement in the experimental group from pre-test to three-month follow-up test.

2. No improvement in the control group.

Null hypothesis:

1. No Time*Group interaction, implying that any change from pre-test to three-month

follow-up is the same for both groups.

Table 8.2

Representation of Analysis 2: Within-group Effects

Analysis 2	Pre-test	Intervention	Post-test	Three-month follow-up test
Experimental groups 1&2	Time 1	Intervention	Time 2	Time 3
Experimental group 3	Time 3	Intervention	Time 4	Time 5
Wait-list control group	Time 3	Intervention	Time 4	Time 5

Expected outcome:

1. Improvement in the experimental and control groups from pre-test to three-month

follow-up test.

Null hypotheses:

1. No Time*Group interaction.

2. No Time main effect interaction, implying no change over time for the control and

experimental groups treated as one group.

This layout of Analyses 1 and 2 provides a framework for the discussion of the research results in this chapter. The next subsection reports on the quantitative and qualitative findings of the intervention phase.

8.3 Results

Before reporting on the results, a brief summary is given of the research sample: The sample of the pre- and post-test assessments of the experimental group consisted of 16 couples (n = 32) and two identified patients, which amounted to a total of 34 participants, while the wait-list control group consisted of five couples (n = 10). During the three-month follow-up assessments, the experimental group consisted of 13 couples (n = 26) and two identified patients, with a total of 28 participants, while the wait-list control group consisted of five couples (n = 10) couples. Only four (n = 8) of the wait-list control group couples attended the workshop. Attrition accounted for three (n = 6) of the experimental group and one (n = 2) of the wait-list control group couples not attending the follow-up sessions. They also did not return the questionnaires, which were faxed to them as an added measure to optimise the return rate.

8.3.1 Quantitative Results

In accordance with the two sets of hypotheses, the quantitative data was explored in two ways in the main data analysis. Firstly, Analysis 1 explored the within- and between-group effects, while Analysis 2 explored the within-group effects. Both analyses were done by employing a two-way repeated measures analysis of variance (ANOVA). The quantitative data consisted of the data obtained from the Family Problem Solving and Communication Scale (McCubbin et al., 1996) and the Beck Depression Inventory-II (Beck et al., 1996).

8.3.1.1 Analysis 1: Within- and Between-group Effects

Analysis 1 focused on the within-group effects. The possible effects of the intervention programme were investigated by exploring whether the family communication and problem solving of the experimental group had improved from the pre-test (n = 34) to the three-month

follow-up test (n = 28), and whether the wait-list control group (n = 10) scores had remained unchanged over time. Secondly, it investigated the between-group effects by comparing the measures of the wait-list control group and those of the experimental group over time. The impact of the intervention programme will be evident with a statistically significant Group*Time interaction effect on either the affirming subscale scores, the incendiary subscale scores or the total scale scores of the FPSC. The null hypothesis (H_0) will not be rejected if no Group*Time interaction is found, implying that any change from pre-test to three-month follow-up is the same for both groups. This, in turn, implies that the intervention programme did not have a statistically significant effect on either of the three scores of the FPSC scale.

The following section explores these outcomes of the FPSC scale. In addition, this section will also investigate the effect over time of the BDI-II scores.

8.3.1.1.1 Results obtained with the Family Problem Solving and Communication Scale

The following ANOVA table gives a layout of the interaction and main effects of gender, group, and time regarding the affirming communication scores, obtained with the corresponding subscale of the FPSC.

Table 8.3

ANOVA: Results Obtained with the Affirming Communication Subscale of the FPSC

Fixed effect test	Num. DF	Den. DF	F	p
Gender	1	16	0.14464	.70871
Group	1	16	0.63745	.43633
Time	1	16	0.09773	.75861
Gender*Group	1	16	0.07947	.78163
Gender*Time	1	16	0.17407	.68207
Group*Time	1	16	0.37894	.54683
Gender*Group*Time	1	16	2.79669	.11389

Note.
Num. DF: numerator degrees of freedom
Den. DF: denominator degrees of freedom

Table 8.3 presents the ANOVA as performed on the results of the affirming communication subscale of the FPSC scale. The results reveal no statistically significant interaction effects of Gender*Group*Time [F (1, 16) = 0.38, p = .11], Gender*Time [F (1, 16) = 0.17, p = .68], Group*Time [F (1, 16) = 3.38, p = .54] and Gender*Group [F (1, 16) = 0.08, p = .78]. This statistically insignificant trend was also found with the main effects of Time [F (1, 16) = 0.10, p = .76], Group [F (1, 16) = 0.63, p = .43] and Gender [F (1, 16) = 1.14, p = .70].

In essence, this ANOVA (Table 8.7) reveals that there was no statistically significant difference between the experimental group and the control group over time (Group*Time interaction), which means that the intervention programme did not have a statistically significant impact on the affirming communication of the participants.

Table 8.4 presents the ANOVA results for the main and interaction effects of the incendiary communication scores, obtained with the corresponding subscale of the FPSC.

Table 8.4

ANOVA: Results Obtained with the Incendiary Communication Subscale of the FPSC

Fixed effect test	Num. DF	Den. DF	F	p
Gender	1	16	0.19671	.17986
Group	1	16	0.54484	.47112
Time	1	16	3.64417	.07437
Gender*Group	1	16	2.20950	.15660
Gender*Time	1	16	0.01002	.92151
Group*Time	1	16	3.64417	.07437
Gender*Group*Time	1	16	0.93584	.34775

According to Table 8.4, a trend was found between the Group*Time interaction [F (1, 16) = 3.64, p = .07], although it was not statistically significant on the 5% level. Figure 8.1 illustrates this trend.
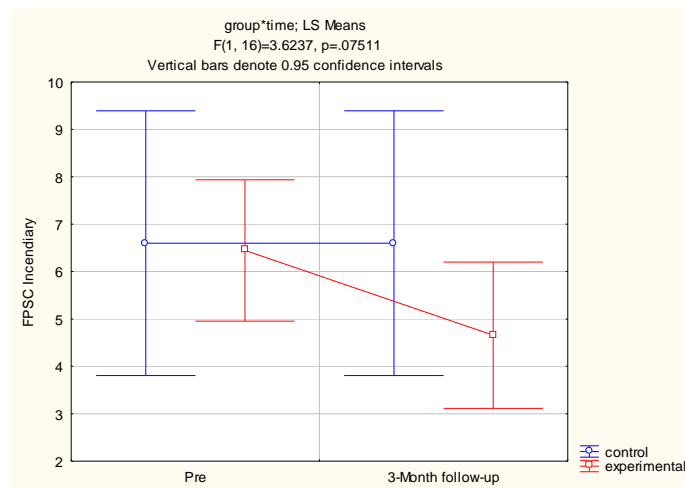
Figure 8.1. Group*Time interaction according to the incendiary communication subscale.

Figure 8.1 presents a graphical display of the data of the Group*Time interaction, which is displayed separately for the control (blue line) and the experimental group (red line). This interaction displays the average scores of the experimental and control groups at the pre-intervention and at the three-month follow-up assessments. For the pre-test, both groups had fairly similar incendiary communication scores. Following the trend in the data of the experimental group, there was a decrease in scores between the pre-test and the three-month follow-up test, while the control group's scores stayed unchanged. However, this trend is not statistically significant on a 5% level (p = .07).

The post-hoc Fisher Least Significant Difference analysis (LSD) also supported this trend in the Group*Time interaction. The LSC analysis found a statistically significant difference (p < .01) between the experimental group's pre-test and three-month follow-up assessment, while a p value of .99 was found for the wait-list control group's pre-test and three-month follow-up assessments. This indicates that the wait-list control group's score on the incendiary subscale stayed the same over time.

In conclusion, this ANOVA shows that a trend (not statistically significant on a 5% level) in terms of Group*Time interaction was found and that the groups differed over time. In other

words, negative communication, as measured by the incendiary communication subscale of the FPSC, decreased for the experimental group. The post-hoc LSD analysis supported this trend.

Table 8.5 presents the ANOVA for the main and interaction effects of the Total Score of the FPSC scale.

Table 8.5

ANOVA: Results Obtained with the FPSC (Total Score)

Fixed effect test	Num. DF	Den. DF	F	p
Gender	1	16	0.94592	.34525
Group	1	16	0.64278	.43445
Time	1	16	1.99332	.17715
Gender*Group	1	16	0.96885	.33962
Gender*Time	1	16	0.01057	.91940
Group*Time	1	16	2.41148	.14000
Gender*Group*Time	1	16	1.86493	.19095

Table 8.5 show that no statistically significant effects were found for either the interaction effects of Gender*Group*Time [F (1, 16) = 1.86, p = .19], Group*Time [F (1, 16) = 2.41, p = .14], Gender*Time [F (1, 16) = 0.01, p = .91] and Gender*Group [F (1, 16) = 1.97, p = .33], or for the main effects of Time [F (1, 16) = 1.99, p = .18], Group [F (1, 16) = 0.64, p = .43] and Gender [F (1, 16) = 0.94, p = .34].

In summary, this ANOVA (Table 8.5) shows that there was no statistically significant difference between the experimental and control groups over time (Group*Time interaction), which means that the intervention programme did not have a statistically significant impact on family problem solving and communication as measured the total scores of the FPSC.

The following subsection addresses the results of the ANOVA done on the scores obtained with the BDI-II.

8.3.1.1.2 Results obtained with the Beck Depression Inventory (BDI-II)

Table 8.6 gives a layout of the ANOVA results for the main and interaction effects of the BDI-II scores.

Table 8.6

Main and Interaction Effects (ANOVA) of the BDI-II

Fixed effect test	Num. DF	Den. DF	F	p
Group 1	1	18	0.02937	.86583
Time	1	18	5.37647	.03238
Group1*Time	1	18	1.19068	.28958

Table 8.6 presents the results of the ANOVA as performed on the total scores of the BDI-II. No statistically significant effects were found with the interaction effect of Group1*Time [F (1, 18) = 1.19, p = .29] or with Group 1 [F (1, 18) = 0.02, p = .86] as main effect. However, Time [F (1, 18) = 5.38, p = .03] as main effect did indicate a statistically significant effect. This effect is graphically illustrated in Figure 8.2.
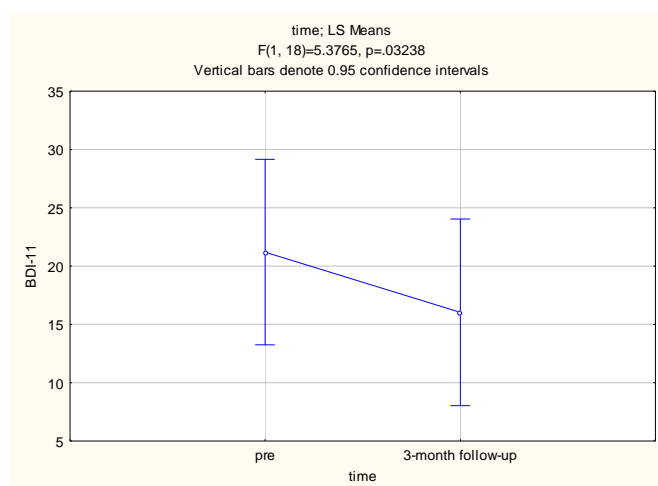
Figure 8.2. Distribution of the time interaction on the BDI-II scores.

Figure 8.2 presents a graphical display of the data of the Time main effect. This interaction displays the average joined scores for both the experimental and control groups at the pre-

intervention and the three-month follow-up assessments. Following the trend of the joint group's data, a statistically significant reduction in scores between the pre-test and three-month follow-up assessments were found on a 5% level (p = .03). This result indicates that the depression levels for the experimental and wait-list control groups had reduced significantly over time, with no difference between the two groups. The mean joint scores for the two groups on the BDI-II were 21.20 (SD = 3.78) for the pre-test, which reduced to a mean of 16.04 (SD = 3.80) at the three-month follow-up assessment. Thus, the average depression score declined from the moderate range to the mild range.

It therefore is clear that the depression rates of the wait-list control group reduced statistically significantly without the intervention, and the experimental group's rates also decreased after the intervention programme. Analysis 2 will be discussed in the next subsection, focusing on the within-group effects.

8.3.1.2 Analysis 2: Within-group effects

Analysis 2 focused on the within-group effect after the intervention programme had been administered to both the experimental and wait-list control group. The wait-list control group therefore was also subjected to the intervention programme, without an additional control group, in order to determine whether an increase in sample size would have supported the trend found in Analysis 1, specifically regarding the Group*Time interaction for incendiary communication. The possible effect of the intervention programme was investigated by exploring whether family communication and problem solving (FPSC total score) improved in the experimental groups from the pre-test (n = 34) to the post-test (n = 34) and then the three-month follow-up test (n = 28), and for the wait list control groups from the pre-test (n = 8) to the post-test (n = 8) and then the three-month follow-up test (n = 8).

The first null hypothesis (H_0) will be rejected if no Group*Time interaction is found, implying that any change from pre-test to post-test to three-month follow-up assessment is the same for

both groups (i.e., experimental and wait-list control group). The second null hypothesis (H_0) pertaining to the Time main effect will be rejected if change over time, for the experimental and wait-list control groups, is found when treated as one group. It was expected that a shift would be seen from pre-test to three-month follow-up testing, measuring the long-term effect of the intervention programme, and not from pre-test to post-testing, as the post-testing was done directly after the intervention programme.

The following section explores the outcomes of Analysis 2 regarding the measures obtained with the FPSC as well as the BDI-II.

8.3.1.2.1 Results obtained with the Family Problem Solving and Communication Scale (FPSC)

The results of the ANOVA are presented in Table 8.7. It shows the main and interaction effects of Gender, Group and Time, specifically with regard to scores obtained with the affirming communication subscale.

Table 8.7

Main and Interaction Effects (ANOVA) of the Affirming Communication Subscale (FPSC Scale)

Fixed effect test	Num. DF	Den. DF	F	p
Gender	1	19	0.07019	.79391
Group	1	19	0.19029	.66758
Time	2	33	0.00955	.37536
Gender*Group	1	19	0.45311	.50897
Gender*Time	2	33	0.36285	.26996
Group*Time	2	33	0.37581	.68964
Gender*Group*Time	2	33	5.69579	.00749

From Table 8.7 it is clear that no statistically significant interaction effects of Gender*Group [F (1, 19) = 0.45, p = .50], Gender*Time [F (2, 33) = 0.36, p = .27] and Group*Time [F (2, 33) = 0. 38, p = .69] were found. Likewise, no statistically significant main effects were found for Gender [F (1, 19) = 0.07, p = .79], Group [F (1, 19) = 0.19, p = .67] or Time [F (2, 33) = 0.00, p = .38].

The non-significant interaction effect of Time as main effect indicates that the experimental and wait-list control groups did not show statistically significant differences over time. Thus, the intervention programme had no effect on the positive family communication measured by the affirming communication subscale of the FPSC.

However, the ANOVA results present an interesting finding, as was elicited by the Gender*Group*Time interaction [F (2, 33) = 5, 70, p <.00], which revealed a strong statistically significant interaction on the 1% level. This significant interaction is highlighted in Figure 8.3.

gender*group*time; LS Means
F(2, 33)=5.4201, p=.00922
Vertical bars denote 0.95 confidence intervals
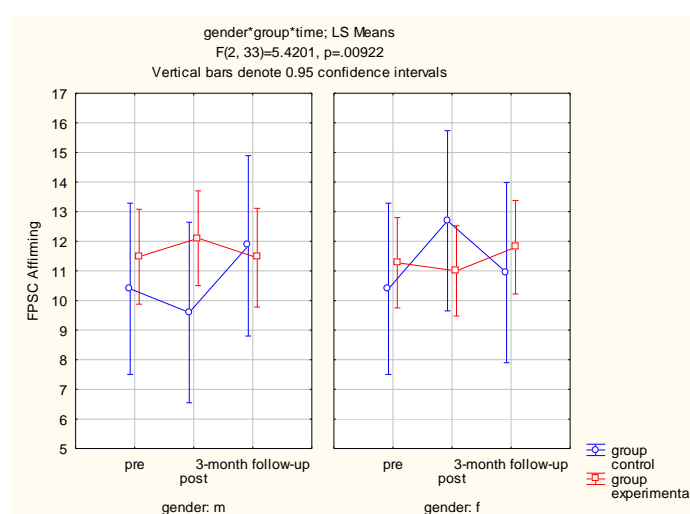
Figure 8.3. Distribution of the Gender*Group*Time interaction obtained with the affirming communication subscale.

Figure 8.3 presents a graphical display of the data of the Gender*Group*Time interaction, which is displayed separately for the control (blue line) and the experimental groups (red line) and for the male and female participants. The experimental group appeared to stay fairly constant over time for males and females. The control group, however, tended to decrease and then increase for males, and followed the opposite pattern for the females. This interaction does not seem to have a clinical explanation, and might be unique to this specific sample.

In Table 8.8 the results of the ANOVA are presented for the main and interaction effects of scores obtained with the Incendiary communication subscale of the FPSC.

Table 8.8

Main and Interaction Effects (ANOVA) of the Incendiary Communication Subscale (FPSC Scale)

Fixed effect test	Num. DF	Den. DF	F	p
Gender	1	19	0.01175	.91482
Group	1	19	0.12232	.73038
Time	2	33	5.68702	.00755
Gender*Group	1	19	0.22499	.64067
Gender*Time	2	33	0.98949	.38253
Group*Time	2	33	0.27325	.76261
Gender*Group*Time	2	33	0.88694	.42150

According to Table 8.8, the interaction effects of Gender*Group*Time [$F_{(2, 33)} = 0.89$, $p = .42$], Gender*Time [$F_{(2, 33)} = 0.99$, $p = .38$] and Gender*Group [$F_{(1, 19)} = 0.22$, $p = .64$] did not reveal any statistically significant interactions. The main effects of Gender [$F_{(1, 19)} = 0.01$, $p = .91$] and Group [$F_{(1, 19)} = 0.12$, $p = .73$] also showed no statistically significant effects. The main effect of Time [$F_{(2, 33)} = 5.69$, $p < .00$] did reveal a statistically significant interaction and will be discussed below.

The non-statistically significant interaction effect of Group*Time [$F_{(2, 33)} = 0.27$, $p = .76$] indicates no differences between the experimental and wait-list control group over time after both had undergone the intervention programme. Figure 8.4 gives a visual representation of these findings.
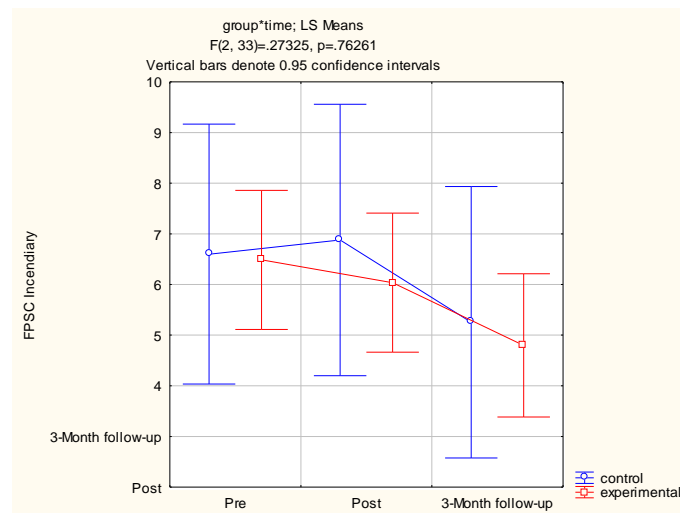
Figure 8.4. Distribution of the Group*Time interaction effect obtained from the incendiary communication subscale.

Figure 8.4 presents a graphical display of the Group*Time interaction, which is displayed separately for the control (blue line) and the experimental groups (red line). This interaction displays the average scores for the experimental and control groups at the pre-intervention, post-intervention and three-month follow-up assessments. The figure highlights the fact that the scores of both groups decreased and that no statistically significant difference was found between the groups at the three-month follow-up assessment. This means that the intervention programme had the same effect on both groups. Because the two groups did not differ statistically over time, the analysis could be expanded by exploring the two groups together and investigating Time as main effect.

The Group*Time findings are supported by Time as main effect (see Table 8.12), which revealed a statistically significant effect on the 1% level. This statistically significant trend supports the trend obtained with Analysis 1, by implying that a possible increase in sample size might have resulted in a statistically significant trend in Analysis 1. Analysis 2 revealed that the intervention programme impacted significantly on both groups from the pre-test to the three-month follow-up assessment regarding negative communication. However, this result was found without an

additional control group and is thus not conclusive in nature. Figure 8.5 highlights this statistically significant interaction.
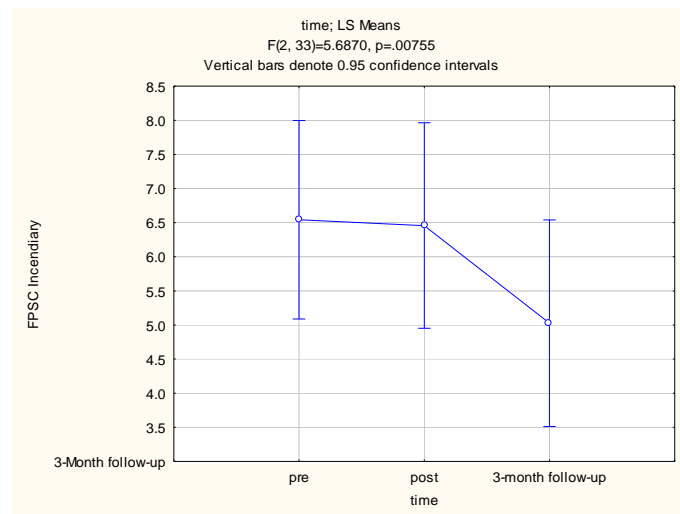
Figure 8.5. Distribution of the Time main effect for scores obtained with the incendiary communication subscale.

