FAMILY FUNCTIONING AND ITS RELATION WITH SELF-ESTEEM AMONG DRUG ADDICTS

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ABSTRACT

The objective of this study is to observe the pattern of family adaptability and family cohesion of the rehabilitees and family type in terms of its functionality amongst drug addicts. It is also to ascertain if there exists a relationship between family adaptability and family cohesion in a drug-addict's family; family adjustment and family cohesion with self-esteem of drug-addicts; and between family functioning and self-esteem of drug addicts. A survey was carried out at Pusat Serenti Dengkil, Selangor by interviewing 200 subjects for research phase 1; 172 for research phase 2; and 202 for research phase 3. The research instruments are Family Adaptability and Cohesion II Scale (FACES II) and Culture Free Self-Esteem Inventory (CFSEI). The findings shows that majority of the residents came from families that are broken and separated in terms of family cohesion, families that are rigid and too structured in terms of family adaptability and families that did not function. A significant relationship between family cohesion and family

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adaptability was observed. It was also found that the higher the score in family cohesion, the lower the self-esteem and the higher the family adaptability score, the higher the self esteem scores. Implications for rehabilitation are discussed.

ABSTRAK

Tujuan kajian ini adalah untuk memerhatikan hubungkait di antara penyesuaian dan kohesi keluarga di kalangan residen yang dikaitkan dengan kefungsian keluarga penagih-penagih dadah. Disamping itu, ia adalah untuk mengenal pasti jikalau wujud hubungan di antara penyesuaian dan kohesi keluarga di kalangan keluarga penagih dadah; penyesuaian, kohesi dan harga diri; dan kefungsian dan harga diri. Tinjauan dilakukan di Pusat Serenti Dengkil, Selangor dengan cara menemuduga 200 residen untuk fasa penyelidikan pertama; 172 untuk fasa penyelidikan kedua dan 202 untuk fasa penyelidikan ketiga. Ukuran kajian yang digunakan ialah Adaptability dan Cohesion II Scale (FACES II) dan Culture Free Self-Esteem Inventory (CFSEI). Dapatan kajian menunjukkan bahawa kebanyakan residen datang dari keluarga berpecah-belah dan berpisah-pisah dari segi kohesi keluarga; keluarga yang terlalu keras, terlalu berstruktur dari segi penyesuaian keluarga dan keluarga yang tidak berfungsi dengan baik. Kajian turut mendapati dengan meningkatkan kohesi keluarga, harga diri menurun; dan semakin tinggi penyesuaian keluarga, maka semakin tinggi juga skor harga diri. Implikasi untuk pemulihan turut dibincangkan.

Introduction

Drugs can be defined as any psychoactive chemical substances, natural or synthetic, that will modify the functions of the human body system when taken internally, resulting in the body's total dependence on the influences of the substance and subsequently endangering the well-being of oneself, family, community and country (Scorzelli, 1987).

Drug addiction is a continuous problem for Malaysia that has begun a few decades ago. Substantial allocations have been dispensed by the government to combat this problem. Nevertheless, the problem persists with the number of drug addicts increasing every year.

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National Anti-Narcotics Agency reveals that between 1988-2005 there were an estimated 289,763 number of registered drug addicts The first quarter of this year only (Jan-Mac 2006) there were 7,001 drug addicts were identified with 2,933 of them (41.89%) being beginners and the remaining 4,068 (58.89%) were relapse offenders. Many have a high degree of resistance to therapy, and relapse may be frequent with up to 90% having one relapse during the first 4 years following treatment (Diamond, 2000). Drug addicts in Malaysia are mainly youth ranging between 20 to 29 years of age especially men, which is the most productive stage in life where they could have been assets to the development of a country.

Many approaches have been undertaken by the government to resolve the drug problem. One of which was the legislation of the drug abuse and drug distribution, for instance, the Dangerous Drug Act 1952 (revised 2002), Drug Dependent Act (Treatment and Rehabilitation, 1983), Dangerous Drug Act (LLPK-Special Preventive Measures) 1985, Dangerous Drug Act (Forfeiture of Property) 1988 and the Poison Act 1952 (revised 1989). In 2004, the National Anti-Drug Agency Act was passed by the parliament which gives enforcement capabilities to the agency.

Other strategies taken by the government is the formation of the National Anti-Drug Agency (NADA) which organize various programs for drug rehabilitation through the formation of many rehabilitation centers (Pusat Serenti) all over the country. NADA also provide support to several civil societies such as the Malaysia Drug Prevention Society (PEMADAM), The Association of Ex-Drug-Addicts or PENGASIH, the alumni of NADA which is known as PENDAMAI and many other Non-Governmental Organizations to aid and support the anti-drug movement in the country.