Figure 8.5 presents a graphical display of the data of Time as main effect. This displays the average joined scores of the experimental and wait-list control groups at the pre-intervention, post-intervention and three-month follow-up assessments. A statistically significant difference between pre-test and three-month follow-up assessment scores on incendiary communication for the joint group is illustrated. This statistically significant interaction supports the notion that the trend found in Analysis 1 might have been of statistical significance, on a 5% level, with a bigger sample size.

The post-hoc LSD analysis supports the above-mentioned finding. No statistically significant difference was found from pre- to post-testing (p = .86), which was expected, as the post-testing was done directly after the intervention programme. The programme focused on the long-term effect and a three-month follow-up assessment was conducted, for which a p-value of < .00 was found. This finding supports the statistically significant difference between pre-test and three-month follow-up assessment for the joined group on Time as main effect.

In summary, these ANOVA results point out that no statistically significant effect was found in terms of the Group*Time interaction, which means that the groups did not differ over time, and that the intervention programme therefore had the same effect on both groups. Time as main effect showed that the joined scores of both groups reduced significantly over time. Analysis 2 indicates that the intervention programme might have reduced the negative family communication patterns in both groups to a statistically significant extent. However, these results are seen as preliminary, as Analysis 2 was executed without a control group and only to further explore the findings of Analysis 1. It is thus not conclusive in nature regarding the impact of the intervention programme, but strongly suggests that an increased sample size might have revealed a statistically significant change in Analysis 1 regarding the decrease in incendiary communication.

Table 8.9 gives a layout of the ANOVA results and shows the main and interaction effects for scores obtained with the FPSC (total score).

Table 8.9

Main and Interaction Effects (ANOVA) for the FPSC scale (Total score)

Fixed effect test	Num. DF	Den. DF	F	P
Gender	1	19	0.04249	.83888
Group	1	19	0.17433	.68098
Time	2	33	3.67068	.03636
Gender*Group	1	19	0.43683	.51659
Gender*Time	2	33	0.02543	.97491
Group*Time	2	33	0.06787	.93452
Gender*Group*Time	2	33	1.82602	.17695

Table 8.9 shows that no statistically significant effects were found for the interaction effects Gender*Group*Time [$F_{(2, 33)} = 1.82$, $p = .18$], Gender*Time [$F_{(2, 33)} = 0.02$, $p = .97$] and Gender*Group [$F_{(1, 19)} = 0.44$, $p = .52$], or for the main effects of Gender [$F_{(1, 19)} = 0.04$, $p = $

.84] and Group [F (1, 19) = 0.17, p = .68]. Furthermore, Table 8.13 indicates a statistically insignificant interaction effect of Group*Time [F (2, 33) = .07, p = .93], which implies that no difference was found between the experimental and the wait-list control groups over time after both groups had been exposed to the intervention programme. Figure 8.6 gives a visual representation of the Group*Time interaction.
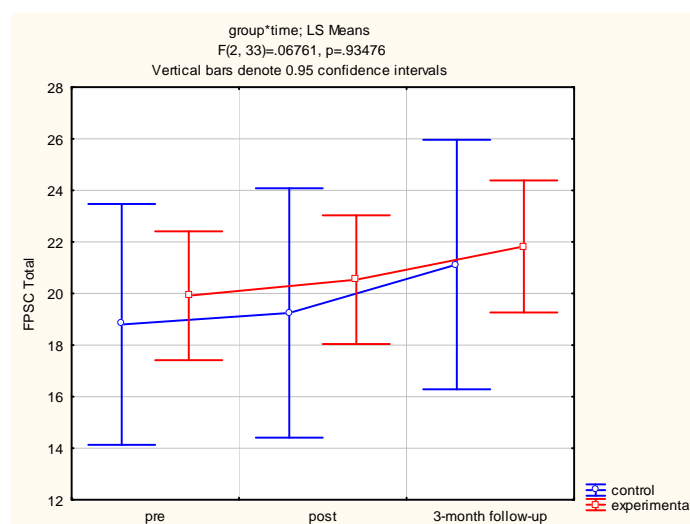
Figure 8.6. Distribution of the Group*Time interaction for scores obtained with the FPSC (total score).

Figure 8.6 presents a graphical display of the data of the Group*Time interaction, which is displayed separately for the control (blue line) and the experimental groups (red line). It displays the average scores of the experimental and control groups at the pre-intervention, post-intervention and three-month follow-up assessments. According to the graph there is a steady increase in scores from the pre- and post- to three-month follow-up assessments for both the experimental and the wait-list control groups. This figure highlights the fact that both group's scores increased over time and that no statistically significant difference was calculated between the groups. This means that the intervention programme had the same effect on problem solving and communication (FPSC) in both groups. Because the two groups did not differ over time, the

analysis could be expanded by exploring the two groups together and investigating Time as the main effect.

Time [F (2, 33) = 3.67, p = .03] as the main effect revealed a statistically significant effect on the 5% level. This indicates that the total score of the FPSC increased significantly for the joint group from the pre-assessment to the three-month follow-up assessment. Figure 8.7 gives a visual representation of this statistically significant interaction.

time; LS Means
F(2, 33)=3.6567, p=.03677
Vertical bars denote 0.95 confidence intervals
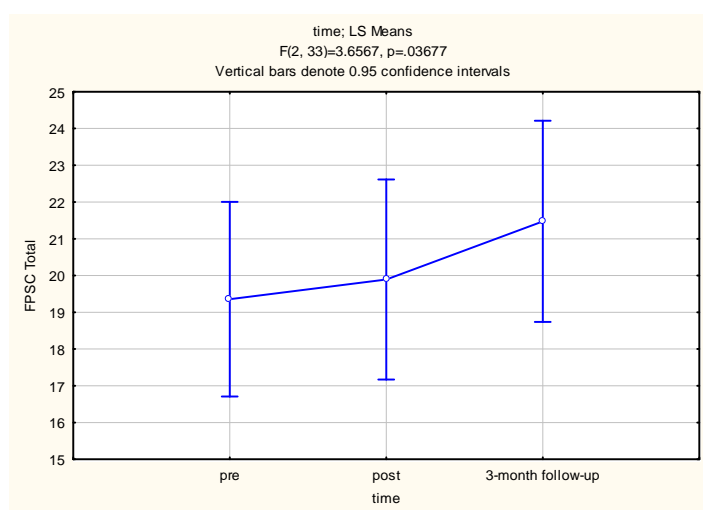
Figure 8.7. Distribution of the Time main effect for scores obtained with the FPSC (total score).

Figure 8.7 presents a graphical display of Time as main effect. This interaction displays the average joint scores of both the experimental and control groups at the pre-intervention, post-intervention and three-month follow-up assessments. Following the trend of the joint group's data, a statistically significant difference (increase) in scores between the post- and three-month follow-up assessments was found on a 5% level (p = .04).

A non-significant p-value of .51 indicates an insignificant change from the pre- to the post-test, but a statistically significant (p = .01) increase in the scores from the pre-test to the three-month follow-up assessment. This supports the notion that the joint group's scores improved in the three-month period after the intervention.

In summary, this ANOVA result indicates that no statistically significant interaction effect was found in terms of the Group*Time interaction, which means that the groups did not differ over time and that the intervention programme had the same effect on both groups. Time as main effect supported this interaction effect further and showed that the joint scores of both groups were reduced significantly over time. This means that the total scores of both groups on the total score of the FPSC scale (McCubbin et al., 1996) increased with statistical significance. This significant increase in the total score might only be reflective of the statistically significant difference found for the incendiary communication subscale, as no significant difference was found for the affirming communication subscale, and both these scores add up to the total score of the FPSC scale.

8.3.1.2.2 Results obtained with the Beck Depression Inventory (BDI-II)

Table 8.10 gives a layout of the ANOVA results, and the main and interaction effects of scores obtained with the BDI-II.

Table 8.10

Main and Interaction Effects (ANOVA) of Scores Obtained with the BDI-II

Fixed effect test	Num. DF	Den. DF	F	p
Group	1	18	0.33164	.57224
Time	1	18	0.01654	.89919
Group*Time	1	18	1.36638	.25857

In Table 8.10 the ANOVA results are shown for the total scores of the BDI-II. No statistically significant effects were found for either the interaction effect of Group1*Time [F (1, 18) = 1.37, p = .26] or the main effects of Group 1 [F (1, 18) = 0.33, p = .57) or Time [F (1, 18) = 0.01, p = .99]. This means that no statistically significant change regarding the depression rates (BDI-II) occurred over time for the joint group. For the joint group a mean score of 17.40 (SD = 3.57)

was obtained at the pre-test and 17.14 (SD = 3.68) at the three-month follow-up test. Thus, on average over time, the identified patients scored in the mildly depressed range.

The subsequent section reports on the qualitative results of Phase 2 of the research.

8.3.2 Qualitative Results

The qualitative data comprised two sets of data. Firstly, each participant completed six open-ended questions directly after the intervention programme. Secondly, each participant had to complete two open-ended questions that were posed at the three-month follow-up assessment. The grounded theory analysis method was used to categorise the qualitative data obtained from the open-ended questions (Glaser & Strauss, 1967).

8.3.2.1 Post-testing

Table 8.11 provides a summary of the specific categories, frequencies and percentages found for each question posed to the participants immediately after the intervention programme.

Table 8.11

Post-intervention Assessment: Categories, Frequencies and Percentages of Participants that

Responded in each Category (n = 42)

Categories	Frequencies	Percentages
1. How did you experience the workshop?		
(a) Workshop experience	38	90
Positive experience		
(i.e., constructive, profitable, beneficial)		
Personal growth experience	5	21
(i.e., learning new concepts)		
Couple growth experience	5	13
(b) Workshop		
Constructive workshop style	21	50
Group format constructive	15	36
(c) Workshop suggestions		
More workshops	4	10
Time: Too long	1	2
2. How might it have been different?		
(a) Satisfied with workshop	25	60
(c) Practical suggestions	14	33
(i.e., more group discussions, follow-up sessions)		
(b) Group format constructive	10	24
3. What did you learn about yourself, your family or life in general?		
(a) Personal growth	31	74
(i.e., problem solving, communication)		
(b) Family	18	43
(i.e., family management and functioning)		
(c) Normalisation	13	31
(i.e., not the only family with problems)		
(d) Life	1	2

(table continues)

Table 8.11 (continued)

Post-intervention Assessment: Categories, Frequencies and Percentages of Participants that

Responded in each Category (n = 42)

Categories	Frequencies	Percentages
4. Will you be able to apply what you have learned?		
(a) Workshop applicable	42	100
5. How could you remember the topics we have discussed in the workshop?		
(a) Remember specifics (i.e., I-feel, Chinese symbol)	23	55
(b) Workbook	17	40
(c) Remember and remind their partners	9	21
(d) Spend time together as a couple	2	5
(e) None	1	2
6. Any suggestions for future workshop about the information, the format of the workshop or the exercises?		
(a) Satisfied (i.e., successful, well organised, applicable)	30	71
(b) Content suggestions (i.e., more couple-interaction, role-play opportunity)	10	24
(c) Time and length (i.e., shorter, presented over two days)	6	14
(d) Material (i.e., copies of material facilitator presented)	2	5
7. Suggestions to the facilitator?		
(a) Satisfied (i.e., good listening skills and made people feel at ease)	32	76
(b) Follow-up suggestions (i.e., couple sessions, involve teens)	9	21
(c) Content suggestions (i.e., background music, read less, show with pointed)	3	7

Table 8.11 reveals that the majority of the participants (90%) experienced the workshop as a constructive, profitable, beneficial and enriching educational experience, while 21% also experienced it as an added personal growth experience by learning new concepts regarding communication (i.e., active listener, I-feel sentences) and 13% regarded it as a couple growth experience. Half (50%) of the participants commented on finding the workshop style constructive, and 36% mentioned that the group format was constructive.

Responses to the second question show that 60% of the participants were satisfied with the workshop and did not feel that anything should change. It was further found that 24% of the participants experienced the group format of the workshop as beneficial and constructive. Practical suggestions were made by 33% of the participants. Some of the participants mentioned that the workshop should run over a longer period of time to allow more time for in-depth group discussions regarding the material. Follow-up sessions, including children and encouraging other racial groups to attend were some of the suggestions.

The third question revealed that 74% of the participants experienced the workshop as a personal growth experience regarding problem solving, communication and self-development. Also, 43% of the participants mentioned that the workshop assisted on with a learning curve regarding family management and functioning (i.e., family time, rules, boundaries, discipline). A third (31%) of the participants indicated that the workshop experience assisted them in normalising their own family problems in comparison to other families' problems.

All (100%) the participants responded positively to the fourth question by indicating that they found the workshop applicable to their situation.

In response to the fifth question, 55% of the participants said that they would remember the detail of the workshop by remembering specifics, like the Chinese symbol for listening and I-feel sentences. A further 40% indicated that the workbook and the notes they made would assist them

for future reference. About a fifth (21%) of the participants mentioned that they would remember the group discussions and by reminding their partner about the workshop material. These participants further indicated that they would share their experience with other people in an attempt to remember the experience and material.

Question six revealed that most (71%) of the participants were satisfied with the workshop and commented on the fact that they felt it was successful, well organised and applicable for small groups. However, 23% of the participants gave constructive content feedback by suggesting more couple interaction and couple-focused work, as well as more role-play opportunities, video material and activities. Some (14%) suggested that the workshop should be shorter or be presented over a two-day period. It was also mentioned that more attention should be given to equal speaking time for the participants.

Regarding the seventh question, it was clear that most (76%) of the participants were satisfied with the facilitator's style. They mentioned that they felt inspired by the facilitator and that the facilitator exhibited good listening skills and made people feel at ease. About a fifth (21%) of the participants also mentioned the need for follow-up sessions (i.e., couple sessions, involving teens and presenting workshops to others).

In summary, the post-assessment qualitative data reveals that the participants in general regarded the workshop as a very positive experience. A few practical suggestions were made, which could benefit future planning and repetition, especially regarding the time frame of the study. It might be an option to spread the workshop over two days in order to assist with consolidation of the material, and to allow for more group discussion.

The following section addresses the categories and frequencies found in the qualitative data obtained from the three-month follow-up assessment.

8.3.3.1 Three-month Follow-up Assessment

Table 8.12 presents the categories, frequencies and percentages found in response to the open-ended questions posed to the participants at the three-month follow-up assessment meeting.

Table 8.12

Three-month Follow-up Assessment: Categories and Percentages found from Open-Ended Questions (n = 36)

Category		Frequencies	Percentages
1. Did the FCW impact on the communication in your family?			
(a) Impact:	Yes	29	81
	Short Term	6	17
	No	1	3
(b) Improvement:	Communication skills	26	72
	Problem solving	11	31
	Family functioning	9	25
	(i.e., family time, humour)		
	Personal growth	3	8
	Obstacles	1	3
2. Did the workshop contribute to improving your family functioning?			
(a) Impact:	Yes	27	75
	No	4	11
	Always been good	3	8
	Short term	2	6
(b) Improvement:	Family skills	16	44
	(i.e., shared decision making)		
	Family cohesion	12	33
	(i.e., relationships improved)		
	Family structure	10	28
	(i.e., spend more time together)		
	Normalising family processes	5	13
(c) Obstacles for change:	Hazards	6	17

According to the results of the three-month follow-up data, 81% of the participants felt that the workshop impacted positively on their family's communication, while 17% felt that the results were short term. Only one participant felt that it did not impact on his/her family communication. Furthermore, 72% of the participants mentioned that the communication skills in their family improved. Some of the aspects they mentioned were better communication and listening skills, more openness, honesty and respect, and being more aware and understanding of each other's feelings. A further 31% of the families indicated that their familial problem solving improved in terms of having more discussions, improved decision making, improved emotional regulation during difficult times, less conflict and normalising conflict. A quarter (25%) of the participants responded to this question by saying that their family functioning improved due to better communication. Improved familial relationships were mentioned, with an increase in family time, humour, rituals and boundary setting. More emphasis was placed on creating a family culture of resolving issues and raising awareness by including children. One (3%) of the obstacles for change was that 'life is hectic' and this hampered change.

The majority (75%) of the participants felt that the workshop contributed positively to their general family functioning, while 11% felt that their family functioning had not improved and 6% said that the improvement was short term. Another 8% mentioned that they felt that their family functioning was always of a high standard. It was found that 44% of the participants mentioned that their family skills had improved by incorporating discussion regarding problems, shared decision making, better family communication, less conflict and implementing tools to cope with difficulties. Family cohesiveness improved for 33% of the families through better relationships, being more accommodating and incorporating humour. Discussion of family 'highs' and 'lows' was also mentioned, and this provided a sense of togetherness. Furthermore, 28% of the participants mentioned that they noticed structural improvement in their families (i.e., spending more time together, clearer functioning, sharing the workload and having meals together). However, 17% of the families indicated a few hazards for change, namely little time

together as a family, commitment issues, life being difficult, partner denial and the fact that the children did not attend the workshop.

In summary: the qualitative data of the three-month follow-up assessment revealed that 81% of the participants felt that the workshop impacted positively on their family's communication, while 75% of the participants mentioned that the workshop contributed positively to their general family functioning. Thus, in general, the participants revealed that the programme had a positive long-term effect on family communication and family functioning. The following section concentrates on the discussion and integration of the biographical, quantitative and qualitative results of the intervention phase.

8.4 Integration of Findings

Despite a comprehensive literature search it was found that limited research has been done on the evaluation of a family communication intervention programme, especially within the family resilience paradigm. This might be due to the fact that family psycho-education programmes are not readily evaluated because they are not easy to implement, are not always compatible with the theoretical training of clinicians, and are intricate and highly time consuming in terms of organising (Brent & Giuliano, 2007). However, interesting research exists regarding couple communication, which will be discussed.

According to the biographical data, the identified patients and the spouses had a mean age of 42 and 43 years respectively, and the majority of the couples (86%) were married for the first time, with a mean length of marriage of 17 years. The majority of these couples had two children, with the mean age of the first child being 16, while the mean age of the second child was 12 (see Chapter 5 for a more detailed discussion). However, it is important to cite that the life cycle stage of the participating families was families with teenagers and young adults (McCubbin & McCubbin., 1988; Olson et al., 1985). This family life stage is multifaceted in the sense that the parents are in their middle adulthood, while the children are experiencing adolescence.

The biographical data on the depression status of the identified patients revealed that the majority of the identified patients (86%) were female and 14% were male, which is in keeping with general male versus female depression rates (American Psychiatric Association, 2002; Kaplan & Sadock., 1998). The identified patients had been living with depression between one to two years (23%), three to five years (27%), six to ten years (18%) and more than ten years (27%) previously, while only 5% had been living with depression for less than a year. This suggests that most of these families had been dealing with depression in the family set-up for some time.

Mead (2002) suggests that depression, like any marital distress, needs to be considered as a chronic source of stress. Gender is viewed as a possible moderating factor (Gordon, Baucom, Epstein, Burnett & Rankin, 1999; Heene, Buysse & Van Oost, 2007; Mead, 2002). This might especially be a mediating factor in the current research population, in which 86% of the females had been living with MDE. The review of Mead (2002) suggests that marital distress affects both spouses, but may have a greater impact on women. Heene et al. (2007) also found that depressed females reported significantly lower levels of marital adjustment compared with males. It seems reasonable to argue that depression precipitates the marital distress cycle, which in this population might have a greater impact on the women (Mead, 2002; Heene et al., 2007). For this reason, possible gender differences were explored between the intervention group and the wait-list control group during Analyses 1 and 2.

Analysis 1 revealed a trend suggesting that negative communication in these families reduced after a three-month period, although not on a 5% significance level (see Table 8.8). Analysis 2 was conducted in an attempt to explore this trend with a bigger sample size by presenting the intervention programme to the wait-list control group. Analysis 2 (see Table 8.12) supported this trend found in Analysis 1, with a statistically significant difference between the pre-test and three-month follow-up test. This suggests that a bigger sample size might have resulted in a statistically significant finding in Analysis 1. Another important finding is that affirming communication did not improve significantly over time, as shown by both Analyses 1 and 2 (see

Tables 8.7 and 8.11). This is worth noting and might have to do with the specific sample of families, with one parent suffering from depression. This will be discussed in the following section.

The statistically significant Time*Group effect for family problem solving and communication (FPSC total score) in Analysis 2 (see Figure 8.6) might only be reflecting the decrease in negative communication (see Figure 8.5). This indicates that family problem solving and communication might not have shifted, despite the statistically significant effect found (see Figure 8.6).

Analysis 1 revealed that the depression experienced by the identified patients decreased significantly for both the wait-list control group and the experimental group (see Table 8.10). However, the depression levels were still within the mild to moderate range, which suggests that the impact of the depression in these families should not be underestimated. It is worth noting that the level of depression decreased in both the wait-list control group and the experimental group, without the wait-list control group undergoing the intervention programme. A possible explanation for this is the Hawthorne effect (Merret, 2006), suggesting that the attention they received might have had an impact on the identified patients' perceived depression rates.

The quantitative evaluation of the impact of the intervention programme did not reveal an overall change in communication in the families, as discussed above, but suggested a strong tendency towards a decrease in negative communication. However, according to the post-test qualitative data analysis, 90% of the participants experienced the workshop as a positive contribution to their family's communication. All the participants felt that the workshop was relevant and applicable. At the three-month follow-up assessment, 81% of the participants mentioned that the intervention programme had had a positive impact on their family's communication, and 75% felt that it also improved their family's functioning over the three-month period. These findings

are supported by previous research, especially regarding the communication of the couple (see next section for details).

Although no specific gender differences were found in this study, previous studies have found that especially the mood of mothers may have an influence on family communication. The majority of the identified patients were females and, over time, their depression levels decreased to a mild to moderate range. This is still moderately high and the impact of the parent's depression in these families should be considered. Mead (2002) says that it is possible that living with a depressed wife means that the communication patterns of these couples tend to be more negative. This complicated negative communication pattern, which appears to be mediated by the gender of the depressed spouse, might have impacted on the results of the current study (Mead, 2002). This finding is further endorsed by the study of Heene et al. (2007), in which it was found that depressed women and their partners reported more destructive ways of conflict communication than control couples. Renick, Blumberg and Markham (1992) have indicated that the long-term effect (18 months) of a prevention and relationship enhancement programme includes that the couples engage in lower levels of negative communication, which corresponds with the findings of the current study. In addition, Gardner and Wampler (2008) argue that negative affect (i.e., disgust and contempt) in a relationship strongly correlates with marital dissatisfaction and dissolution. Once a couple becomes trapped in the state of negative affectivity, it becomes very difficult to exit that state. Negative affectivity forms the basis of negative communication, which seems to have shifted for the current research group after it had been exposed to the intervention programme. The findings of these studies provide a possible reason for the reduction in negative communication in this study. Due to the longstanding impact of depression in these families, the real respite needed in terms of family communication might have been to decrease negative communication. This might have impacted on the unchanged affirming communication results in this study.

Other factors that might have impacted on the results of the intervention programme were commitment of the parental couple or ambivalence levels regarding the importance of communication in these families. Effective communication is generally related to marital adjustment (Gordon et al., 1999; Stanley, Markman & Whitton, 2002). However, the awareness and expectation levels of couples regarding marital adjustment relate significantly to motivation levels in terms of improving marital relationships (Gordon et al., 1999). Gordon et al. (1999) found that, because women present with greater relationship awareness, they are more likely to be attuned to the discrepancies in their relationship. On the other hand, it was found that men tend to be less attuned to these discrepancies, which might create a lower level of investment for men in terms of communication. These findings suggest that a central focus of improving communication in families may not be entirely effective, because different levels of commitment, awareness and ambivalence might hamper the motivation to work on communication. This suggests that different commitment and awareness levels might have existed in the current research, which might have impacted on the outcomes. However, the results of the prevention and relationship enhancement programme of Renick et al. (1992) revealed that gender differences appeared especially regarding commitment to the relationship. It seems likely that males who choose to participate in intervention programmes might be more dedicated to working on their relationship. This might support the hypothesis that the men who completed the intervention programme of the current study were motivated and had high commitment levels regarding effective communication in their families, even before attending the intervention programme.

Another factor to consider is the fact that this intervention programme was a once-off workshop without follow-up sessions. According to the literature, a gender difference seems to exist regarding the need for follow-up sessions. Renick et al. (1992) found that females pointed to the need for regular follow-up sessions, while males did not exhibit this need, which indicates that males might respond better than females in the long run to the structure of skills training and

once-off workshops. Despite the possible gender differences, the need for skill consolidation and follow-up sessions became clear through the qualitative data analysis. Although most of the participants (71%) were satisfied with the workshop, 23% gave constructive feedback by suggesting more couple interaction and couple-focused work, as well as more role-play opportunities, video material and activities. Some (14%) suggested that the workshop should be shorter and be presented over two days. More attention to equal speaking time for the participants was also mentioned. A fifth (21%) of the participants suggested follow-up sessions.

Stanley et al. (2002) also mentioned a gender difference regarding divorce rates. They suggest that male-initiated divorce rates are strongly associated with negative interaction in the marriage, while female-initiated divorce rates are related to lower positive connection in the marriage. The fact that the current intervention programme lowered the negative interaction in these families might control for male partners initiating a divorce (Stanley et al., 2002). In addition, the intervention programme created the opportunity for positive connection in the relationship, which in turn might assist in controlling for divorce rates from a female perspective.

The studies of Rhoades and Stocker (2006) and Butler and Wampler (1999) revealed two interesting factors to take into consideration regarding the outcome of the evaluation of this intervention programme. Firstly, Rhoades and Stocker (2006) found that males and females rated each other's communication as highly similar to their own, which suggest that individuals may project their own communication style onto their partners. This factor might have impacted on the current study, as the participants had to rate their family's communication pattern and might have projected their own communication patterns. Butler and Wampler (1999) reasoned that intervention programmes regarding communication might be influenced by a couple's sceptical 'wait and see' stance regarding the durability and permanency of the improved communication patterns. This might provide a possible answer for the fact that the intervention programme did not impact statistically significantly on communication as a whole in these families, as reflected by the total score of the FPSC Scale (McCubbin et al., 1996).

The merging and integration of previous research with the current research findings firstly sheds light on the findings and, secondly, presents several factors that may have influenced the current findings. A few factors were considered in understanding the findings, namely the impact of ongoing high depression rates in a family, negative communication associated with this study population, gender difference regarding communication, marital satisfaction, commitment and ambivalence and the time frame of intervention programmes.

8.5 Conclusion

Chapter 8 commenced with a review of the aims of the intervention phase. The research results, namely the biographical, qualitative and quantitative findings, were outlined. In summary, Analysis 1 revealed a trend suggesting that negative communication decreased in these families after the intervention programme, although not on a 5% significance level. Analysis 2 supported this trend, with a statistically significant difference between the pre-test and three-month follow-up test. Nevertheless, this finding is not conclusive, as Analysis 2 was explorative in nature and an additional control group was not employed to consolidate this result. Furthermore, the intervention programme did not have a statistically significant effect on positive, affirmative communication. In the second half of this chapter, the results were discussed and integrated with existing research. Despite the small sample size, which might have impacted on the final outcome of the study, the existing literature also reveals certain factors that should be considered in understanding the outcome of the research. Thee factors that might have had an influence on and could help us to understand the findings are the impact of the ongoing depression rates of a parent in the families, negative communication patterns, gender differences regarding communication, marital satisfaction, commitment and ambivalence and the fact that the intervention programme was a once-off event without follow-up sessions.

The following chapter presents conclusions, a critical review of this research and recommendations.

CHAPTER 9

CONCLUSIONS, CRITICAL REVIEW AND RECOMMENDATIONS

9.1 Chapter Preview

This final chapter focuses on the conclusions, critical review and recommendations of the current study. The chapter commences with a review of the aims addressed in Phases 1 (Description phase) and 2 (Intervention phase) of the research. General conclusions in terms of research findings are linked to the aims and objectives of the study. The research contributions made by the current study within the South African context are discussed. The final two subsections firstly give a critical review of the challenging aspects and limitations of the study, and secondly address recommendations drawn from the current research for future research directions.

9.2 Research Questions and Findings Revisited

The research was divided into two phases, namely the Descriptive phase (Phase 1) and the Intervention phase (Phase 2). The next section revisits the research questions and findings of the current study.

The first research question was: 'Which qualities of resilience are present in families in which a parent has been living with depression?' The methodology of the descriptive phase addressed this aim. The results of the descriptive phase revealed various population-specific correlations between the independent variables and the dependent variable, family adaptation, as measured by The Family Attachment Changeability Index 8 (FACI8) (McCubbin et al., 1996). The strongest statistically significant correlation was found between family problem solving and communication (FPSC, McCubbin et al., 1996) and family adaptation (FACI8, McCubbin et al., 1996). Both the correlation and regression analyses of the quantitative results indicated that family problem solving and communication was a significant predictor of family resilience for the current population. The qualitative data also supported this finding. These findings steered the development of the intervention programme, aimed at enhancing family problem solving and

communication in order to enhance family resilience, namely a Family Communication Workshop.

The second research question was: 'What should an intervention programme entail that has been designed to enhance a certain identified quality of resilience in families in which a parent has been living with depression?' The first step of the intervention phase addressed this question by developing a family intervention programme, namely The Family Communication Workshop. The intervention programme was developed by integrating three theoretical underpinnings, namely family resilience, psycho-education and adult education. These theories were integrated and Caffarella's (2002) 12-step interactive model was used to guide the programme development, implementation and evaluation.

The third research question was: 'Does the designed intervention programme succeed in reaching its objective, namely to develop a certain identified quality of resilience in families in which a parent has been living with depression?' The second part of the intervention phase addressed this question by evaluating the intervention programme by way of an experimental design (pre-test/post-test (wait-list) control group design). Analysis 1 revealed a trend (not statistically significant on a 5% level) suggesting that negative communication, as measured by the incendiary communication subscale (FPSC), reduced over a three-month period after the intervention programme. This trend was supported by a statistically significant difference in Analysis 2. However, this finding is not conclusive, as an additional control group was not used for Analysis 2. It suggests, however, that a bigger sample size might have been conclusive in nature regarding this finding. The intervention programme did not have a statistically significant effect on positive affirming communication over a three-month period. The qualitative data of both the post-test and three-month follow-up assessment supported the notion that the programme was successful in achieving its aim. The post-test data of the participants revealed that they perceived the programme in a very positive light – as a beneficial and educational experience. The three-month follow-up assessment revealed that 81% of the participants felt that

the programme impacted positively on their family's communication, and 75% of the participants also stated that the programme contributed positively to their general family functioning.

9.3 Conclusions

The value and unique contributions of the present study are discussed in the following section.

The study contributed to the body of emerging research that prefers a focus on the promotion and study of health as opposed to a focus on illness only. The study and exploration of family resilience factors form the basis of current studies done in the field of family resilience.

In the current study the researcher chose a triangular research design by incorporating qualitative and quantitative data collection in order to allow for rich and comparable research findings. Firstly, the research project investigated the resilience factors associated with families in which a parent has been living with depression and, secondly, it developed, implemented and evaluated an intervention programme aimed at enhancing a specific resilience factor. The decision was rooted in evidence generated from a literature survey in which it was found that there was limited prior research exploring these families from a resilience point of view. The high-risk factors associated with these families also suggested that continuous research and intervention programmes are vital in order to strengthen these families at risk. This study contributed to the already existing body of knowledge regarding family resilience. It specifically broadened the knowledge with regard to family resilience in families with a parent that has been living with depression. No previous studies have investigated resilience qualities for this specific population of families, or developed a programme in an attempt to enhance a specific resilience factor in this population.

A significant contribution of this study is the fact that family problem-solving communication stood out as a statistically significant contributor to family adaptation in these families. This clear indication allowed for the development of a specific intervention programme in an attempt

to enhance this quality. This aim and the development, implementation and evaluation of the intervention programme are unique and opened up a specific research area to be explored in future studies.

Numerous new focuses were introduced in this study. Firstly, the programme was developed to focus on the couple as the core group in these families. This decision was supported by practical consideration and the experimental design employed in the study. Practically it made more sense to focus on the core of the family instead of on the entire family. This minimised internal and external validity issues. Secondly, the reason for choosing a one-day workshop instead of a longer intervention was fuelled by the fact that resources are often limited in South Africa and people's motivation levels might waver if they have to attend a workshop that kept them from work for numerous days. Thirdly, a further consideration was that there is limited previous research on shorter term interventions in the resilience field. Despite the possible limitations associated with a short-term intervention, the once-off pre-test post-test design allowed the researcher to follow the participants over a three-month period to evaluate the impact of the one-day workshop.

Another unique characteristic of the research was the nature of the experimental design, in which the participants were randomly allocated to an experimental and a control group. The present study was conducted in such a way that the wait-list control group received the intervention during the course of the study, allowing the treatment outcomes of the intervention group and wait-list control group to be compared.

In essence, the present study was an attempt to address the need for an intervention programme that could strengthen families living with a member with a psychiatric disorder. It further empirically explored the effectiveness of the programme by means of an experimental design with longitudinal characteristics in order to assess participants over time. According to the qualitative results, the intervention programme appeared to have had a positive impact, although

not conclusive in nature, on the families who participated, especially regarding the reduction of negative communication. Quantitatively, a trend was also found (although not statistically conclusive) specifically regarding the reduction of negative communication. This addressed the question whether shorter term interventions are beneficial over time. In order to ensure ongoing research in this field, the intervention programme was designed in the format of a step-by-step facilitator's manual, a participant's workbook and a PowerPoint presentation. This will assist future interventions, and with the replication and implementation of the programme.

9.4 Critical Review

The following sections address the challenging aspects as well as the limitations of the research.

9.4.1 Challenging Aspects

There were specific challenges that had to be overcome in the Descriptive phase and the Intervention phase of the research project. Firstly, the main challenge of the Descriptive phase was to recruit families for the research project. In order to adhere to ethical considerations, the recruitment procedure involved various other professionals, who had to refer families who met the inclusion criteria. This process was time consuming and the researcher had to continuously remind her colleagues of the inclusion criteria and motivate them to refer families. It was found that the families did not respond readily to flyers and posters, which suggested that personal contact in terms of referrals to the research project was crucial. In addition, strenuous ethical procedures (telephonic follow-ups and information letter, as described in Chapter 4) were followed in terms of contacting the participants and allowing them to make an informed decision regarding their participation in the research. The completion of the questionnaires in the descriptive phase involved three members of the family. This went hand in hand with numerous practical arrangements regarding each member's schedule in order to arrange a contact session. This was a labour-intensive process, as all the recruitment and contact sessions with the families were done by the researcher to limit extraneous factors that might have influenced the research results.

Secondly, one of the main challenges with regard to the intervention phase was to compile a one-day intervention programme. Due to limited, mostly not applicable, previous intervention programmes associated with family resilience, the researcher had to use and integrate various theoretical approaches in order to design a one-day workshop. Another important methodological challenge was that some of the participants did not attend the intervention programme, which had a major impact on the sample size, especially of the control group. This was unfortunate, but ethically it was important to allow the participants to withdraw at any stage of the research project. It appeared that the main reason for withdrawal was work commitments.

9.4.2 Limitations

Some potential limitations of the study are addressed in this section. Firstly, a methodological shortcoming was that a non-probability purposive sampling technique was employed. The limitations of this sampling procedure are that external validity might be limited and the results might not be representative of the general population. There might also be significant differences between the individuals who volunteered to participate in the research study and those who chose not to. This might have had a specific impact on the participants who enrolled for the intervention programme, as their motivation might have been higher than those who did not want to participate. Motivation levels might have an influence on the research results.

Secondly, in conjunction with the first limitation, the sample obtained was not representative of all families in South Africa, because the study was conducted at only one specific military hospital. The non-probability nature of the sample essentially means that the results cannot be generalised to the general population of families in which a parent has been living with depression. Thus, the findings and conclusions of this study are preliminary and should be duplicated in other settings to allow for representative findings.

Thirdly, the researcher continuously aimed at increasing the sample size but, due to a limited population and time constraints, the sample sizes of the descriptive and intervention phase are

not optimal. However, despite the small sample size, the study still revealed reliable and statistically significant results, which could be build upon in future research.

Fourthly, during the Descriptive phase there was a difference in procedure, as some of the family members could not attend the initial family sessions and were either seen individually or had to complete the questionnaires at home in order to increase the sample size. A deviation in procedure was also necessitated in the Intervention phase, when some of the participants could not attend the three-month follow-up group assessment and individual arrangements were made with them, either by faxing the questionnaires to them or arranging an alternative contact session.

9.5 Recommendations

It is recommended that, apart from taking into consideration and improving on the limitations of the present study, further research in this regard should also take the following into account. Firstly, the current study was directed at a very distinct sample of military families, mainly from a middle socio-economic background, thus the generalisation of the findings to families from a lower socio-economic background remains limited. Therefore, to be able to generalise the findings, research should be directed at samples from families who are more representative of the broader South African context, including high-risk communities.

Secondly, the main finding regarding the evaluation of the intervention programme was that a trend was found suggesting that the intervention programme possible reduced negative communication in these families. This trend is not conclusive and replication of the research could assist with refining this finding and optimising knowledge and understanding of family communication in these families. If this finding could be investigated further using larger samples of families, significant contributions could be made to the research on family resilience in families in which a parent has been living with depression. It is strongly suggested that a control group be utilised in all areas of analysis in order to compare the groups effectively.

9.6 Conclusion

The final chapter addressed the conclusions, critical review and recommendations of to the current study. The main contribution of this research is that it took the identification and description of specific family resilience qualities of a specific sample a step further, by developing, implementing and evaluating an intervention programme. In the second phase of the research, the recommendations of previous studies were implemented in the design, implementation and evaluation of an intervention programme in order to address family problem solving and communication. The main findings of the current research were, firstly, that family problem solving and communication correlates in a statistically significant way with family adaptation in families in which a parent has been living with depression and, secondly, that negative communication reduced (not statistically significant on a 5% level) after the intervention programme, measured over a three-month period. Replication of the research could assist with the consolidation of this finding.

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ADDENDUM A

ADVERTISEMENT

OPPORTUNITY TO PARTICIPATE

• WHAT: •
a DOCTORAL study in psychology at the University of Stellenbosch.

• ABOUT: •
the study focuses on family resilience – families' strengths and coping skills in difficult times. We are interested in how your family copes in difficult times.

• REASON: •
improve resilience in families with one parent diagnosed with Depression.

• HOW: •
we will compile a parental training programme aiming to improve coping skills.

• POSSIBLE BENEFIT: •
participation in the new programme which aims to teach coping skills and to increase family's strengths.

• TO PARTICIPATE: •
Does your family have the following CHARACTERISTICS?
- One parent/partner receives treatment for Depression at 2 Military Hospital.
- You have a teenage child (10-18 yrs) living at home.

FOR MORE INFORMATION:

Contact the researcher, **Carin Bester** at:

021-7996324

or

For the researcher to contact you:

Leave your name and contact number in the box AT PSYCHOLOGY reception

2nd Floor
Psychology Department
2 Military Hospital

ADDENDUM B

INFORMATION LETTER

INFORMATION LETTER

Dear Family,

Thank you very much for your time. We would like to invite you to participate in a research project.

The aim of the project is to explore and describe family resilience in families where one parent has been living with Major Depressive Disorder. Family resilience is about strengths and coping skills families use in difficult times.

Your family meets the criteria for participating in the project and we believe that we will learn a lot from your family. We are particularly interested in your coping skills as a family in difficult times. In the following section you will find an outline of the proposed procedures of the project.

1. We will contact you to set a time to meet at your nearest sickbay/hospital to complete the questionnaires and for you to personally meet me and enjoy a cup of tea. Included you will also find a letter which you can present at your workplace as confirmation that you are participating in a valid medical research project.

2. It is requested that both parents as well as an adolescent of the family attends this meeting, as telephonically discussed with you.

3. You will be requested to complete a few questionnaires during this first contact session. The questionnaires will approximately take 60 minutes to complete.

4. Thereafter, the data will be used to develop a parental programme. This programme will focus on enhancing parental family skills, which parents can use at difficult times. Please discuss as a parental couple your interest in the programme as one of you will have the opportunity to indicate your interest on the Biographical Questionnaire.

5. If you meet the criteria for participating in the programme you will be contacted. The same programme will be repeated twice and we will indicate to you whether you will participate in the first or second programme.

6. If you decide to participate in the programme you will be contacted to complete some questionnaires in order to determine the effectiveness of the programme.

These procedures will again be discussed with you at the first meeting. Should you have any questions you will have the opportunity to raise them to the researcher at the first encounter.

Participating in this study is voluntary, and you have the right to withdraw at any time without prejudice. All information will be treated as confidential and anonymous.

Thank you for your co-operation.

Yours sincerely,

Ms C. Bester   Prof. A.P. Greeff
(Researcher)   (Promoter: Department of Psychology: US)
(021-7996324)

ADDENDUM C

LETTER AS EVIDENCE FOR THE WORKPLACE

LETTER AS EVIDENCE FOR THE WORKPLACE

Hereby we would like to confirm that -- is taking part in

a medical research project at a Military Health Service Centre on ------------------------------.

You are welcome to contact the researcher should there be any questions.

With kind regards,

Ms C. Bester   Prof. A.P. Greeff

(Researcher)   (Promoter: Department of Psychology: US)

(021-7996324)

BRIEF AS BEWYS AAN DIE WERKSPLEK

Hiermee wil ons graag bevestig dat --deelneem

aan 'n mediese navorsingsprojek by 'n Militêre Gesondheidsdienssentrum op --------------------.