There are many factors contributing to the drug problem, one of which being the family institution itself. Family adaptability is defined as the ability of a family system to change or modify the structures, authority, relationship and role according to situations and stresses in its development. Cohesion on the other hand is the level of participation of family members in caring about and helping each other in the family that can affect a person and the personality traits of the family members.

There have been several studies that have looked into family issues among drug users and abusers. Azaman Ahmad (2000) surveyed over 70 subjects in Pusat Sereti Karak, Pahang discovered that the more positive the perception of a drug-addict of his/her family function, the lesser the risk of recurring addiction. Results from this study conformed past studies by Mahmood, Md. Shuaib and Ismail (1996); Christian Kroll (1987) and Chua Mooi Kim (1993). Family relationship and communication are also found to be at low levels in a drug-addict's family (Abdullah Al-Hadi & Iran Herman. 1998; Otero Lopez et al, 1989; Ong Teck Hong, 1989) and Hayati Saad (1994).

Objectives

The main objective for this research is to observe the pattern of family adaptability and family cohesion of the rehabilitees and family type in terms of its functionality amongst drug- addicts. This research is to determine if there exists a relationship between the family adaptability and family cohesion in a drug-addict's family. Subsequently, this research also will observe (i) the relationship between family adjustment and family cohesion with the drug-addict's self esteem and (ii) the relationship between family functioning and the drug-addict's self-esteem.

Methodology

A survey was carried out for this research, interviewing 200 subjects (research phase 1), 172 (research phase 2) and 202 (research phase 3) from Pusat Sereti Dengkil, Selangor rehabilitees. The research instruments used in this survey was Family Adaptability and Cohesion II Scale (FACES II) constructed by Ohlsen (1991) that contains 30 items and Culture Free Self-Esteem Inventory (CFSEI) that contains 90 items. The data was collected from three phases of research.

Results

Reliability of research instruments

Almost all research instruments used in this research shows a good reliability value. The value of alpha for FACES II was 0.63

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at research phase 1, 0.71, at research phase 2 and 0.82 at research phase 3. While for CFSEI the value of alpha for research phase 1 was 0.56, for research phase 2 was 0.62 and for research phase 3 the value of alpha was 0.79.

Descriptive Analysis

1. Age groups of rehabilitees of the Dengkil Pusat Serenti according to phases of research: Diagram 1 represents the age groups according to phases of the research. There are 4 age groups of drug addict rehabilitees in the Dengkil Pusat Serenti. Diagram 2 shows that the number of drug addicts in the 21-30 age group consist of 19.0% from the total number of rehabilitees in research phase 1, 19.2% in phase 2 and 3.74% in phase 3. Age group B (31-40 years) totals 44.0% in research phase 1, 51.2% in phase 2 and 38.1% in phase 3. Age group C (40-50 years) is at 33% in research phase 1, 12.2% in phase 2, and 22.3% in phase 3. Age group D (51-60 years) is 8% in research phase 1, 4.7% in phase 2 and 4.5% in phase 3. The following diagram 1 shows the age group of drug addicts between 21 -60 years. In general, it is discovered that the highest number of addicts among all the age groups is the age group between 31- 40 years. This is the age group when one is most productive in terms of labor or workforce.
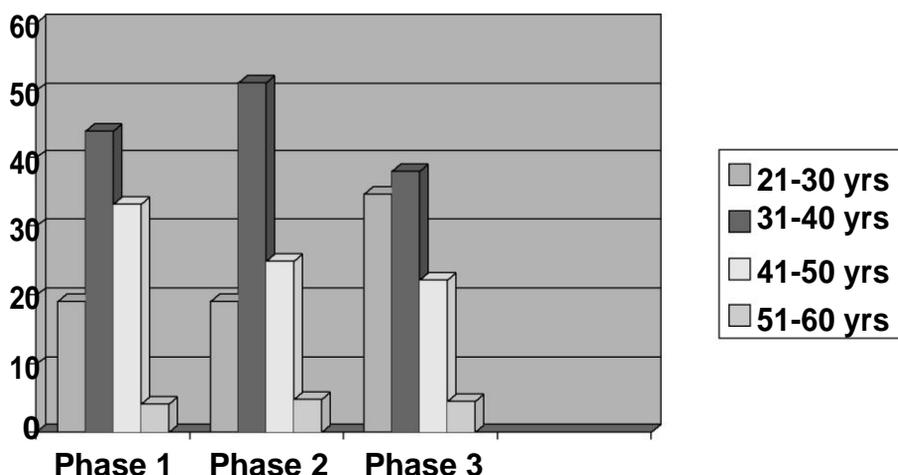