U is welkom om die navorser te kontak indien daar enige vrae is.

Met vriendelike groete,

Me C. Bester   Prof A.P. Greeff

(Navorser)   (Promotor: Departement Sielkunde: US)

(021-7996324)

ADDENDUM D

CONSENT FORM

CONSENT FORM

The study is conducted for the completion of a doctoral degree in psychology at the University of Stellenbosch. The aim of the project is to explore, describe and enhance family resilience in families where one parent has been living with Major Depressive Disorder. Your family meets the criteria for participating in the project and we believe that we will learn a lot from your family. We are particularly interested in your coping skills as a family in difficult times. Family resilience is about strengths and coping skills families use in difficult times. Patients of the psychology and psychiatry department of the military hospital are involved in the study. The aim is to complete the first part of the research in which you will participate in 2006. In the following section you will find an outline of the proposed procedure of the project:

1. At this meeting you will be requested to complete a few questionnaires. The questionnaires will take approximately 60 minutes to complete.

2. Thereafter, the data will be used to develop a parental programme. The exact structure of the programme will be decided upon after the interpretation of the statistics from the completed questionnaires. However, it is anticipated that the programme will be in a workshop format with approximately two contact sessions. This programme will focus on enhancing family skills that parents can use in difficult times. Our sessions will be recorded, as this will help us to remember exactly what was said in the sessions. Please discuss as parental couple your interest in this programme, as one of you will have the opportunity to indicate your interest to participate in it on the Biographical Questionnaire.

3. If you meet the criteria for participating in the programme you will be contacted. The same programme will be repeated twice and we will indicate to you whether you will participate in the first or second programme. If you indicated that you wanted to partake in the programme but were not included in the initial rollout of the programme, you will be contacted to partake in the second rollout.

4. If you decide to participate in the programme you will be contacted to complete questionnaires in order to determine the effectiveness of the programme.

Participating in the research provides you with the opportunity to possibly participate in the parental programme that will aim to enhance parental family skills. The results of this study will also be used to contribute to knowledge on family resilience. No overt risks or discomfort are foreseen for participation in the study. All the information obtained during this study will remain confidential, to be used as data only. No one individual's data will be released to any party. Participation is voluntary and you will not be compensated beyond receiving refreshments at meetings and enjoy the added benefit of participation in the parental intervention programme.

You will also receive a participation certificate on completion of the intervention programme. You are free to raise any question regarding the research project at any given time by either raising it immediately, or by contacting the researcher at 021-799 6324.

Declaration of Participant

I confirm that I have read this document and that I understand the contents thereof. I acknowledge that I have been fully informed and grant my voluntary participation in the above-mentioned research project, conducted by the Department of Psychology, University of Stellenbosch. Furthermore, I acknowledge that participating in this study is voluntary, and that I have the right to withdraw at any time without prejudice. I am satisfied that all information will be treated as confidential and anonymous.

Furthermore I declare that I have been given the opportunity to ask questions regarding these procedures and confirm that I can raise any question regarding the research project at any time to the researcher.

I hereby give permission that the Department of Psychology make use of the results of the study for research purposes, on condition that the confidentiality of the data is maintained.

I grant this as a voluntary contribution in the interest of training and knowledge.

Signatures of participant and witness

……………..	…………….	……………………….	……..
Print Name	Force Number	Signature of Participant	Date

……………..	…………….	………………………	……..
Print Name	Force Number	Signature of Witness	Date

TOESTEMMINGSVORM

Die studie vorm deel van 'n doktorale graad in sielkunde aan die Universiteit van Stellenbosch. Die doel van die projek is om die veerkragtigheid van gesinne waar een van die ouers met Major Depressiewe Steuring leef, te verken, te beskryf en te ontwikkel. Gesinsveerkragtigheid gaan oor die hanteringsvaardighede wat gesinne in moeilike tye aanwend. Ons stel veral belang in die hanteringsmeganismes wat u gesin gebruik om in moeilike tye te oorleef. Pasiënte van die sielkunde en psigiatrie departemente van die Militêre Hospitaal vorm deel van die studie. U gesin voldoen aan die vereistes om deel te neem aan die navorsing en ons glo dat ons baie by u gesin kan leer. Daar word gepoog om hierdie gedeelte van die navorsing in 2006 af te handel. Hieronder volg 'n uiteensetting van hoe die proses gaan verloop.

1. Tydens hierdie kontaksessie sal daar van al drie van u verwag word om 'n paar vraelyste te voltooi. Die vraelyste sal ongeveer 60 minute neem om te voltooi.

2. Met dié inligting sal ons ook 'n intervensieprogram waaraan u as ouerpaar kan deelneem, saamstel. Die presiese formaat van die program sal bepaal word na die interpretasie van die vraelyste. Dit word voorsien dat die program die struktuur van 'n werkswinkel met ongeveer twee kontaksessies, sal aanneem. Die sessies sal opgeneem word aangesien dit ons sal help om presies te onthou wat gesê is. Die program gaan daarop fokus om die vaardighede wat gesinne in moeilike tye kan help, op te skerp. Bespreek asseblief as ouerpaar u belangstelling in die program. Een van u sal die geleentheid kry om u moontlike belangstelling om aan die program deel te neem, op die Biografiese Vraelys aan te dui.

3. Indien u aan die kriteria voldoen om aan die program deel te neem, sal ons u daaroor kontak. Die program word twee maal herhaal en ons sal u in kennis stel of u aan die eerste of tweede program kan deelneem. Indien u aangedui het dat u wel aan die program wil deelneem, maar nie in die eerste program aanbieding daarvan ingesluit is nie, sal u wel met 'n volgende datum waar u die geleentheid sal kry om die program te voltooi, gekontak word.

4. Indien u sou deelneem aan die program, sal u telefonies gekontak word om 'n gepaste datum af te spreek ten einde die impak van die program op 'n latere stadium te toets.

Deelname aan die intervensieprogram sal voordelig wees aangesien daar met die program gepoog gaan word om ouers se familievaardighede op te skerp. Die resultate van die studie gaan ook bydra tot die kennisbasis van gesinsveerkragtigheid. Geen ooglopende risiko of ongemaklikheidsfaktore word voorsien as daar aan die studie deelgeneem word nie. U deelname aan die projek is vrywillig. U sal nie verdere vergoeding ontvang behalwe versnaperings en die voordeel dat u kan deelneem aan die intervensieprogram vir ouers nie. U sal ook 'n voltooiingsertifikaat ontvang vir die voltooiing van die intervensieprogram. Indien u enige vrae

aangaande die navorsing het, kan u dit nou rig , of op enige tydstip die navorser kontak by 021-799 6324.

<u>Verklaring van Deelnemer</u>

Hiermee bevestig ek dat ek hierdie dokument gelees het en die inhoud verstaan. Ek erken dat ek volledig ingelig is en dat ek vrywillig deelneem aan bogenoemde projek aan die Universiteit van Stellenbosch. Verder verklaar ek dat ek die reg het om enige tyd sonder benadeling aan die studie te onttrek. Ek is tevrede dat alle inligting vertroulik en anoniem hanteer word. Ek erken dat ek ook geleentheid gehad het om enige vrae aangaande die navorsing te vra en ek bevestig dat ek op enige tydstip onduidelikhede kan uitskakel deur die navorser daaroor te vra.

 Ek verleen hiermee toestemming dat die Departement Sielkunde die resultate kan gebruik vir navorsingsdoeleindes, op voorwaarde dat die vertroulikheid van die data beskerm word.

Ek bied hierdie deelname aan as 'n vrywillige bydrae in die belang van opvoeding en kennis.

Handtekening van deelnemer en getuie

………….   …………….   ………………………   ……..
Naam   Magsnommer   Handtekening van Deelnemer   Datum

…………..   ………………   ………………………   ……..
Naam   Magsnommer   Handtekening van Getuie   Datum

ADDENDUM E

BIOGRAPHICAL INFORMATION

BIOGRAPHICAL INFORMATION

All information on this questionnaire will be treated as confidential en will be processed anonymously.

<u>Please mark the appropriate block and provide the requested information</u>:

1. **Live in** …………………………………………………………………… (town/city)

2. **Marital status** (Mark the block which represents you current position the best and give the number of years)

How many times have you been married? …………   Your partner? …………

How long have you been in this current relationship? …………..years

3. **Family composition**   (Indicate which child is going to complete the questionnaire)

	Self	Partner	Child 1	Child 2	Child 3	Child 4	Child 5
Age							
Gender							

Is anyone else living with you (non family member)?

No ☐   Yes ☐

If yes, please provide an explanation ……………………………………………………… …

4. Occupation, Education, Income and Home Language

Please provide a short description of your occupation (e.g. temporary/full time/nature of the work?)

……..…………….…………………………………………………………………………………

………………………………….…………………………………………………………………

Please provide a short description of your partner's occupation (e.g. temporary/full time/nature of the work?)

.…………………………………………………………………………………….………

……………………………..…………….……………………………..………..………………

Highest qualification received by:

Yourself ☐ Primary School ☐ Secondary School

☐ Diploma ☐ Degree

☐ None

☐ Other (specify)………………………………………

Your Partner ☐ Primary School ☐ Secondary School

☐ Diploma ☐ Degree

☐ None

☐ Other (specify)…………………………………….

What is your family's total income per year?

☐ less than R100 000 ☐ R151 000 – R180 000

☐ R101 000 – R120 000 ☐ R181 000 – R200 000

☐ R121 000 - R150 000 ☐ more than R200 000

What is your home language?

Afrikaans ☐ English ☐ Xhosa ☐ Other ☐ (specify) ………………...

5. When were you first diagnosed with depression?

1-2 years ago ☐ 3-5 years ago ☐ 6-10 years ago ☐ more ☐

6. What treatment do you currently receive for your depression?

Medication ☐ Therapy (Psychologist) ☐ Support group ☐

Other ☐ please specify

…………………………………………………………………………………………………

Please specify whether you have received previous treatment for your depression that, in your view, added value to your functioning.

……256

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7. Would you as parental couple be interested to partake in the parental intervention programme?

☐ Yes ☐ No

8. In your own words, what are the most important factors, or strengths, which helped your family lately?

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BIOGRAFIESE INLIGTING

Alle inligting in hierdie vraelys word as streng vertroulik beskou en u besonderhede sal anoniem verwerk word.

<u>Merk asseblief die toepaslike blokkie, of verskaf die verlangde inligting:</u>

1. Woonagtig in …………..…………………………………………….(dorp of stad)

2. Huwelikstatus (Merk die blokkie wat u <u>huidige</u> posisie die beste beskryf en skryf die aantal jare in)

U hoeveelste huwelik is hierdie?   ………….   En u eggenoot?……………

Hoe lank is u nou al met u huidige maat getroud?   …………..jare

3. Gesinsamestelling   (Dui duidelik aan watter kind die vraelyste gaan voltooi)

	Self	Maat	Kind 1	Kind 2	Kind 3	Kind 4	Kind 5
Ouderdom							
Geslag							

Is daar iemand anders (nie gesinslid) wat saam met julle woon?

Nee ☐

Ja ☐ verduidelik asseblief

…………………………………………………………………………………………………..

4. Werk, Opleiding, Inkomste, Huistaal

Gee asseblief 'n kort beskrywing van **jou** werk (bv. Tydelik/permanent? Aard van werk?).

……..………….…………………………………………………………………………………

………………………………….………………………………………………………………

Gee asseblief 'n kort beskrywing van **jou maat** se werk (bv. Tydelik/permanent? Aard van werk?).

………………….…………………………………………………………………….…………

…………………………..………….…………………………………………………………

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Wat is die hoogste kwalifikasie ontvang deur:

U self
☐ Laerskool   ☐ Hoërskool

☐ Diploma   ☐ Graad

☐ Geen

☐ Ander (spesifiseer)………………………………

U maat
☐ Laerskool   ☐ Hoërskool

☐ Diploma   ☐ Graad

☐ Geen

☐ Ander (spesifiseer)………………………………

Wat is u gesin se geskatte bruto inkomste per jaar?

☐ Minder as R100 000   ☐ R151 000 – R180 000

☐ R101 000 – R120 000   ☐ R181 000 – R200 000

☐ R121 000 - R150 000   ☐ meer as R200 000

Wat is julle huistaal?

Afrikaans ☐   Engels ☐   Xhosa ☐   Ander ☐ (spesifiseer) ……

5. Wanneer is u die eerste keer met depressie gediagnoseer?

1-2 jaar terug ☐   3-5 jaar terug ☐   6-10 jaar terug ☐   meer ☐

6. Watter behandeling ontvang u tans vir u depressie?

Medikasie ☐   Psigoterapie (Sielkundige) ☐   Ondersteuningsgroep ☐

Ander ☐ spesifiseer asseblief

………………………………………………………………………………………………………

Spesifiseer asseblief, indien u enige behandeling vir u depressie in die verlede ontvang het, wat volgens u van waarde was vir u huidige funksionering?

………

………

7. Stel u, as ouerpaar, belang om deel te neem aan die intervensieprogram vir ouers?

☐ Ja ☐ Nee

8. In u eie woorde, wat is die belangrikste faktore, of sterktes, wat u gesin die afgelope tyd gehelp het?

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ADDENDUM F

INVITATION TO WORKSHOP

Dear …………………………….......... Couple,

You, as a couple, are cordially invited to attend and be hosted at the:

Family Resilience Workshop

Date: 20 August 2007
Venue: Officer's Conference Facility, Combined Club (Officer's Side), Military Hospital
Time: 08:30-17:00
Programme: Family Resilience Workshop

Time		Workshop Programme
8:30-8:45		**Arrival and Registration**
8:45-10:00	Session 1	**Introduction**
10:00-10:15		Refreshments
10:15-11:15	Session 2	**Communication**
11:15-11:30		Refreshments
11:30-12:30	Session 3	**A Positive Climate for Family Communication**
12:30-13:30		Lunch
13:30-14:30	Session 4	**Effective Communication**
14:30-14:45		Refreshments
14:45-15:45	Session 5	**Effective Problem Solving Through Communication**
15:45-16:00		Refreshments
16:00-17:00	Session 6	**Goal Setting and Closure**

Your attendance and participation are highly valued and appreciated. It is my hope that the workshop will be of great benefit to you and your family. Please feel free to contact me should there be any queries.

Kind regards,
Carin Bester
Clinical Psychologist, Military Hospital
021-7996324
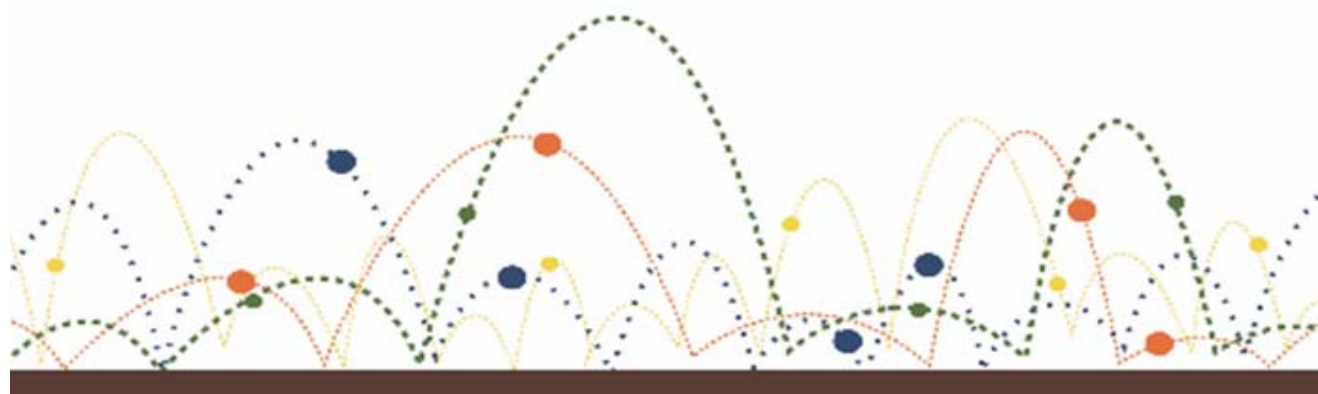
ADDENDUM G

FAMILY COMMUNICATION WORKSHOP: FACILITATOR'S MANUAL

FAMILY COMMUNICATION WORKSHOP

FACILITATOR'S MANUAL
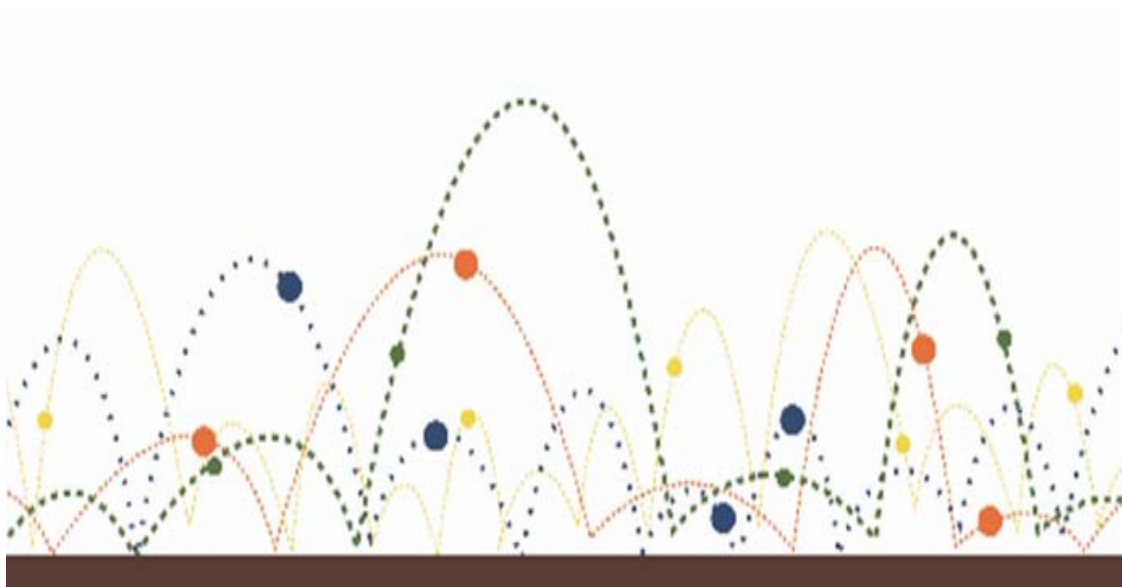
FACILITATOR'S MANUAL
FAMILY COMMUNICATION WORKSHOP

Aim of the Workshop

The One-day Family Communication Workshop has a two-fold aim. Firstly, it aims to raise awareness and increase insight and knowledge regarding communication in families where one parent has been living with depression and, secondly, it focuses on experiential learning exercises for effective familial communication that could be implemented in and integrated into the family system. This will result in improved communication and the fostering of growth in terms of family resilience.

Objectives of the Workshop

Objective 1: To brief the participants regarding the workshop, to evaluate the participants, to be introduced to one another and to establish workshop rules.
Objective 2: To deconstruct the concept of communication and to use it as a tool to analyse and discuss an example of family communication.
Objective 3: To introduce and raise awareness and insight regarding the concept of 'a climate for positive family communication' in order to enhance clear, direct and open communication.
Objective 4: To introduce and raise awareness and insight about 'effective communication' within the family setup, and to practise several active listening techniques in order to enhance communication skills and open emotional expression.
Objective 5: To introduce and exercise a 'problem-solving plan' for the family in order to enhance collaborative problem solving.
Objective 6: To set goals for future family communication and to evaluate and reflect on the workshop.

Facilitator's Guide:

1. This is a step-by-step facilitator's manual:
The facilitator's dialogue is indicated as follows:
          Facilitator: In normal font style.

Instructions and actions that should be followed by the facilitator are indicated as follows:
          Instructions: *In italic font style*.

Possible questions are provided periodically and should be implemented if needed to encourage
     group discussion:
          Possible questions: *In italic font style*.

2. The aim and objectives of each session are listed at the beginning of the session. For each activity there also is a statement of the purpose of the activity. This is included to orientate the facilitator regarding the session and should not be mentioned to the participants.
3. Each session's objectives are marked with the allocated numerical number throughout the text.
4. The references used are indicated by means of the allocated letter of the alphabet throughout the text.
5. The materials required for each session are listed at the beginning of the session.
6. The allocated time for each section of a session is provided in brackets throughout the text.
7. All the activities are included in the participants' workbooks.

Walsh's (2003, p. 133) theory and key processes on family communication within the family resilience paradigm were used as the framework for this one-day family communication workshop.

1. Clarity
   - Clear, consistent messages (words and actions)
   - Clarification of ambiguous situations: truth-seeking/truth-speaking

2. Open emotional expression
   - Sharing a range of feelings (joy and pain; hopes and fears)
   - Mutual empathy, tolerance for differences
   - Responsibility for differences
   - Responsibility for own feelings and behaviour, avoiding blaming
   - Pleasurable interactions; humour

3. Collaborative problem solving
   - Creative brainstorming, resourcefulness
   - Shared decision making: negotiation, fairness, reciprocity
   - Conflict resolution
   - Focusing on goals, taking concrete steps, building on success, learning from failure
   - Proactive stance: preventing problems, crises: preparing for future challenges

Material Required
Manual for Facilitator
Workbook for Participants
Laptop and Projector
PowerPoint Presentation
Time Required
One day from 09:00-17:00

References
(a) Alpaslan, N. (1997). *Methods and means for a meaningful marriage*. South Africa: Perskor.
(b) Adler, R.A., Rosenfeld, L.B., Towne, N., & Proctor 11, R.F. (1998). *Interplay: The process of interpersonal communication (7th ed.)*. New York: Harcourt Brace College Publishers.
       (bi) Deborah Weider-Hatfield (1981) (as cited in Adler et al., 1998)
(c) National Council for Mental Health (1986). *Life skills for self-development*. Johannesburg: National Council for Mental Health.
(d) Rooth, E. (1995). *Lifeskills: A resource book for facilitators*. Pietermaritzburg: Interpak.
(e) Korb, K.L., Azor, S.D., & Leutenberg, E.A. (n.d.). *Life management skills: Reproducible activity handouts created for facilitators*. (Vol 2, pp. 13-14).
(f) Nelson, T.N. (Ed.) (2003). *Family communication: Families matter*. A newsletter series for parents of school-age youth. Network, DE: Cooprative Extension, University of Delaware. Retrieved June, 2, 2007, from http://ag.udel.edu/extention/fam/
(g) Peterson, R., & Green, S. (1999). *Families first: keys to successful family functioning*. Publication 350-092. Retrieved June, 2, 2007, from *www.ext.vt.edu/pubs/family/350-092/350-092.html*
(h) Walsh, F. (1998b). *Strengthening family resilience*. New York: The Guilford Press.
       (hi) Gottman, 1998 as cited in Walsh 1998b
       (hii) Gottman 1994 as cited in Walsh 1998b
       (hiii) Beavers & Hampson, 1990; Satir, 1988 as cited in Walsh 1998b
       (hiv) Beavers & Hampson, 1993 in Walsh as cited in Walsh 1998b
       (hv) Epstein et al., 1993 as cited in Walsh 1998b
(i) Walsh, F. (2003b). *Normal family processes: Growing diversity and complexity (3rd ed)*. New York: Guildford Press.
(j) Video: *Little Miss Sunshine*

Workshop Programme

Time	Programme
8:00-9:00	**Arrival and Registration**
9:00-10:00	**Session 1:** **Introduction** General Overview Evaluation Icebreaker
10:00-10:15	Refreshments
10:15-11:15	**Session 2:** **Communication** Communication Building Blocks Video: *Little Miss Sunshine*
11:15-11:30	Refreshments
11:30-12:30	**Session 3:** **A Climate for Positive Family Communication** Group Discussion Rules Positive and Negative Responses
12:30-13:30	Lunch
13:30-14:30	**Session 4:** **Effective Communication** I-feel Statements Active Listening Parenting Skills
14:30-14:45	Refreshments
14:45-15:45	**Session 5:** **Effective Problem Solving Through Communication** Problem Solving Plan Exercise: Problem Solving
15:45-16:00	Refreshments
16:00-17:00	**Session 6:** **Goal Setting and Closure** Goal Setting Evaluation Group Evaluation

SESSION ONE: INTRODUCTION

Aim of the Session

The first session aims to brief the participants regarding the workshop, to evaluate their family communication, to introduce participants to each other and to establish workshop rules.

Objectives of the Session

1. Briefing participants and to introduce participants to the one-day workshop on family communication.
2. Allowing participants to complete the evaluation questionnaires for research purposes.
3. Providing a brief introduction regarding family resilience and communication.
4. Introducing the themes of group work and the group communication process.
5. Facilitating a process in which participants will decide on group rules. These will allow for a safe workshop space with an atmosphere of warmth, acceptance, humour and enjoyment, which is essential for learning, participation, extension and exploration of personal and family growth.
6. Facilitating an 'icebreaker' exercise to introduce participants to each other, set them at ease in the new situation, and allow for active involvement in all sessions of the workshop (d).
7. Introducing the function of the participant's workbook, as it will be used by the participants throughout the workshop and thereafter.

Material Required

Evaluation: questionnaires.
Workbook (pp. 4-6) and pen for each participant.
Icebreaker: large label and a thick marker pen.
Flipchart and paper.

Procedures

<div align="center">Introduction (2 minutes)</div>

Facilitator: (1) Good morning, ladies and gentlemen, and thank you for attending this one-day workshop on Family Resilience, or more specifically on Family Communication. Your attendance is appreciated and your presence indicates your commitment to your family and its functioning. [As you all know by now, this workshop is part of my research study for a doctoral degree in Psychology. Your participation is incredibly valuable in so far as it adds to the already existing body of knowledge on these matters, and will thereby also help other families in the future].

We are going to work together as a group, which means that we are going to discuss topics relating to communication, and practise some communication techniques that you can use in the future.

Each of you received a workbook (7), which will help you to participate in the workshop. Apart from the space provided for you to make notes, we will also complete some exercises in it as we proceed. This will allow you as a couple to work on implementing the concepts we'll discuss relating to your family.

<u>Evaluation</u> (10 minutes)

<u>Facilitator:</u> (2) But before we continue, I'd like to invite you to complete the following questionnaires (FPSC, BDI, open-ended questions, as well the Informed Consent questionnaire for those of you who haven't yet completed one). Please complete them as honestly as possible without discussing them with each other. We are interested in a true reflection of your family, rather than how you think your family should be.

<u>Instruction</u>: *Give participants a few minutes to complete the questionnaire and assist where necessary.*

<u>Family Resilience</u> (h) (10 minutes)

<u>Facilitator</u>: (3) Thank you for completing the questionnaires. We are now ready to continue with the workshop. Please turn to page 4 in your workbook. You are welcome to make notes in the space provided for this purpose. Let's begin with a brief overview of family resilience and the role of communication in the family.

The concept of family resilience is a relatively new one, which has been developed over the last few years. Family resilience is about family functioning and adaptation.

This area of psychology focuses on the family's potential to cope with difficulties, or even more so, to recover from difficult situations and experiences. A good analogy is that of a coiled spring, which has been stretched, and then springs back to normal once the tension is released. The same concept is true for a family that manages to rebound from and overcome difficult times, including simply coping with daily living.

Family stress and difficulties have an impact on the whole family system, such as when a parent suffers from depression. This has a ripple effect on the family system - everybody, from the parents to the youngest child, needs to work on adjusting to the situation. For example, depression in a family might have an impact on the marital relationship in the sense that the partners' roles might change, such as when mom is too tired to cook and dad has to take control of the household chores. Or suddenly we don't talk about what's going on with dad these days. He is not his usual self, but we think it is better to keep quiet. Certain coping strategies need to be activated for the family to cope with the situation and to function as a family.

This leaves us with the question of how families deal with, or survive, or sometimes even thrive in these circumstances, and how to activate these coping strategies. The family resilience field gives us some answers to these questions. It is said that families inherently have the strengths to face these difficulties, which we call resilience factors.

Family communication in particular presents a critical resilience factor. Family communication assists you and your family with coping, adjustment and adaptation.

<u>Communication</u> (h)

<u>Facilitator:</u>
Look as this quote:

'Once a human being has arrived on this earth, communication is the largest single factor determining what kinds of relationships he makes with others and what happens to him in the world around him' (Virginia Satir)

(3) Agreement exists that good communication is vital to family functioning. But then … What is good communication? Definitions of good communication often tend to be vague and

idealistic and people tend to hold different views on it, especially as it relates to communication between different family members in a family setup.

For example: teenagers' views on open communication may differ dramatically from their parents' views. Teenagers might view their parents' communication as intrusive and wish that they would listen to their opinions and stop telling them what to do. Meanwhile, the parents wish for teenagers to be more open, obedient, and to tell them what they are up to … not always easy, you'll agree!

As you all know, the challenges families face are becoming increasingly complex these days, with the pressures of dual-income situations and financial burdens. All of these pressures make good communication even more difficult, and families therefore must work on good communication skills.

Our workshop can assist with this. It aims to strengthen your family resilience by raising your awareness of family communication, because communication facilitates all aspects of family functioning. We'll also revisit concepts that you might be familiar with, as well as practise certain communication skills.

<center>Workshop Structure (3 minutes)</center>

Facilitator: (1) On the screen you'll see the layout of today's workshop, and it is also given on page three of your workbook. This first session we're busy with, from 08:00 to 09:00, is an introduction to the workshop in which I have given you a brief overview of family resilience and communication. To add to this I'd like to explain how we arrived at this focus on family communication. [In the first phase of the research study, when you completed questionnaires, it was found that communication in families is a very important building block for resilience in families where one parent has been living with depression. Although family communication is generally shown to be vital for family functioning, the data of your questionnaires significantly indicated the importance of communication in your families. Hence it was decided to focus on enhancing family communication in this workshop.]

Some of our discussions will take place in the larger group, while other conversations will take place in groups of five to six people or only between you and your spouse. This will enable you to learn from each other, but more importantly also to work on new ways of communicating in your family and to revisit and share with each other those methods and behaviours that have worked in your family.

After this initial session we will have five hour-long sessions until five o'clock. After each session we will have a 15 minute break in which coffee, tea and snacks will be served, with a lunch break of one hour, when lunch will be served. During the next session (2nd session) we will talk about communication and watch a video clip; the third session will focus on how to create 'a climate for positive family communication'; the fourth session will focus on 'effective communication', while the fifth session will introduce a 'problem-solving plan'. Then we will use the last session for 'goal setting and closure'. All of these terms may sound very abstract, but we'll clarify them as we continue.

Before starting with the next session, it is important for us to get to know each other so that we can create a safe environment for you to discuss and share your opinions and experiences, in order for us to learn from each other.

<p style="text-align:center;"><u>Group Rules and Confidentiality</u> (10 minutes)</p>

<u>Facilitator</u>: (4) Please turn to page 5 of your workbook. For our workshop to be effective, everybody should understand that, as a group, we should keep communication channels open so as to discuss, share and practise communication skills. Thus one of the aims of this workshop is to provide you with examples of these communication skills, which you can also implement in your family. To assist with this process it will be important for the members of the group to take turns to talk and have equal speaking rights. We should further focus on listening to each person's opinion with respect and giving positive feedback. Please, feel free to ask a question at any stage if you are unsure about something or if there is anything that you do not understand.

<u>Facilitator</u>: (5) It is also important to lay down boundaries/rules or group norms so that each of us feels safe in this space and feels free to share and express our own unique experiences and opinions.

Please take a moment to reflect on the conversation rules you think most critical to enable all of us to participate equally, and indicate to us which group rules you wish to consider.

<u>Instruction</u>: *Ask a different volunteer each time to write a rule on the flip chart. Facilitator to encourage members' ideas and mention the one of the other group norms if the group does not come forth with them. Allow participants to share their views on the proposed rules.*

<u>Facilitator:</u> (d)
1. Everyone must have an equal opportunity to speak and participate. When a participant speaks, everyone else listens.
2. Punctuality should be maintained.
3. Absence from sessions or parts of sessions is not allowed.
4. Participants cannot attend to other matters during the workshop, as this will interrupt the proceedings.
5. Participants must agree to keep the group's activities and discussions confidential.
6. Participants must attend all sessions.

<u>Facilitator:</u> Thank you for giving your ideas on our group rules. We will leave them on the board so that we are constantly reminded of them as we go along.

Icebreaker: Positive Labels

Purpose:

(6) *To introduce the participants to each other, set them at ease in the new situation and ensure their active involvement in this and the following sessions (d).*

An atmosphere of warmth, acceptance, humour and enjoyment is essential for learning, participation, and the extension and exploration of personal growth (d).

Instruction:

Give each participant a large label and a thick marker pen.

Facilitator:

We are going to do a fun activity to get to know each other. Please write your name and a positive word to describe yourself on the label. The descriptive word should start with the first letter of your name, like Adorable Andy.

Instruction:

Allow a few minutes.

Facilitator:

Are you ready to share your label with the rest of the group? Let's start here on my right-hand side. Please explain to us why you have chosen this specific word.

Instruction:

Allow each participant to call out their label and share what he/she means with it.

Facilitator:

Thank you for sharing. What do you think is the purpose of the exercise?

Instruction:

Allow for a group discussion regarding the icebreaker. Use these questions if the discussion needs guidance.

What happened? / How did you feel? / What did you learn?

Facilitator: Now that we've been introduced to each other, I'd like to invite you to enjoy some refreshments together. Please make sure that we're all seated at 10:15 sharp so that we may continue with the workshop.

SESSION TWO: COMMUNICATION

Aim of the Session

The aim of the second session is to deconstruct the concept of communication and to use it as a tool to analyse and discuss an example of family communication.

Objectives of the Session

1. Introducing communication building blocks by way of an experiential learning activity and group discussion, in order to raise awareness and increase insight regarding the types and components of communication.
2. Introducing participants to an example of family communication, namely a video clip of the film *Little Miss Sunshine*, in order to stimulate a group discussion regarding family communication.

Material Required

Workbook (pp. 6-7)
Laminated shapes (Appendix 1)
Video: *Little Miss Sunshine*
Thick marker pen, large piece of paper and Presstick

Procedures

Facilitator: Welcome back! In this session, which is discussed on page 6 of your workbook, we are going to work in groups and discuss certain concepts of communication in general and family communication in particular.

Activity: Communication Building Blocks (e) (20 minutes)

Activity: Communication Building Blocks

Purpose:
(2) To raise awareness of verbal, nonverbal, one-way and two-way communication, and to promote open communication.

Facilitator:
For this exercise, we need three volunteers and we'll work within the larger group.

Instructions:
Get the laminated shapes ready (Appendix 1)
Ask participants to turn to page 6 in their workbooks.
1. Ask for a volunteer, and instruct him/her (without showing the handout to others) to…
   (a) Choose one shape
   (b) Describe the shape to the group, using <u>verbal</u> cues only, so that the others can accurately draw it in the blocks provided on page 6 in their workbooks. Use one-way communication only. Do not allow questions/comments from the group. Do not use nonverbal cues (hand motions, body gestures, etc.).

Encourage the group members to show their drawings to the volunteer to compare their copies with the original.

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2. Continue the activity by instructing the second volunteer to describe a different shape <u>verbally</u>, but this time to include <u>nonverbal cues</u> as well. Use one-way communication only.

Encourage the group members to draw their shapes and then to show their drawings to the volunteer to compare their copies with the original.

3. Continue the activity by instructing the third volunteer to describe another shape verbally and nonverbally, allowing for two-way communication with group members. Group members are allowed to pose questions to the volunteer regarding the shape they must draw.

Discuss the members' reactions and responses to each of the three different exercises, emphasising the benefits of verbal, nonverbal, one-way and two-way communication.

<u>Facilitator</u>:
So, as we have seen from this exercise, all communication involves three components, namely the sender (the person who initiates the message), the message (the content of the communication) and the receiver, who is the intended recipient of the message. All three components have to work together in order for communication to be successful. This means that you, as the sender, have to speak or convey your message in such a way that the receivers understand you clearly and well and, as a receiver of any message, one must listen in such a way that the sender feels understood and heard. But, more about this later in the workshop.

We have looked at the basic building blocks of communication. Now we'll introduce a formal definition of communication, namely that communication is 'the interchange of messages between two or more persons. These messages can be verbal, nonverbal, behavioural interaction and bodily gestures. Nonverbal communication, like facial and bodily gestures and tones of voice, can be very powerful in communicating messages and may either qualify (when they are congruent) or disqualify (when they are incongruent) the intended verbal message.'
 (c) (The National Council of Mental Health, 2000, p. 79).

In other words, good communication involves much more than just the message, and actually asks of us as human beings to communicate with our entire being, in an open, honest and direct way.

<u>Facilitator</u>:
Thank you for your participation. With these concepts in mind we are going to go directly to the next exercise.

(e) (Korb et al., Vol 2, pp. 13-14).

<u>Discussion: *Little Miss Sunshine* (j)</u> (40 minutes)

Discussion: *Little Miss Sunshine*

<u>Purpose</u>:
(1) Introduce the participants to an example of family communication via a video clip from Little Miss Sunshine *in order to stimulate a group discussion on family communication.*

<u>Facilitator</u>:
We'll now view a video clip from the movie, *Little Miss Sunshine*. Who has seen it? Okay, for those that haven't seen it and to remind those who have, allow me to give you a brief introduction by reading the description of the movie on the back of the DVD cover:

[Take a hilarious ride with the Hoovers, one of the most endearingly fractured families in comedy history. Father Richard (Greg Kinnear) is desperately trying to sell his motivational success program … with no success. Meanwhile, 'pro-honesty' mom Sheryl (Toni Collette) lends support to her eccentric family, including her depressed brother (Steve Carell) fresh out of the hospital after being jilted by his lover. Then there are the younger Hoover's – the 7-year-old, would-be beauty queen Olive (Abigail Breslin), and Dwayne (Paul Danol), a Nietzsche-reading teen who has taken a vow of silence. Topping off the family is the foul-mouthed grandfather (Alan Arkin), whose outrageous behaviour recently got him evicted from his retirement home. When Olive is invited to compete in the 'Little Miss Sunshine' pageant in far-off California, the family piles into their rusted-out VW bus to rally behind her – with outrageous results]

I'd like to invite you to look at the story afresh and think about the dynamics in and communication styles of this family.

Facilitator:
Please divide into five groups of four each – that is two couples in a group. You are group one, two, three, four and five. I would like you to discuss the following questions in your group after you have seen the video clip.

Question 1: Each group will be allocated a particular character to watch specifically. Ask yourself as a group what the communication pattern of your allocated character is, and what the impact of it on the rest of the family might be?
Question 2: What did you notice in terms of Family Resilience in this movie?

Instruction: *Allocate a character to each group.*

Facilitator:
Group 1: Mom
Group 2: Dad
Group 3: Grandpa
Group 4: Daughter
Group 5: Brother and Uncle

Instruction:
Play video clip: Little Miss Sunshine (20 min)

Facilitator:
You have 10 minutes to discuss the questions in your group, following which we'll provide an opportunity for you to give feedback to the group.

Instruction:
After 10 minutes, allow each group to give feedback and allow time for discussion.

Facilitator: With this session we unpacked the concept of communication and reflected on open communication through verbal, nonverbal and two-way communication, which provides the receiver with the clearest picture of a message and thus improves understanding between people.

(f) Communication is a basic building block of relationships. It is through communication that we convey our thoughts, feelings and connections to one another, which is the core of our being human. So, in the process of developing good communication skills, we also enrich ourselves and the people around us. Think back a bit to those experiences in your life when you felt heard

and completely understood, as well as those experiences where you have felt completely misunderstood and not heard. Generally, when we feel heard and understood, we behave in a less irritated, angry, stressed and abrasive manner. We are more open to resolving problems than when we feel misunderstood. Feeling heard and understood also develops trust and care between people and in families.

In the following session we are going to look at how one creates 'a climate for positive family communication'. In other words, what building blocks should we put in place in order for communication to work for us in our family? Let's break for 15 minutes and then continue with our conversation on family communication.

SESSION THREE: A CLIMATE FOR POSITIVE FAMILY COMMUNICATION

Aim of the Session

The aim of the third session is to introduce and raise awareness and insight regarding the concept of a 'positive family communication climate' that will enhance clear, direct and open communication.

Objectives of the Session

1. Providing a brief overview of the subject of creating 'a climate for positive family communication' and to introduce the basic aspects of the concept to participants.
2. Discussing and introduce the rules to create a positive family communication climate and to create awareness regarding the general guidelines for effective communication in the family.
3. Increasing implementation and integration of these positive communication rules and positive responses in the family by means of a group discussion.

Material Required

Workbook (pp. 8-10)

Procedures

Creating a Climate for Positive Family Communication (h) (5 minutes)

Facilitator: (1) We continue on page 8 of your workbook. In the previous session we concluded with the question: Which building blocks should we put in place for communication to work for us in our family? In other words, we are going to look at a broad family communication framework that fosters and allows for positive, effective communication. In this workshop we are going to refer to it as 'a climate for positive family communication'.

So, in order to create a positive climate for family communication, communication should be direct, clear, specific and honest. But what does this mean in practical terms? It means that family members say what they mean and mean what they say. Keep messages straightforward and easy to understand. The message must be conveyed to the person for whom it is intended – for instance, not through your child if your message was actually meant for your partner. It is important for verbal and nonverbal messages to be consistent and to correlate with each other, as we explored and discussed in the exercise on communication building blocks. This will enable each family member to know the nature of and their current position in family relationships, instead of being confused by hidden messages.

So, if you are truly excited about your husband coming home from work, then your words and your body language have to say the same thing. You can't lie on the couch if he enters the room and say 'Glad you are home!' (*facilitator crosses arms*). Rather get up to greet him, and display a welcoming posture.