Diagram 1: Age Groups according to the research phase

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2. Marital status of the Dengkil Pusat Serenti rehabilitees according to phases of the program: Diagram 2 represents the marital status of the rehabilitees in the Dengkil Pusat Serenti according to the phases of research. It is shown that in the first research phase, bachelors or unmarried rehabilitees cover 75.5% of the total number of rehabilitees whilst 11.5% are married and others, 11%. In phase 2, bachelors/unmarried amount to 70.3% of the total number, whilst married 18% and others 10.9%. Meanwhile, in phase 3, 65.8% are found to be bachelors/unmarried, 23.3% married and others 10.9%. Overall, it could be summarized that in Phase 1, the largest number of rehabilitees consists of the bachelors or unmarried, and the same pattern is repeated in phases 2 and 3.
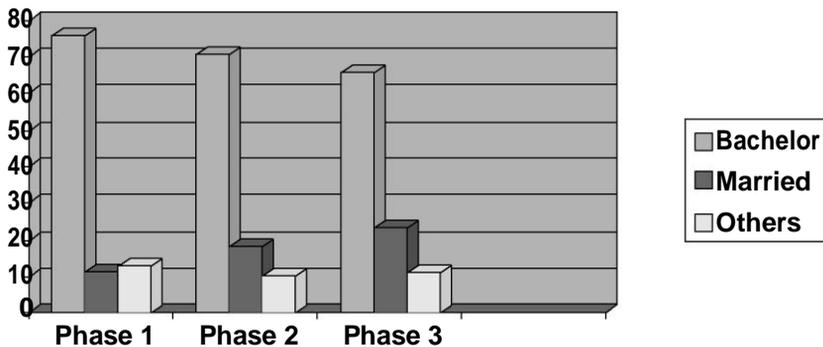

Diagram 2: Marital Status according to research phase

3. Academic achievement of rehabilitees at the Dengkil Pusat Serenti: Diagram 3 explains the degree of academic achievement of the rehabilitees of the Dengkil Pusat Serenti according to research phases. From the diagram, it is demonstrated that in phase 1, rehabilitees with only primary school education level constitutes 23.5% of the total number of rehabilitees at the center. 37.5% have lower secondary school education level whereas the rest, 34%, have full secondary school education level. In phase 2, 22.1% of the rehabilitees at the center only succeeded in obtaining primary school education, whereas 30.8% managed to achieve lower secondary school education level and 36.6% are with secondary school level of education. In phase 3, 19.3% have only primary

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school education level, 32.2% with lower secondary school education level and the remaining 40.6% have secondary school education level. From this it can be observed that most of the rehabilitees started taking drugs during their lower secondary and secondary school years. This is the stage of adolescent human development, and it is also known as the stage of "storm and stress by Hall, (1904).
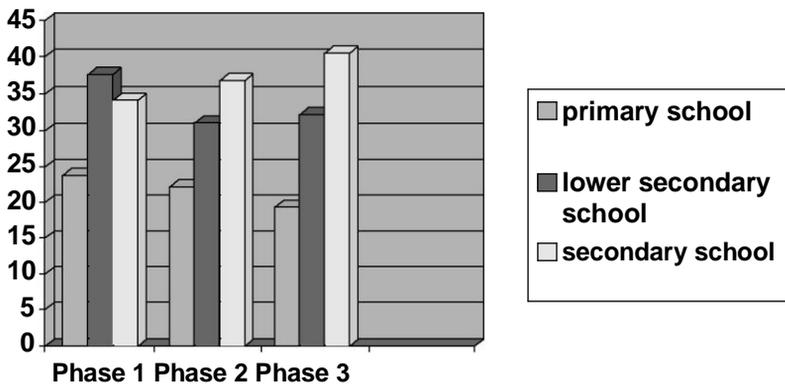