It has been found that setting family rules or agreements is a helpful tool in facilitating clear communication, which allows for 'a climate for positive family communication'. If family rules are clearly defined, they will organise the interaction between family members and help members to be clear about the family's code of conduct. So each member will know what is

expected of him or her in terms of behaviour and in terms of interaction with each other. Family rules remind me of game rules in sports such as rugby, soccer or hockey. Rules provide us with boundaries, which offer a safe space in which we can play the game, succeed and feel content. Clearly defined rules help family members to be clear about what to do or not to do, which in turn assists with effective family functioning. But, you may ask, how do we set clear and specific family rules? It starts by being very clear and specific about what it is you want for your family, and to communicate this to your family. But, as you will see in the fifth session, you can also use a 'problem solving plan', which you can implement to work on setting specific family rules.

If, for instance, communication is unclear and left unresolved, it breeds confusion and misunderstanding and the family members do not know what is expected of them. This is not conducive to 'a climate for positive family communication'. In this negative climate, family members will operate on faulty assumptions or make attempts at 'mind reading'. This will lead to unnecessary conflict and unmet needs in the family. Ongoing uncertainty about what is expected from each member blocks family functioning and may lead to frustration. Such a state of affairs does not assist families in dealing with difficult situations.

Clear communication is especially important when crisis strikes a family. Family members often have different readings of a crisis situation, which necessitates that you provide them with clear and direct information about a particular situation – for instance about a threatening situation of unemployment. Encourage the members of the family to voice questions, or call a family meeting with your children to clarify uncertainties around the situation. This will help the family members, as they will most likely make their best contribution to the family when they can make sense of the situation, and find clarity on the future and determine how to best deal with the crisis at hand together.

Families should avoid entertaining a situation in which everybody knows that something is going on in the family, but nobody is allowed to say anything about it. This usually happens when family members try to protect one another from painful or upsetting information. Silence and secrecy create barriers to understanding and decision making and impede family members from relating to one another spontaneously. An assumption that one must avoid is the myth that when family members haven't asked questions, they're not concerned.

Discussion: A Climate for Positive Family Communication

Purpose:
To increase awareness of the rules for a positive family communication climate.
To increase awareness of the ways to create a positive family communication climate.
To encourage the use of communication rules and positive responses in the family.

Facilitator:
The importance of clear, direct and open communication cannot be overemphasised. Let's use the remainder of this session to look at how one can create 'a climate for positive family communication'. This will foster open, clear and direct communication and help the family members to feel free to express their thoughts, emotions and needs. This, in turn, will create a healthy and resilient family system.

Instruction:
Allow for group interaction and discussion of these questions. Encourage participation and brainstorming.

Facilitator:
(4) Let's brainstorm as a group and design ways to create a positive climate for family communication. By this we mean a climate that will encourage people to communicate, rather than be scared to say what they think, feel, want and need. You can write all the ideas we come up with in your workbook.

Other Possible Questions:
What do you think is the value of having family meetings?
How could family meetings assist family functioning?
What family rules may assist communication in the family, and how?

Facilitator:
Thank you for exploring these proposals together. To continue the introduction of the ideas that we are discussing, we'll now investigate ideas about creating a climate for positive family communication. We'll review those ideas you've already mentioned, along with the ideas included in your workbook for future reference.

(2) Rules for a Climate of Positive Family Communication (a)
1. Choose the right time to communicate – for instance, not when you enter the home after a long day at work.
2. Be positive. Guard against negative communication.
3. Always try to communicate in a pleasant tone of voice, such as a 'soft and direct' tone of voice.
4. Try to make clear and specific statements – don't take it for granted that the other person knows what you mean.
5. Truthfully say what you think, feel, need and plan.
6. Listen actively. Specific and clear communication can be obtained by using 'I messages'. 'You messages' come across as blaming. We'll explore active listening in the following section.
7. Set clear and direct family rules and boundaries.

(3) Responses that Create a Climate for Positive Family Communication (a)
How should we communicate in practice to grow a positive climate of family communication climate? Let's look at the following responses.

Negative Responses	Positive Responses
1. Evaluation	**1. Descriptive**
'You are not making any sense!'	'I don't understand the point you're trying to make.'
'You're inconsiderate!'	'I would appreciate it if you'd let me know when you're running late – I was worried!'
2. Control	**2. Problem orientation**
'Get off the phone - now!'	'I need to make an important call. If you can give me five minutes, I'll let you know when I'm off.'
3. Strategy	**3. Spontaneity**
'What are you doing Friday after work?'	'I have a piano I need to move Friday after work. Can you give me a hand?'
'Tom and Judy go out to dinner every week.'	'I would like to go out to dinner more often.'
4. Neutrality	**4. Empathy**
'That's the way the cookie crumbles!'	'I know you put a lot of time and effort into this project!'
'No big deal - people get promotions here all the time.'	'Congratulations! I'll bet you're pretty excited about the promotion.'
5. Superiority	**5. Equality**
'You don't know what you're talking about!'	'I'm not sure I agree.'
'No, that's not the right way to do it!'	'I'd be happy to help if you'd like – just let me know.'
6. Certainty	**6. Provisional**
'That will never work!'	'My guess is that you'll run into problems with that approach.'
'You'll hate that class! Stay way from it!	'I didn't like the class much at all!'

(b) Jack Gibb's Categories of Defensive and Supportive Communication (Ader et al., 1998, p.364).

Facilitator: Thank you. Before we take a break I would like to share the following with you. (f) To communicate well takes time and practise. For most people it does not come naturally and therefore you should make an active attempt to improve your communication skills if you aim to see real improvement in relationships. The communication skills and techniques we will work on might seem strange at first, and you may feel awkward initially. However, if you persist, the skills will eventually become part of you and will enable you to improve your communication with people both inside and outside the family.

Please keep this session, 'a climate for positive communication', in mind, since we are going to build on it during the next session, when we will talk about 'effective communication' in the family setup. We will look at how you as a family can talk to each other so that you feel heard and understood. This is called active listening. You will have to work on this and teach this way of talking and listening to your children. It will allow you to create and enjoy an emotionally healthy family climate.

SESSION FOUR: EFFECTIVE COMMUNICATION

Aim of the Session

The aim of the fourth session is to introduce and raise awareness of and insight into 'effective communication' within the family setup, as well as to practise several active listening techniques to enhance open emotional expression.

Objectives of the Session

1. Providing a brief overview of the topic of 'effective communication' in the family and to introduce the basic communication concepts to the participants.
2. Introducing an experiential learning exercise on sharing a wide range of feelings in order to increase the identification of emotions by using 'I feel' statements, which will assist participants to take responsibility for own feelings and behaviour.
3. Discussing and introduce active listening in the family so as to create awareness and insight regarding this concept.
4. Identifying and practise positive communication skills, identify ineffective parental communication skills and assist participants to recognise and practice effective means of communicating with children, which will allow the parents to be emotional coaches of their children.

Material Required

Workbook (pp 11-17)

Procedures

Content: Effective Communication (h) (10 minutes)

Facilitator: (1) In this session we are going to look at effective communication in families, from page 11 in your workbook. How does one communicate effectively in families? Firstly, it is said that the emotional tone in families is quite important. Thus a comfortable, warm, cheerful and optimistic family tone assists with family functioning. Secondly, it is important for family members to understand that all feelings are acceptable. Family members should be allowed to express their feelings freely and, in return, be able to tolerate different emotions and levels of expression. This means that family members allow each other to be angry, sad, disappointed or, on the other end of the spectrum, to be happy, excited and so on.

Therefore, if you have reprimanded your teenager and he reacts in anger, you could confirm his anger by saying, 'I can see that you are very angry right now, but that is not the way we talk to each other', instead of saying 'Don't be angry! And don't shout at me!' as we have discussed in the previous session.

We should talk in a way that shows that we understand other family members' feelings, needs and uniqueness. Family members should avoid blaming or attacking each other, or being over critical, as this could lead to vicious conflict cycles that create a negative family communication climate (hiii). Family members should be encouraged to show interest in what others have to say. This will create a general expectation that other family members will try to understand one's point of view.

But this is easier said than done, especially in difficult times, because good listening alone is simply not enough if people do not also change their behaviour when they need to do so (hii). As we all know and often say, the best way to respond is both in word and deed.

Sometimes previous experiences, like divorce or violence in the family, result in many fears in families. Family members often become so concerned that any conflict might lead to a family break-up that they avoid raising issues at all costs. In situations like these, communication becomes very closed and secretive so as to avoid sharing painful feelings or to protect children and other family members. However, this strategy does not work. It fuels family secretiveness and cuts family members off from one another, which ultimately destroys families. Thus, family conflict in moderation is not bad – it helps family members to engage with one another and keeps communication channels open.

Children become extremely confused when their parents try to protect them from hurt by hiding the real facts or their emotions about a situation. This sends mixed messages to the children and they are likely to blame themselves and feel bad or unlovable. If you, as a parent, are not open about your feelings, your children will also be secretive about their feelings. If children can't voice their needs and feelings, they could develop behavioural problems or symptoms of distress. Their suppressed feelings might even surface in their relations with their peers at school, or in other relationships.

Thus, being aware of your own emotions will enable you to teach your children to communicate openly and to assist them, especially with feelings such as anger and sadness. You will become their emotional coach (hi). If children receive emotional coaching from both parents, they show better peer relationships, perform better at school, have fewer behavioural problems and physical illnesses, and are less prone to outbursts. It also provides a model for children what their own marital and familial relationships could be like. This brings us to the important subject of couple communication.

Your emotional relationship as a couple is a blueprint for your children's emotional health (hv). When the two of you, as parents, and specifically as a couple, interact in a warm, supportive way so that you feel loved, valued and safe, your children will more than likely follow the same pattern and also be healthy and happy.

However, I am sure you know that men and woman are different and communicate differently. Women often feel that men do not talk enough about the relationship, do not share feelings, or that they aren't really listening. Men often just wish that woman would stop bugging them, and might complain about a disappointing sex life. Women build relationships by focusing on connecting with the other person, while men focus on facts and problem solving. This obviously leads to difficulties in communication. In times of conflict, men tend to withdraw and sexualise their need for closeness and support, while women tend to smother their partners with the need to feel connected in a crisis situation. Because men and women see the world and relationships differently, it is very important to try to understand each other from an emotional point of view. This can be done by asking: How does my wife feel? Why is my husband irritated?

We have learned that a family crisis can actually benefit family functioning. But how? A crisis can force family members to deal with unexpressed feelings and unmet needs in order to survive. For instance, one partner's threat of divorce could provide a trigger for important conversations and necessary changes to keep the family together.

Open communication should be encouraged for the family to deal with any crisis. Different feelings will emerge at different stages of a crisis, and will be expressed in different ways by

each family member. This will give the family an opportunity to focus on open communication, so that family members can freely express what they think and feel. By focusing on open communication, family members will be able to depend on each other for support and understanding, and move through the crisis together.

But all these emotions may sound a bit threatening. We must remember that open discussion of positive feelings like joy, excitement or satisfaction is just as vital, if not more so, than a discussion of negative feelings. Families can handle quite a bit of conflict, as long as it happens within a positive family communication climate, as we have discussed in the previous session.

Families seemingly have to perform a balancing act by embracing both the good and the bad in each situation.

Activity: Emotions (e) (20 minutes)

Activity: Emotions

Purpose: (Appendix 2)
(2) *To improve the identification of emotions by gaining knowledge and experience of 'I feel' statements.*
To recognise options as a result of being in control.
To increase awareness of emotions and of the existence of a variety of words to express emotions, with assistance of visual representations.
To increase usage of these words.

Facilitator:
With all this in mind, let us look at that open communication and the expression of feelings will entail in practice. The first, very important, technique is to use 'I feel' statements. Did you know that the words 'I feel' are two of the most powerful words when used together to assert yourself. Personal power is lost when 'you make me feel' statements are used.

Facilitator:
I am now going to introduce the following very important 'I feel' formula to you (page 12 of your workbook).

A complete 'I feel' statement has four parts, which look as follows:
(1) The other person's behaviour (When you …)
(2) Your feelings (I feel …)
(3) Give a consequence (because …)
(4) Give a specific positive behavioural request (I want you to …)

For example: 'When you talk about my grades in front of my friends I feel embarrassed, because I am worried that they might think that I am stupid. I want you to talk to me about it in private!'

Instruction:
Enquire whether all participants understand the formula and answer questions appropriately.

Instruction:
Instruct each group member in sequence to select an emotion from the handout and share it with the group using the 'I feel' formula.

Facilitator: Let's practise it together. Please select an emotion from page 13 in your workbook and use the 'I feel' formula. I will give you some time to work on it and then ask you to share your example with the rest of the group.

> ''I feel …………………when…………………….because…………………could you…………………'
>
> Facilitator: Thank you for sharing your examples. What do you think are the benefits of the 'I feel' statement? (*allow a few minutes for discussion*).
>
> Facilitator:
> You will feel much more in control of and responsible for your own feelings when you use the 'I feel' technique. 'You make me feel' is a communication 'bad habit' that gives control to the other person. 'I feel' is in essence stating 'I choose or allow myself to feel', which conveys a message that you take responsibility for your own feelings and choices.
>
> Using the 'I feel' technique will further help you to identify your emotions clearly, which is a very effective skill in communication. It allows the people around you, like your family, to get a clearer picture of what it is that you are saying, which will help them to understand you and respond in a way that makes you feel heard. This is a very powerful technique to create an open two-way communication channel. It works especially well in family setups, and children are never too young to learn this technique. They can simply start by practising the first part of the 'I feel' formula by saying 'I feel sad when you shout at me'. We will focus on this element later in the session.

(e) (Korb et al., Vol 1, pp. 6-8).

Active Listening (20 minutes)

Facilitator: (4) The 'I feel' statements that we have practised are part of active listening. What is active listening? Well, 'active listening' (workbook, page 15) is a certain way of talking to other people so that you take responsibility for your own feelings and so that other people feel you understand them. This is very helpful in family setups (b).

A table indicating the usage of the 'I', 'We' and 'You' languages are included in your workbook, on page 14, and you can study this at a later stage. We are not going to discuss this aspect in the workshop, but it will provide you with useful additional information about these pronouns.

Instruction: *Facilitator to omit this table for the presentation, but look at it for your own background to the workshop.*

Pronoun	Advantages	Disadvantages	Recommendation
'I' language	Takes responsibility for personal thoughts, feelings and wants.	Can be perceived as egotistical and self-absorbed when used inappropriately without listening to the other person.	Use descriptive 'I' messages in conflict when the other person does not perceive a problem. Combine 'I' with 'We' language in conversations. Use active listening skills.

'We' language	Signals inclusion, immediacy, cohesiveness and commitment. *'We as a family stand together through thick and thin.'*	Can speak improperly for others.	Combine with 'I' language, particularly in personal conversations. Use in group settings to enhance sense of unity. Avoid when expressing personal thoughts, feelings and wants.
'You' language	Signals other-orientation, particularly when the topic is positive. *'You're a star for helping me wash the dishes.'*	Can sound evaluative and judgmental, particularly during confrontations.	Use 'I' language during confrontation.

(b) (Adler et al., 1998, p.157).

(b) Active listening is actually a therapeutic tool rooted in the therapeutic approach of the well-known psychologist, Carl Rogers, and thus carries quite a bit of weight!

It is extremely important for you as parents to use the model and to demonstrate active listening to your children to allow them to become familiar with it. This will also assist them in relationships outside the family. The research is clear that active listening helps the listener to understand the other person better, and helps the speaker to elaborate and clarify his or her ideas. This enables each member of the family to take responsibility for his or her own feelings and behaviour, which in turn stops members blaming each other.

Active listening is an approach to listening that involves suspending judgement, withholding evaluation, and striving to hear both surface messages and underlying meaning. It encourages open emotional expression, with the sharing of a wide range of feelings being encouraged and accepted in families.

(3) The rules for active listening (a; b) are well illustrated in this Chinese language symbol which means 'to listen'. The symbol consists of four signs, which capture the four parts of listening, namely ears, eyes, undivided attention and the heart. Listening therefore involves several parts of you.
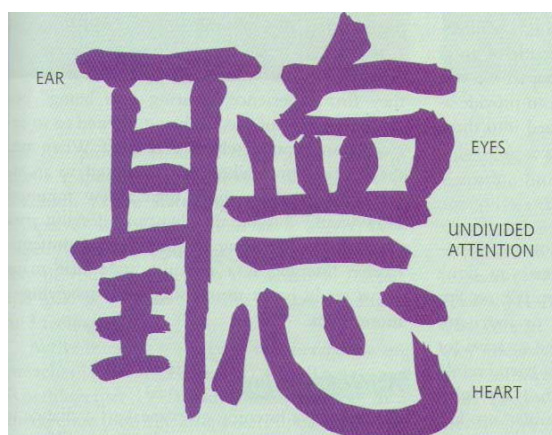
(b) (Adler et al., 1998, p. 219).

1. Ears: listen attentively – not with divided attention; instead, try to hear all the facts and feelings that underlie the message.
2. Eyes: Keep good eye contact.
3. Undivided attention: Act attentively regarding what is heard. Try to stop doing whatever might distract you from listening.
4. Heart: Ask well-phrased, emphatic questions for the sake of clarity.

(3) There are also three types of active listening responses, namely questioning, paraphrasing and empathising (b), which are also discussed in your workbook (page 16) for future reference. We will not discuss them here.

Instruction: *Facilitator to omit this section in brackets (next paragraph up to p 24), but look at it for your own background to the workshop.*

[1. Questioning (b)
Questioning occurs when the listener ask the speaker for more information – questioning is not interrogation. Sincere questioning is aimed at understanding others. Let's look at the following table, which gives a layout of the do's and don'ts regarding questioning.

Don'ts	Do's
Questions that trap the speaker 'Did you?' 'Isn't that right?'	**To clarify meaning** 'What did you mean when you said he had been unfair to you?'
Questions that make statements 'Are you finally off the phone?' 'You lent money to Tony?'	**To learn about others' thoughts, feelings and wants** 'What do you think about the new plan?' 'How did feel when you heard the news?'
Questions that carry hidden agendas 'Are you busy on Friday night?' 'Will you do me a favour?'	**To encourage elaboration** 'Tell me more about that' 'Keep going … I'm with you.'
Questions that seek 'correct' answers 'Honey, do you think I am overweight?' 'Which shoes do you think I should wear?'	**To encourage discovery** 'So, what do you see as your options?' 'What would be your ideal solution?'
Questions based on unchecked assumptions 'Why aren't you listening?' 'What's the matter?'	**To gather more facts and details** 'What did you do then?' 'What did she say after that?'

(b) (Adler et al., 1998, p. 224).

Paraphrasing (b)

The second type of active listening is paraphrasing. Paraphrasing is feedback; you put the speaker's words in your own words. Paraphrasing allows you to find out if the message received is the message sent. It is a way of finding out whether you understood the other person correctly. This is a helpful technique, as too many questions sometimes might become counterproductive and may seem more like cross-examination rather than genuine interest.

You can paraphrase messages at two levels, namely:

1. Feedback of factual information (summarising facts, data and details)

'We've agreed that we'll take another few days to think about our choices and make a decision on Friday … right?'

2. Feedback of personal information

Restating factual information is relatively easy. But it takes a sensitive ear to listen for the underlying, think-feel-want components in communication. Let's have a look at this wife's thoughts as an example (p. 225):

Bob has hardly been home all week – he's been so busy with work. He rushes in just long enough to eat dinner, and then buries himself at his desk until bedtime. Then he tells me today that he's going fishing with his buddies. I guess men are just like that – job first, play second, family third.

What is this wife thinking, feeling and wanting? Paraphrasing can help:

'Sounds like you're unhappy (feeling) because you think Bob's ignoring you (thought) and you want him to spend more time at home (want).'

In many cases you can focus on one or two of these components.

3. Empathising (b)

Empathising is another active listening style. Empathising occurs when a listener acknowledges the content and validity of a speaker's perceptions (pp. 226-227). Empathy is to listen with your heart. Let's look at the following table.

Empathising	Not Empathising
'I can see that really hurts.'	'Don't worry about it!'
'You seem to be really happy about that.'	'That's a silly way to feel!'
'I know how important that was to you.'	'Hey, it's only a game!'
'Wow, that must be rough.'	'You'll feel better tomorrow!'
'This means a lot to you, doesn't it?'	'Well your problem is obvious, you just have
'It hurts to feel unappreciated.'	to …'
'I think I've felt that way too.'	'You know it's your own fault!'
'Looks like that really made your day.'	'Don't blame me, I have done my part!'
'I can see you feel strongly about that issue.'	'A minus, why didn't you get an A!'

(b) (Adler et al., 1998, pp. 227). **]**

Facilitator: (f) It is often surprising to see how conversations and relationships change in a positive way when you focus on actively listening to the other person, rather than thinking of your own next response.

Activity: Parenting Skills

Purpose:
(5) *To identify and practise positive communication skills in order to enhance parenting.*
To recognise ineffective means of communicating with children.

Instruction:
Allow for group discussion regarding active listening.

Facilitator:
What do you think of active listening?
To what extent will you be able to use these techniques and types of active listening?

Facilitator:
Thank you for sharing your thoughts with us. Let's explore active listening further in a practical way, specifically in connection with your relationship with your child. Establishing positive communication with your child today will lay a good foundation for your relationship in the future.

Actively listening allows you to listen with interest and understanding. It gives you guidance regarding the expression of your thoughts and feelings using 'I feel' messages, which will enhance your relationship with your children and the rest of your family. Positive 'you seem' messages can also be used effectively when you want to reflect children's feelings back to them and/or clarify their feelings. Open-ended, follow-up questions allow for further communication, as already discussed.

At times, particularly during emotionally-loaded situations, we may resort to the previous poor communication habits we were used to in the past. 'You' messages are negative for a number of reasons. As we've discussed, they will simply lead to attaching a negative label on the child, closing the door to effective communication and blaming the child for our feelings.

Now it is your turn to practise.

Instructions:
Ask the participants to turn to page 17 of the workbook and explain the exercise to the group.
Divide the group into five subgroups (two couples per group).
Go through the two practise examples with the group.
Ask group members to complete the handout.
Encourage group members to choose one situational role-play and present it to the rest of the group.
Facilitate the feedback on and interpretation of this activity.
Process benefits and encourage future application of this activity.

Situation	Negative 'You' message (labelling, blaming, ridiculing, etc.)	'I' Message (expressing our thoughts/feelings)	Positive 'You-Seem' message (reflecting back and/or clarifying child's feelings) with **follow-up, open-ended question**
Your 10-year-old child is getting low grades at school	*You can't do anything right! You're a poor student!*	*I'm concerned about your grades.*	*Lately you seem disinterested in your school work and your grades in this report card are low. What's going on?*
You suspect your teenager has been experimenting with drugs	*You've been using drugs, I just know it! You won't amount to anything! You're no good!*	*I'm worried that you've been trying drugs and I don't want anything to happen to you. Let's talk about it.*	*You seem distant from us lately. It seems like you're under pressure from your friends. What can I do to help?*
1.			
2.			
3.			

Facilitator:
(c) As parents, we have the task of teaching our children how to communicate well, as discussed in the section on 'I feel' statements. One of the first steps in teaching your children how to communicate well is to listen to them actively, as we have just discussed. When we listen to our children actively we are letting them know that they, in turn, have to listen to us actively. But, apart from being good role models, how can one teach children to listen actively (f)?
Let us consider some suggestions:
  (i) Children need to pay attention – so you have to ask your child to look at you when you are talking, or you must go down on your knees to be on the same level when you talk to your child.
  (ii) Be sure that your child understands your message; ask him or her to repeat in their own words what you've agreed to.
  (iii) You can also ask them what feelings of yours they've become aware of (i.e. anger, sadness, happiness). In this way they will be able to connect feeling and content.
  (iv) If your child does not repeat the message or your feelings clearly, it provides you with the opportunity to clarify both of these elements and to help your child with active listening.

Children learn the most by communicating with adults and by watching how adults communicate with each other.
(e) (Korb et al., Vol 2, pp. 31-32).

Facilitator: We have covered important active listening techniques in an attempt to work on effective communication skills for ourselves and for the wellbeing of our family. These principles, together with our principles for creating 'a climate for positive family communication', will be implemented in the following section, where we are going to focus on effective problem solving through communication.

SESSION FIVE: EFFECTIVE PROBLEM SOLVING THROUGH COMMUNICATION

Aim of the Session

The aim of the fifth session is to introduce and practise a 'problem-solving plan' for the family in order to enhance collaborative problem-solving skills.

Objectives of the Session

1. Giving a brief overview of the topic of 'problem solving' in the family in order to introduce the basic concepts of collaborative problem solving in families.
2. Discussing the importance of dealing with conflict in the family, in order to create awareness regarding the concept and to focus on goals and take concrete steps to resolve conflict.
3. Discussing and introduce the problem-solving plan so as to increase knowledge and awareness of and insight into proper problem solving and conflict resolution, which incorporates active listening, as well as identifying problems, stressors, options and constraints, leading to shared decision making, negotiation, fairness, creative brainstorming and resourcefulness within the family.
4. Introducing an experiential learning exercise of the problem-solving plan in order to give participants an opportunity to experience the plan directly and to work from a proactive stance in their day-to-day living as a family by building on successes, learning from failures and preparing for future challenges.

Material Required

Workbook (pp. 18-23)

Procedures

Effective Problem Solving through Communication (h) (20 minutes)

Facilitator: (1) Life is difficult and each day we are confronted with situations or crises for which we need to find solutions, whether relating to relationship difficulties or practical problems.

In this session, from page 18 in your workbook, we are going to work on an effective problem-solving plan for your family. This plan is only effective within 'a climate of positive family communication', and we will also have to implement all the active listening skills we have practised. It will assist tremendously with your family's functioning.

(2) As we have discussed previously, a family's success does not require a conflict-free environment, but is rather determined by how conflict is entertained and resolved in the family. Families should learn this very important lesson that, as much as conflict is upsetting at times, it is also immensely beneficial for the growth of relationships in the long run. If family members only agree and comply or withdraw all the time, the relationship is at high risk of developing serious problems that will come to the fore only later. (g) Families are faced with balancing the needs and wants of many different people. Naturally conflicts are going to arise, but they can be dealt with constructively to the benefit of everyone.

This seems a bit like a 'Catch 22' situation – on the one hand, we want a peaceful and happy family and, on the other hand, we see that conflict is often helpful and that you should engage

with it. Well, the obvious answer is that we should look at how to handle conflict to ensure that it remains constructive and helpful for growth in the family.

Effective conflict management allows for couples or members of the family to openly disagree, but to do so with good communication skills. The question then is: How can one fight constructively? This means that one should learn how to fight for the benefit of the relationship. Everything that we have worked on so far in terms of good communication skills will be of absolute importance during problem solving.

Please remember our active listening rules, the 'I feel' formula, and the 'You seem' sentences.

Let's look at the to-do list in terms of problem solving or conflict management:
1. Difficult issues must be controlled.
2. Conflicts need to be slowed down.
3. Members may call for 'time-out'.
4. Arguments should be kept constructive.
5. Withdrawal should be avoided.
6. Involvement must be maintained.

With this in mind, families should set specific goals and take concrete steps to achieve them. This will help families to build on success, as well as to learn from mistakes. The acceptance of setbacks allows family members to make mistakes without being judged and to take responsibility for their own part in each endeavour, whether good or bad. Families should learn to address potential problems quickly and effectively.

(3) Problem solving works best when you follow a step-by-step approach. We are going to use a problem-solving plan developed by Deborah Weider-Hatfield (bi). This plan can be used for any type of problem or situation. We will explore this approach focusing specifically on the family setting. It also works very well if you want to use it for family rule setting.

(c) It is impossible for each family member's needs to be met all the time - so families have to work on creating new solutions instead of focusing on being the winner of the situation. Families should work on win-win solutions by being creative in developing solutions to problems, rather than focusing on own needs or wants. Win-win means that we find solutions that, as far as possible, allow everyone to feel that their most critical needs are met. These are solutions that we don't often think of as individual family members, but as a team we could come up with new and even better options.

It is important that all people experiencing the conflict are included in the discussion, which means that either a couple meeting or a family meeting should be held, depending on who is experiencing the conflict. Sometimes 'time-out' is needed before the discussion is started. To come up with win-win solutions, family members need to incorporate the active listening technique that we discussed in the previous session. Families must then focus on using neutral language, with no name calling or passing of judgements. Each person's request needs to be considered and, once everybody feels heard and understood, the process can move to generating new solutions for resolving problems.

Let's look at the specific step-by-step approach involved in problem solving (b). This approach is also dealt with in your workbook, on page 19, so you can make notes and think of a personal example as we go along. You'll also have an opportunity during this session to work through the plan.

1. <u>Define your needs</u>:
Begin by deciding what you want or need.

For instance: after being together for years, Peter starts to check Mary's cell phone. Although this was fine for her in the beginning, she started to feel irritated after a few weeks. At first Mary just thought she was irritated by the fact that Peter did not respect her privacy. But, after more self-examination, she realised that her irritation centred around the underlying message his constant checking actually conveyed, namely that he was questioning her faithfulness. She wanted him to (a) trust her and (b) not to be insecure.

Before starting the problem-solving process, your needs have to be clear to you. It is often necessary to think about a problem alone or to talk to a third person outside the conflict situation about the problem before approaching the person involved.

2. <u>Share your needs with the other person</u>:
Once you've defined your needs, it's time to share them with your partner or with the family. If it is an adult issue, set a time with your spouse. If it is a family issue, set a time with the entire family at a family meeting. The following two guidelines are important:

Firstly, be sure to choose a time and place that is suitable for you and the other people in the family, for instance if it involves your wife, agree on a suitable time when the children are absent, while if it involves the family, call a family meeting when everyone's home and it suits everybody. Unloading on a tired or busy partner will lower the odds that your concerns will be received well and resolved. Likewise, be sure you are at your best. Don't bring up an issue when your anger may get the better of you and the possibility exists that you may paint the problem out of proportion. Secondly, use descriptive 'I feel' language, as we discussed in the previous session (d).

For instance: **I feel** irritated **when** you check my cell phone **because** I wonder whether you do not trust me or whether you may need reassurance of my love for you. **Could you** please help me to understand and tell me why you are doing this?

3. <u>Listen to the other person's needs</u>:
Once your wants and needs are clear, it is time to find out what the other person wants.

Back to the example: When Peter began to talk about his needs, they learned some interesting things. Now the active listening, as discussed in the previous session, becomes very important to use:

Peter: Yes Mary, you are correct, **I feel** insecure **when** you go out with your friends, **because** you never used to do it so often and I also experience you being less open towards me these days.
Mary: Ok, I see what you mean. **I do feel** a bit distant from you, especially **when** you go to golf without telling me in advance, **because** then I feel left out and try to fill my time by spending it with my girlfriends.

Arriving at a shared definition of the problem requires one to create a supportive and confirming climate, again by using the techniques we discussed in the previous session. It is crucial to be non-judgemental, clear, direct, descriptive and empathic, so that you create a friendly family communication climate. It might take some time to arrive at the shared definition of the problem. You might even have to call a second meeting if time is running out. Sometimes a 'time-out' is a

good idea at this point so that all members can spend some time thinking about everybody's needs and formulating their understanding of the problem.

In a family meeting, you as parents should be the facilitators of the meeting. You should focus on eliciting the ideas of all the family members. Assist them in the process of mentioning their own ideas and encourage freedom of choice as far as possible. Each family member should be free to say what they think, feel and what they want to do, from the youngest to the eldest (hiv).

4. Generate possible solutions:

In this step, Mary and Peter have to creatively brainstorm as many solutions as possible to their problem. The best way to brainstorm is to look for as many possible solutions that you can think of without worrying at this stage whether they are feasible or not. A golden rule in brainstorming is to steer away from any criticism of ideas. Another is that if one person suggests something, the other should feel free to build upon the idea. Don't evaluate the ideas as yet.

5. Evaluate the possible solutions and choose the best one:

The best time to evaluate the solutions is after they all have been generated, and after the partners feel they have exhausted all the possibilities. Now the couple has to evaluate each possible solution that was generated in the previous step. The question to ask is, 'How far does each solution enable us to reach the individual and mutual goals?' You might want to give each one a score out of 10. React truthfully and spontaneously as solutions are evaluated.

(h) It will be important for family members to negotiate when deciding on a plan of action or a solution. To be successful negotiators, family members need to learn how to talk and listen with compassion and understanding. Here again, parents should be the role models for their children in terms of how to repair conversations that go badly and how to soothe each other when hurt or upset.

(h) A parent might again call for 'time-out' by saying, 'Let's talk about this later, when we are calmer and can hear each other', instead of allowing things to escalate into a screaming, unsatisfying power struggle. 'Tit-for-tat'-interactions or viewing problems in terms of winning or losing the conversation does not build family functioning. Family members should understand the importance of compromising and creating a win-win situation in order to create a positive communication pattern in the family.

6. Implement the solution:

Now the time has come to try out the best ideas to see if they do indeed satisfy everyone's needs. The key question to answer is **who** does **what** to **whom by when**? This helps to make sure the agreement is clear and everybody knows what to do.

7. Follow up the solution:

After you have tested your solution for a short time, it's a good idea to plan a meeting to talk about progress and how things are going. You may find that you need to make some changes or even rethink the whole situation.

This method of problem solving seems too good to be true in difficult situations. However, research shows that seeking mutual benefit is not only desirable, but works. In fact, it works far better than a win-lose approach.

Activity: Problem Solving

Purpose:
(4) *To increase knowledge of and gain experience in the problem-solving technique.*

Facilitator:
Now it is your time to practise. Think of a problem or a conflict situation in your relationship or in the family that you and your partner can work on during the following exercise.

Activity:
Instruct group members to work together as a couple and complete the handout using one of their own specific examples (Workbook pp. 20)
Facilitator to assist if any questions arise.
Facilitate discussion with entire group as each couple shares their problem situation and chosen plan.
Emphasise importance of looking at all possible options before deciding on a plan to increase satisfaction with the decision. Discuss the idea that not all chosen plans will necessarily be the right ones, but may be the best ones at the time. Modifications may need to be made in the future.

 (e) (Korb et al., Vol 1, pp. 23-24).

Facilitator: As you have seen while working on the problem-solving plan, you also have to use the other active listening skills we have discussed so far in order for it to work effectively. Not one of our communication principles stands in isolation; all of them have to be implemented in order to work at the entire communication climate in your family.

A few problem-solving worksheets are included on pages 21-23 of your workbook so that you can use them in the future, either for problem-solving in your family or for laying down a new family rule. We are now going to take a 15-minute break and thereafter we will have our last session for the day.

SESSION SIX: GOAL SETTING AND CLOSURE

Aim of the Session

The aim of the sixth session is to set goals for future family communication and to evaluate and reflect on the workshop.

Objectives of the Session

1. Creating an activity in which the participants can work on goal setting in terms of their family's communication habits in order to continuously work on family communication.
2. Allowing for a group discussion to reflect on and close the workshop.
3. Evaluating the participants as part of the research process.

Material Required

Workbook (pp. 24-26)

Procedures

Facilitator: We have come to the end of our workshop and, with only one session left, we are going to briefly revisit the concepts regarding family communication that we have covered in each session. We have focused on creating 'a climate for positive family communication', on 'effective communication', and we have worked on the 'problem-solving plan'. With this in mind, I would like each couple to work together in the following activity. This activity will help you to set goals for yourself in terms of your family's communication style. It is very important to set specific goals so that you can continuously work on and monitor communication in your family.

Activity: Goal Setting

Purpose:
(1) *To set short- and long-term goals for family communication.*

Facilitator:
Before you start, allow me to give you a brief overview of the key building blocks of effective communication for families (g):

1. Communicate frequently.
2. Communicate clearly and directly.
3. Be an active listener.
4. Communicate openly and honestly.
5. Focus on effective problem solving.
6. Be positive.
7. Practise, practise, practise good communication.

These building blocks, together with the principles, guidelines, rules and techniques we have discussed and implemented, will serve as a guide for you when you commit to goals for your family in terms of communication.

Setting goals and achieving them gives a sense of direction and self-control to you as a family. Your family's goal setting in terms of communication should start today, so that you can work on your goals as a couple and integrate them with those of your children. On page 25 in your workbook you will find the goal-setting worksheet for you to complete.

For example: We as the Coetsee family commit ourselves to use the 'I feel' statement and will help our children to use it, and we will try to stay calm during conflict situations.

Instruction:
Let each couple work together.
Allow each couple to give feedback to the group regarding some of their goals.

Facilitator:
These goals will help you to stay on track in terms of effective family communication. I would like you to commit to them and suggest that you revisit and revise them on a regular basis.

Evaluation (10 minutes)

Facilitator: (3) Before we come to the final activity of the workshop, I am going to distribute the evaluation forms (FPSC and Appendix 3) for the workshop. Please complete them as honestly as possible.

Activity: Debriefing

Purpose:
(2) To allow the participant to discuss the workshop process.
To give verbal feedback on the workshop.

Facilitator:
Thank you for completing the evaluation forms. We are now going to have our final group discussion.

Instructions:
Ask the group to divide into five smaller groups.
Let them discuss the following questions and allow for feedback to the group.

Questions (Experiential Learning Cycle): (Workbook page 26)
1. How did you experience the workshop?
2. What did you find stimulating in the workshop?
3. How could we improve the workshop?

Facilitator:
Thank you for sharing your views with the group. Your input is highly valued and appreciated.

Facilitator: Allow me to thank you again for participating in the research project and for attending the workshop. It is my hope that this workshop has provided you with tools with which to work further on your family's communication and to strengthen your family resilience. I want to encourage you to practise these principles on a daily basis as individuals, but also as a family. We will meet again in three months' time, on 23 November at 10:00. However, I will contact you before then to confirm your attendance, as this meeting will be very important for all to attend. At that meeting we'll see how each family has progressed and discuss the possible long-term impact of this workshop. We'll do so during an informal get-together. You will also receive a graduation certificate, as well as something to thank you for your participation in the research project.

Appendix 1

COMMUNICATION
BUILDING BLOCKS

Appendix 2

aggressive	alienated	angry	annoyed	anxious	apathetic	bashful
bored	cautious	confident	confused	curious	depressed	determined
disappointed	discouraged	disgusted	embarrassed	enthusiastic	envious	ecstatic
excited	exhausted	fearful	frightened	frustrated	guilty	happy
helpless	hopeful	hostile	humiliated	hurt	hysterical	innocent
interested	jealous	lonely	loved	lovestruck	mischievous	miserable
negative	optimistic	pained	paranoid	peaceful	proud	puzzled
regretful	relieved	sad	satisfied	shocked	shy	sorry
stubborn	sure	surprised	suspicious	thoughtful	undecided	withdrawn

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Appendix 3: Workshop Evaluation Form (Post)

Please complete the following questions and elaborate on your answers.

1. How did you experience the workshop?

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2. How might it have been different?

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3. What did you learn about yourself, your family or life in general?

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4. Will you be able to apply what you have learned to your family situation?

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5. How could you remember the topics we have discussed in the workshop?

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6. Any suggestions for future workshops regarding the information, the format of the workshop or the exercises?

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7. Any suggestions for the facilitator?

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ADDENDUM H

FAMILY COMMUNICATION WORKSHOP: WORKBOOK

FAMILY COMMUNICATION WORKSHOP

WORKBOOK
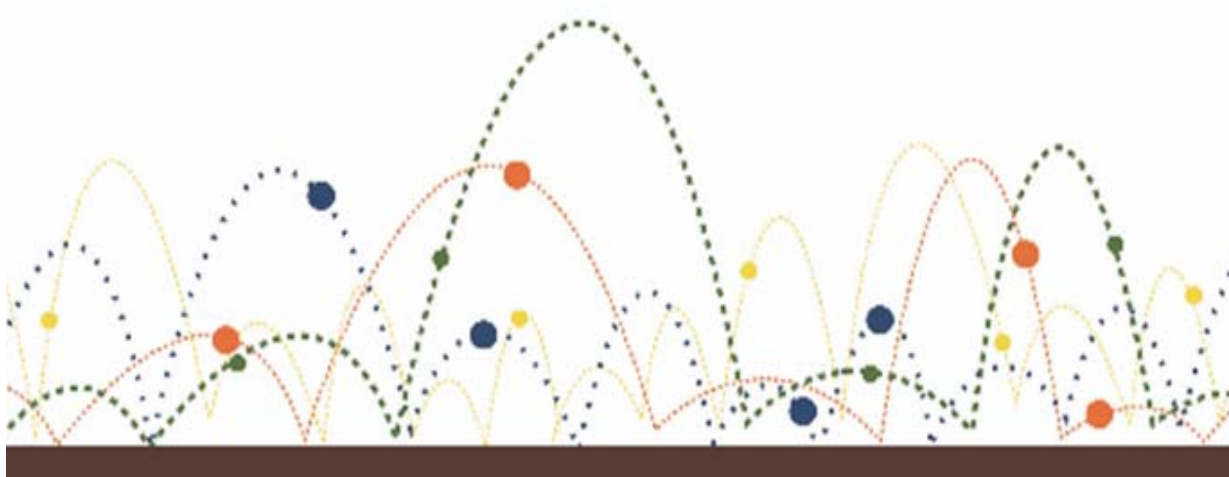
TABLE OF CONTENTS

PROGRAMME FOR THE WORKSHOP

Time	Programme
8:00-9:00	**Arrival and Registration**
9:00-10:00	**Session 1:** **Introduction** General Overview Evaluation Icebreaker
10:00-10:15	Refreshments
10:15-11:15	**Session 2:** **Communication** Communication Building Blocks Video: Little Miss Sunshine
11:15-11:30	Refreshments
11:30-12:30	**Session 3:** **A Climate for Positive Family Communication** Group Discussion Rules Positive and Negative Responses
12:30-13:30	Lunch
13:30-14:30	**Session 4:** **Effective Communication** I-feel Statements Active Listening Parenting Skills
14:30-14:45	Refreshments
14:45-15:45	**Session 5:** **Effective Problem Solving Through Communication** Problem-solving Plan Exercise: Problem Solving
15:45-16:00	Refreshments
16:00-17:00	**Session 6:** **Goal Setting and Closure** Goal Setting Evaluation Group Evaluation

SESSION ONE: INTRODUCTION

Notes: Family Resilience
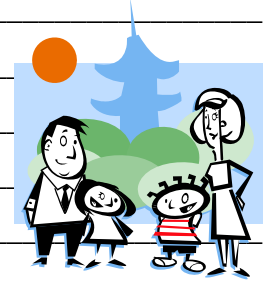
Notes: Family Communication

'Once a human being has arrived on this earth, communication is the largest single factor determining what kinds of relationships he makes with others and what happens to him in the world around him.'
(Virginia Satir)

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Notes: Group Rules

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Notes: Icebreaker

SESSION TWO: COMMUNICATION

Notes: Communication Building Blocks

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4.	5.	6.