Diagram 3: Academic Achievement Levels according to research phase

4. Treatment Phase of Rehabilitees According to research phase: Diagram 4 is the treatment phases of the rehabilitees of the Dengkil Pusat Serenti according to the research phase. From the diagram, it is shown that in research phase 1 the rehabilitees receiving their first treatment phase is at 24%, treatment phase 2 rehabilitees at 25% in treatment phase 3 rehabilitees are at 26% and in treatment phase 4, 25%. Next, in research phase 2, the percentage of rehabilitees receiving treatment phase 1 is at 29.1%, treatment phase 2 are at 26.2%, treatment phase 3 with 26.7% and in treatment phase 4 amounting to 17.4%. In research phase 3, the percentage of rehabilitees receiving treatment phase 1 is at 20.8%, treatment phase 2 rehabilitees are at 27.2%, in treatment phase 3; 24.8% and in the final treatment phase, 27.2%. Overall, it can be summarized that in all research phases, the percentage of rehabilitees in different treatment phases are more or less equally divided.
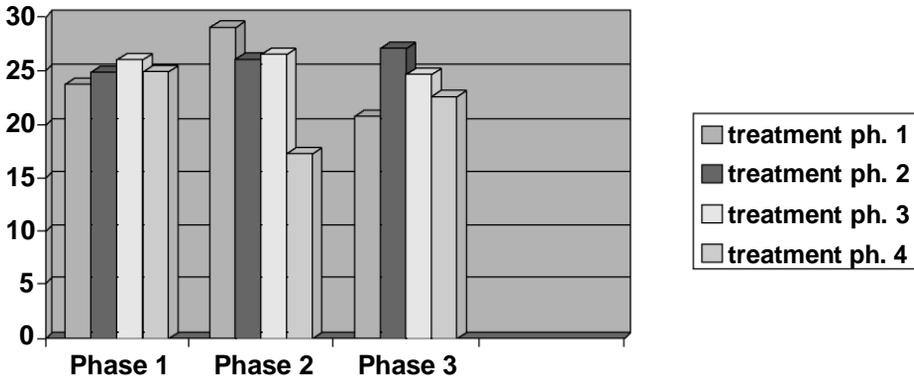
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Diagram 4: Treatment Phase of Rehabilitees According to research phase

5. Family Cohesion Type according to research phases: In terms of family cohesion, 73.7% of the drug -addicts came from broken and separated families (38.9% broken, 34.8% separated) and only 26% perceived that their families as connected or very connected to each other in relationship (25.5% connected, 0.5% very connected) in Research Phase 1. In Research Phase 2, 72.1% of the rehabilitees described their family functionality as broken or separated (35.5% broken, 36.6% separated) and only 38% perceived their family as connected or very connected (20.3% connected, 3% very connected) (refer to Diagram 5). This would mean that the majority of the rehabilitees of the Dengkil Pusat Serenti came from families that are broken and separated in terms of family cohesion.
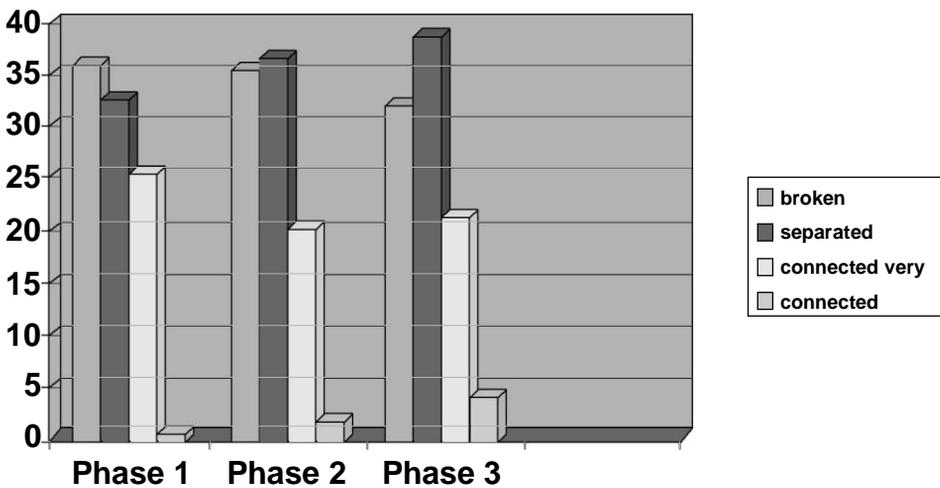