Communication involves three components, namely
    a.   the sender (the person who initiates the message),
    b.   the message (the content of the communication) and
    c.   the receiver, (which is the intended recipient of the message).

Communication is defined as 'the interchange of messages between two or more persons. These messages can be verbal, non-verbal, behavioural interaction and bodily gestures.
Non-verbal communication, like facial and bodily gestures and tones of voice, can be very powerful in communicating messages and may either qualify (when they are congruent) or disqualify (when they are incongruent) the intended verbal message.

Notes: Little Miss Sunshine

'*Take a hilarious ride with the Hoovers, one of the most endearingly fractured families in comedy history. Father Richard (Greg Kinnear) is desperately trying to sell his motivational success program...with no success. Meanwhile, 'pro-honesty' mom Sheryl (Toni Collette) lends support to her eccentric family, including her depressed brother (Steve Carell) fresh out of the hospital after being jilted by his lover. Then there are the younger Hoover's – the 7 year old, would-be beauty queen Olive (Abigail Breslin) and Dwayne (Paul Danol), a Nietzsche-reading teen who has taken a vow of silence. Topping off the family is the foul-mouthed grandfather (Alan Arkin), whose outrageous behaviour recently got him evicted from his retirement home. When Olive is invited to compete in the 'Little Miss sunshine' pageant in far-off California, the family piles into their rusted-out VW bus to rally behind her – with outrageous results.*'

Group1: Mom
Group2: Dad
Group3: Grandpa
Group4: Daughter
Group5: Brother and Uncle

Question 1: Ask yourself as a group what the communication pattern of your allocated character, and the impact of it on the rest of the family might be?
Question 2: What did you notice in terms of Family Resilience in this movie?

Observation: Video

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SESSION THREE: A CLIMATE FOR POSITIVE FAMILY COMMUNICATION

Notes: Group Discussion
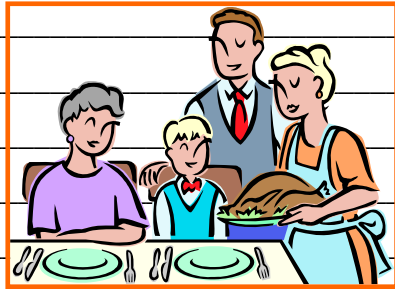
Rules: A Climate for Positive Family Communication

8. Choose the right time to communicate – for instance not when you enter the home after a long day at work.
9. Be positive. Guard against negative communication.
10. Always try to communicate in a pleasant tone of voice, such as a 'soft and direct' tone of voice.
11. Try to make clear and specific statements – don't take it for granted that the other person knows what you mean.
12. Truthfully say what you think, feel, need and plan.
13. Active listening. Specific and clear communication can be obtained by using 'I-messages'. 'You-messages' come across as blaming. We'll explore active listening in the following section.
14. Setting clear and direct family rules and boundaries.

Responses: A Climate For Positive Family Communication

Negative Responses	Positive Responses
1. Evaluation 'You are not making any sense!' 'You're inconsiderate!'	**7. Descriptive** 'I don't understand the point you're trying to make.' 'I would appreciate it if you'd let me know when you're running late – I was worried!'
2. Control 'Get off the phone now!' 'There's only one way to handle this problem!'	**8. Problem orientation** 'I need to make an important call. If you can give me five minutes, I'll let you know when I'm off.'
3. Strategy 'What are you doing Friday after work?' 'Tom and Judy go out to dinner every week.'	**9. Spontaneity** 'I have a piano I need to move Friday after work. Can you give me a hand?' 'I would like to go out for dinner more often.'
4. Neutrality 'That's the way the cookie crumbles!' 'No big deal – people get promotions here all the time.'	**10. Empathy** 'I know you put a lot of time and effort into this project!' 'Congratulations! I'll bet you're pretty excited about the promotion.
5. Superiority 'You don't know what you're talking about!' 'No, that's not the right way to do it!'	**11. Equality** 'I'm not sure I agree' 'I'd be happy to help if you'd like – just let me know.'
6. Certainty 'That will never work!' 'You'll hate that class! Stay way from it!	**12. Provisional** 'My guess is that you'll run into problems with that approach.' 'I didn't like the class much at all!'
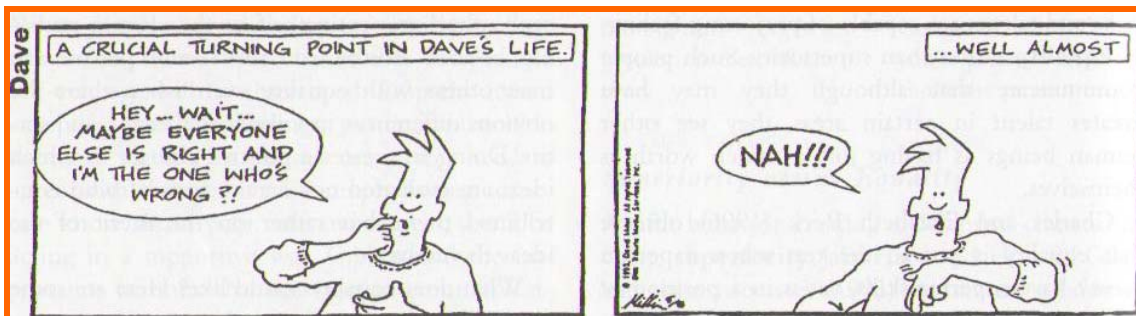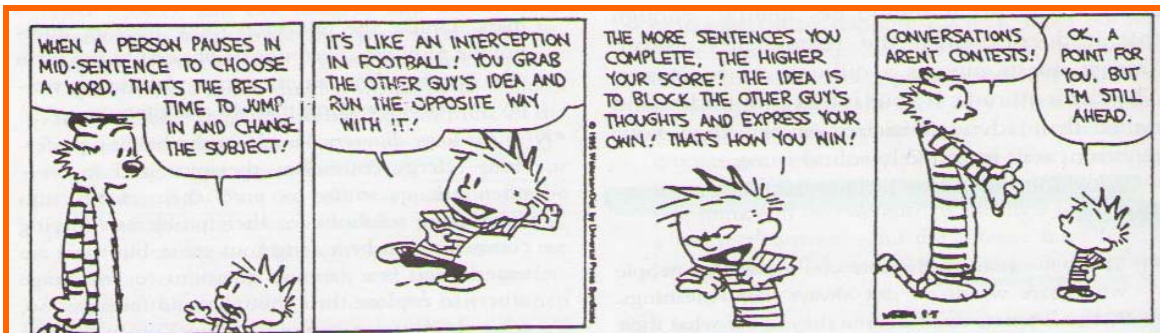
Notes: Effective Communication
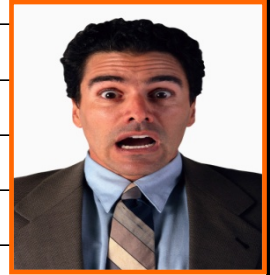
Notes: 'I feel' Statements

'I feel' Statement

A complete 'I feel' statement has four parts, which looks as follows:
1. The other person's behaviour (When you….)
2. Your feelings (I feel…)
3. Give a consequence (because….)
4. Give a specific positive behavioural request (I want you to….)

Example: *'When you talk about my grades in front of my friends I feel embarrassed, because I am worried that they might think that I am stupid. I want you to talk to me about it in private!'*

'I feel ……………when…………… because……………could you………….'

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Faces: Emotions

aggressive	alienated	angry	annoyed	anxious	apathetic	bashful
bored	cautious	confident	confused	curious	depressed	determined
disappointed	discouraged	disgusted	embarrassed	enthusiastic	envious	ecstatic
excited	exhausted	fearful	frightened	frustrated	guilty	happy
helpless	hopeful	hostile	humiliated	hurt	hysterical	innocent
interested	jealous	lonely	loved	lovestruck	mischievous	miserable
negative	optimistic	pained	paranoid	peaceful	proud	puzzled
regretful	relieved	sad	satisfied	shocked	shy	sorry
stubborn	sure	surprised	suspicious	thoughtful	undecided	withdrawn

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EMOTIONAL ROLLER COASTER

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Pronoun	Advantages	Disadvantages	Recommendation
'I' language	Takes responsibility for personal thoughts, feelings, and wants.	Can be perceived as egotistical and self-absorbed when used inappropriately without listening to the other person.	Use descriptive 'I' messages in conflict when the other person does not perceive a problem. Combine 'I' with 'We' language in conversations. Use active listening Skills.
'We' language	Signals inclusion, immediacy, cohesiveness, and commitment. *'We as a family stand together through thick and thin.'*	Can speak improperly for others.	Combine with 'I' language, particularly in personal conversations. Use in group settings to enhance sense of unity. Avoid when expressing personal thoughts, feelings and wants.
'You' language	Signal other-orientation, particular when the topic is positive. *'You're a star for helping me wash the dishes.'*	Can sound evaluative and judgmental, particularly during confrontations.	Use 'I' language during confrontation.

Notes: Active Listening

Chinese Language Symbol Which Means 'To Listen'

EAR
EYES
UNDIVIDED ATTENTION
HEART

Active Listening

5. Ears: listen attentively – not with divided attention, instead, try to hear all the facts and feelings that underlie the message.
6. Eyes: Keep good eye contact.
7. Undivided attention: Act attentively regarding what is heard. Try to stop doing whatever might distract you from listening.
8. Heart: Ask well-phrased, emphatic questions for the sake of clarity

Types of Active Listening

1. Questioning

Questioning occurs when the listener ask the speaker for more information – questioning is not interrogation. Sincere questioning is aimed at understanding others. Let's look at the following table which gives a layout of the do's and don'ts regarding questioning.

Don'ts	Do's
Questions that trap the speaker 'Did you?' 'Isn't that right?'	**To clarify meaning** 'What did you mean when you said he had been unfair to you?'
Questions that make statements 'Are you finally off the phone?' 'You lent money to Tony?'	**To learn about others' thoughts, feelings and wants** 'What do you think about the new plan?' 'How did feel about it when you heard the news?'
Questions that carry hidden agendas 'Are you busy on Friday night?' 'Will you do me a favour?'	**To encourage elaboration** 'Tell me more about that' 'Keep going…I'm with you.'
Questions that seek 'correct' answers 'Honey, do you think I am overweight?' 'Which shoes do you think I should wear?'	**To encourage discovery** 'So, what do you see as your options?' 'What would be your ideal solution?'
Questions based on unchecked assumptions 'Why aren't you listening?' 'What's the matter?'	**To gather more facts and details** 'What did you do then?' 'What did she say after that?'

2. Paraphrasing

The second type of active listening is paraphrasing. Paraphrasing is feedback; you put the speaker's words in your own words. Paraphrasing allows you to find out if the message received is the message sent. It is a way of finding out whether you understood the other person correctly. It is helpful as sometimes too many questions might become counterproductive and may seem more like cross-examination rather than genuine interest. One can use paraphrasing as another alternative.

You can paraphrase messages at two levels, namely:

1. Feedback of factual information (summarise facts, data, and details)
2. Feedback of personal information

3. Empathising

Empathising is another active listening style. Empathising occurs when a listener acknowledge the content and validity of a speaker's perceptions. Empathy is to listen with your heart. Let's look at the following table.

Empathising	Not Empathising
'I can see that really hurts.' 'You seem to be really happy about that.' 'I know how important that was to you.' 'Wow that must be rough.' 'This means a lot to you, doesn't it?' 'It hurts to feel unappreciated.' 'I think I've felt that way too.' 'Looks like that really made your day.'	'Don't worry about it!' 'That's a silly way to feel!' 'Hey, it's only a game!' 'You'll feel better tomorrow!' 'Well your problem is obvious, you just have to…' 'You know it's your own fault!' 'Don't blame me, I have done my part!'

Parenting Skills

Situation	Negative 'You' message (labelling, blaming, ridiculing, etc.)	'I' message (expressing our thoughts/feelings)	Positive 'You Seem' message (reflecting back and/or clarifying child's feelings) with **Follow-up, open-ended question.**
Your 10 year-old child is getting low grades at school	*You can't do anything right! You're a poor student!*	*I'm concerned about your grades.*	*Lately you seem disinterested in your school work with low grades in this last report card.* *What's going on?*
You suspect your teenager has been experimenting with drugs	*You've been using drugs, I just know it! You won't amount to anything! You're no good!*	*I'm worried that you've been trying drugs and I don't want anything to happen to you. Let's talk about it.*	*You seem distant from us lately. It seems like you're getting pressure from your friends.* *What can I do to help?*
1.			
2.			

1. Children need to pay attention – so you have to ask your child to look at you when you are talking or go down on your knees to be on equal level when you talk to them.

2. Be sure that they understand your message; ask them to repeat in their own words what you've agreed to.

3. You can also ask them what feelings of yours they've become aware of (i.e. anger, sad, happy). In this way they will be able to connect feeling and content.

4. If the child does not repeat the message or your feelings clearly, it provides you with the opportunity to clarify both and to help them with active listening.

SESSION FIVE: EFFECTIVE PROBLEM SOLVING THROUGH COMMUNICATION

Notes: Problem Solving

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To-do list: Problem solving or Conflict management.

7. Difficult issues must be controlled.
8. Conflicts need to be slowed down.
9. Members may call for 'time-out'.
10. Arguments should be kept constructive.
11. Avoid withdrawal.
12. Involvement must be maintained.

Notes: Problem-solving Plan

a. Define your needs:

_____
_____
_____
_____

b. Share your needs with the other person:

_____
_____
_____
_____

c. Listen to the other person's needs:

_____
_____
_____
_____

d. Generate possible solutions:

_____
_____
_____
_____

e. Evaluate the possible solutions and choose the best one:

_____
_____
_____

f. Implement the solution:

_____
_____
_____

g. Follow up the solution:

_____
_____
_____

Problem-solving Worksheet

1. Identify the problem (specific):

_____

_____

2. Share your needs with the other person: *(Use the 'I feel' formula)*

_____

_____

3. Listen to the other person's needs: *(Use active listening skills)*

_____

_____

4. Formulate a shared definition of the problem:

_____

_____

5. Be creative and brainstorm options and possible solutions:

- ○ _____

- ○ _____

- ○ _____

- ○ _____

- ○ _____

(Let each member score each option out of 10, discuss the ones with the highest scores)

6. Review steps 1-4 once again and now decide on your plan of action.

7. Implement the solution.

8. Follow up and monitor progress of the solution.

Problem-solving Worksheet

1. Identify the problem (specific):

_____

_____

2. Share your needs with the other person: *(Use the 'I feel' formula)*

_____

_____

3. Listen to the other person's needs: *(Use active listening skills)*

_____

_____

4. Formulate a shared definition of the problem:

_____

_____

5. Be creative and brainstorm options and possible solutions:

- ○ _____
- ○ _____
- ○ _____
- ○ _____
- ○ _____

(Let each member score each option out of 10, discuss the ones with the highest scores)

6. Review steps 1-4 once again and now decide on your plan of action.

7. Implement the solution.

8. Follow up and monitor progress of the solution.

Problem-solving Worksheet

1. Identify the problem (specific):

_____

_____

2. Share your needs with the other person: *(Use the 'I feel' formula)*

_____

_____

3. Listen to the other person's needs: *(Use active listening skills)*

_____

_____

4. Formulate a shared definition of the problem:

_____

_____

5. Be creative and brainstorm options and possible solutions:

 o _____

 o _____

 o _____

 o _____

 o _____

(Let each member score each option out of 10, discuss the ones with the highest scores)

6. Review steps 1-4 once again and now decide on your plan of action.

7. Implement the solution.

8. Follow up and monitor progress of the solution.

Problem-solving Worksheet

1. Identify the problem (specific):

_____

_____

2. Share your needs with the other person: *(Use the 'I feel' formula)*

_____

_____

3. Listen to the other person's needs: *(Use active listening skills)*

_____

_____

4. Formulate a shared definition of the problem:

_____

_____

5. Be creative and brainstorm options and possible solutions:

○ _____

○ _____

○ _____

○ _____

○ _____

(Let each member score each option out of 10, discuss the ones with the highest scores)

6. Review steps 1-4 once again and now decide on your plan of action.

7. Implement the solution.

8. Follow up and monitor progress of the solution.

Notes: Goal Setting

Key building blocks of effective communication in families
8. Communicate frequently.
9. Communicate clearly and directly.
10. Be an active listener.
11. Communicate openly and honestly.
12. Focus on effective problem solving.
13. Be positive.
14. Practise, practise, practise good communication.

Goal Setting: Worksheet

Family's Name:

_____

Goals in terms of Communication in our Family:

_____
_____
_____
_____
_____
_____

Goal 1:

_____
_____

Goal 2:

_____
_____

Goal 3:

_____
_____

Goal 4:

_____
_____

Goal 5:

_____
_____
_____

Notes: Group Evaluation

Questions:
1. How did you experience the workshop?
2. What in the workshop did you find stimulating?
3. How could we improve the workshop?

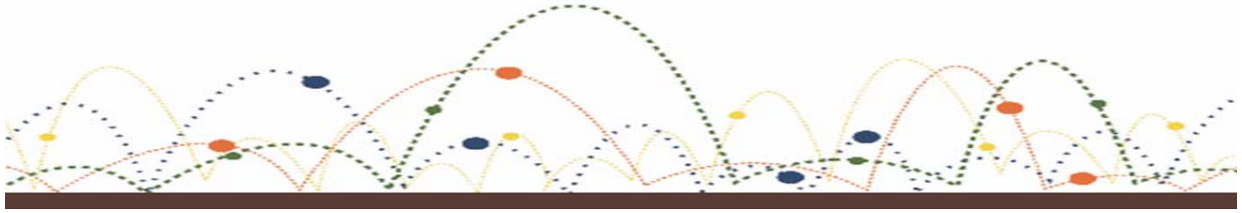**Next Meeting:**
23 November @ 10:00 – 12:00
Officer's Conference Facility, Military Hospital
For
Certification and Evaluation

ADDENDUM I

WORKSHOP EVALUATION FORM: POST

Appendix 3:Workshop Evaluation Form (Post)

Please complete the following questions and elaborate on your answer.

4. How did you experience the workshop?

_____
_____
_____
_____
_____
_____
_____
_____

5. How might it have been different?

_____
_____
_____
_____
_____
_____
_____
_____

6. What did you learn about yourself, your family or life in general?

_____
_____
_____
_____
_____
_____
_____
_____

4. Will you be able to apply what you have learned to your family situation?

_____
_____ 334
_____
_____
_____
_____
_____
_____
_____

5. How could you remember the topics we have discussed in the workshop?

_____
_____
_____
_____
_____
_____
_____
_____

6. Any suggestions for future workshops regarding the information, the format of the workshop or the exercises?

_____
_____
_____
_____
_____
_____
_____
_____

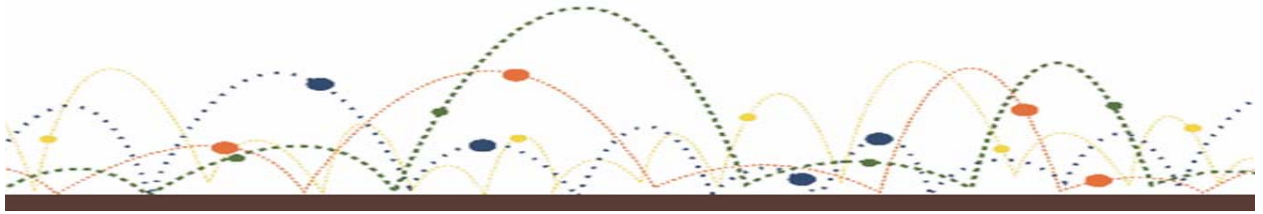7. Any suggestions for the facilitator?

_____
_____
_____
_____
_____
_____
_____
_____

ADDENDUM J

WORKSHOP EVALUATION FORM: THREE-MONTH FOLLOW-UP

Appendix 4: Workshop Evaluation Form
Three-month Follow-up

Please complete the following question and elaborate on your answer.

1. Did the Family Communication Workshop impact on the communication in your family? If so, please indicate in what way. If not, please indicate why not.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

2. Did the workshop on Family Communication contribute to improving your family functioning? If so, please indicate in what way. If not, please indicate why not.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

THANK YOU

ADDENDUM K

FAMILY COMMUNICATION WORKSHOP: CERTIFICATE

CERTIFICATE

FAMILY COMMUNICATION WORKSHOP

It is hereby certified that

_____ participated in

and successfully completed a FAMILY COMMUNICATION WORKSHOP.

The FAMILY COMMUNICATION WORKSHOP addressed the following focus areas:

- Communication building blocks

- Climate for positive family communication

- Effective communication

- Effective problem solving through communication

Facilitator: Clinical Psychologist, Carin Bester

Date: November 2007