Diagram 5: Type of Family Cohesion according to research phase

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6. Type of Family Adaptibility according to research phases: In terms of family adaptibility, 60.6% of the rehabilitees came from families that are rigid and too structured (29.3% rigid and 31.3% structured) whereas 38.5% are from families that are flexible or very flexible (32.0% flexible and 6.5% very flexible) in research phase 1. In phase 2, 50% of the rehabilitees came from families that are rigid or too structured (26.7% firm, 23.3% structured). 42.4% are from flexible or very flexible families (37.2% flexible and 5.2% very flexible). Whereas in phase 3, 57.9% of the rehabilitees came from families that are firm or too structured (28.2% firm, 29.7% structured) whereas 35.6% are from flexible or very flexible families (28.2 flexible and 7.4% very flexible) as shown in Diagram 6. This would mean that the majority of the rehabilitees of the Dengkil Pusat Serenti came from families that are rigid and too structured in terms of family adaptability.
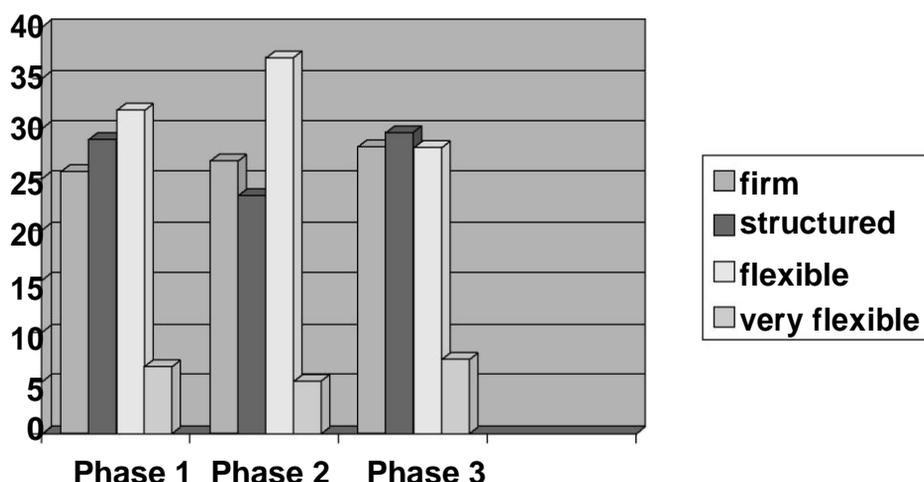

Diagram 6: Type of Family Adaptability According to Phases

7. Type of family functionality according to research phases: In terms of the functions of a family, for research phase 1, 52.5% of the drug-addicts perceived their family functionality as extreme and 38.5% perceived their family functionality as average. In phase 2, 50.6% drug-addicts perceived their family functionality as extreme whereas 40.1% described their families as average. Finally in phase 3, 53.0% of the drug-addicts perceived their family

functionality as extreme and the remaining 39.6% perceived their family functionality as average. From this it can be summarized that a large number of the drug-addicts at the center came from families that did not function, as demonstrated in Diagram 7.
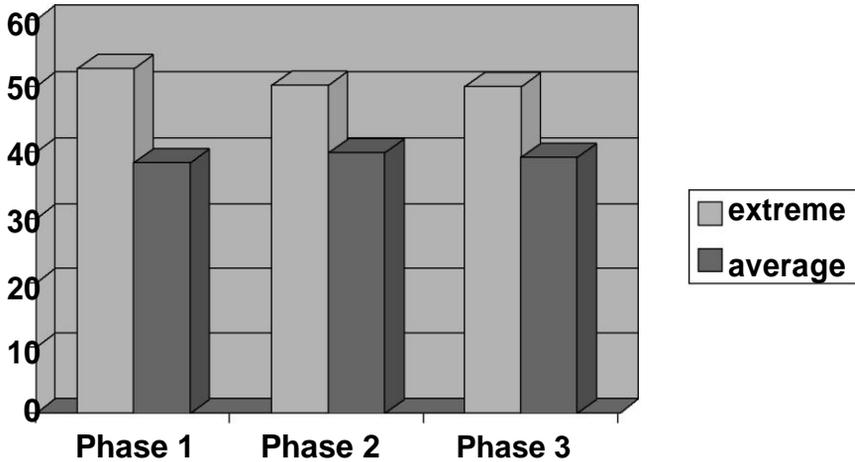

Diagram 7: Type of family functionality according to research phases

Inferential Statistics

1. Relationship between family cohesion and family adaptability

Subsequently from the results it is found that there is a significant relationship between family cohesion and family adaptability in all the research phases, for instance, in Research Phase 1, the value r is significant ($r = 0.73$, $k < 0.05$). In research phase 2 the value r is significant ($r = 0.74$, $k < 0.05$). In research phase 3, the value r is significant ($r = 0.72$, $k = 0.05$), all as simplified in Schedule 1 as follows:

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Schedule 1: The Pearson Correlation of Family Cohesion and Adaptability according to Phases

Phase	Variable	r
Phase 1	Family Cohesion	0.73 *
	Family Adaptability	
Phase 2	Family Cohesion	0.74 *
	Family Adaptability	
Phase 3	Family Cohesion	0.72*
	Family Adaptability	

* $k < 0.05$

2. The Relationship between family cohesion and self esteem

Schedule 2 demonstrates the relationship between family cohesion and self-esteem in all research phases. From the analysis, it can be said that there is a significant relationship between family cohesion and self-esteem, that is $r = 0.20$, $k < 0.05$ for phase 1, $r = 0.29$, $k<0.05$ for phase 2, and $r = 0.36$, $k < 0.05$ (phase 3). The form of relationship is positive, meaning that the higher the score in family cohesion, the lower self-esteem the rehabilitee would have.

Schedule 2: Pearson Correlation between Family Cohesion and Self-esteem

Phase	Variable	r
Phase 1	Family Cohesion	0.20 *
	Self-Esteem	

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Phase	Variable	r
Phase 2	Family Cohesion Self-Esteem	0.29 *
Phase 3	Family Cohesion Self-Esteem	0.36*

* k < 0.05

3. Relationship between Family Adaptability and Self-Esteem

Schedule 3 shows the relationship between family adaptability and self- esteem in all research phases. From the analysis it is found that there is a significant relationship between family adaptability and self - esteem, represented by $r = 0.25$, $k < 0.05$ (phase 1), $r = 0.25$, $k < 0.05$ (phase 2) and finally $r = 0.24$, $k<0.05$ (phase 3). The form of relationship is positive, meaning that the higher the score in family adaptability, the higher the self-esteem. Reversely, the lower the family adaptability score, the lower the self-esteem of the rehabilitees.

Schedule 3: Pearson Correlation between Family Adaptability and Self-Esteem

Phase	Variable	r
Phase 1	Family Adaptability Self-Esteem	0.25 *
Phase 2	Family Adaptability Self-Esteem	0.25 *
Phase 3	Family Adaptability Self-Esteem	0.24*

* k < 0.05

Discussion and implication of the study

This research discovered that the highest number of addicts among all the age groups is the age group between 31-40 years. This is the age group when one is most productive in terms of labor or workforce. This phenomenon contributes to shortage of works force in Malaysia. In order to fulfill this need Malaysia has to hire labor force from foreign country like Indonesia, Bangladesh, Pakistan, Burma, Thailand and African countries.

This study also found that the largest number of rehabilitees consists of bachelors or unmarried men and from 29 one stop drug rehabilitation centers in Malaysia 28 of them are for men except for Bachok Kelantan which is for women rehabilitees. This means that there are more men that are less functional as good husbands for non addict women in Malaysia. The implication is that there is a tendency the rate of population in Malaysia will decrease.

From diagram 3 we can observe that most of the rehabilitees started taking drugs during their lower secondary and secondary school years. This is the stage of adolescence in human development, and it is also known as the stage of "storm and stress" by Hall, (1904). At this stage adolescents are facing with identity crisis within themselves. They want to be free from the bond of their parents. According to Erikson (1968) the primary challenge of adolescent is developing a clear sense of identity. When children reach adolescence and seek to establish their own identities, gradual alignment should occur in parent-child relationships. Nonetheless conflicts over values are common, and power struggles frequently ensue (Silverberg, Tennenbaum, & Jacobs 1992). For adolescent who have disagreement with their parent they always turn to their peers and get influenced easily with the activities of their peers that include the negative ones.

In terms of family adaptability, majority of the rehabilitees of the Dengkil Pusat Serenti came from families that are too rigid and too structured. This means that the family system of the addicts are not flexible to changes or modify the structures, authority, relationship and role according to situations and stresses in its development. This impact the development of each individual in

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the family. While in terms of family cohesion the majority of the rehabilitees of the Dengkil Pusat Serenti came from families that are broken and separated. This means that the level of participation of family members in caring about and helping each other in the family that can affect a person and the personality traits of the family members is very low. Members in a low level of cohesion family always feel rejected and unwanted. In summary most addicts of Dengkil Pusat Serenti came from families with low functionality levels.

There existed a positive relationship between family cohesion and family adaptability for each treatment phases. This proves that the higher the cohesion levels or closeness in a family, the higher the level of family adaptability in creating a successful family. Reversely, the lower the family cohesion then the lower the family adaptability becomes. Findings from this research also proves that there is a significant relationship between family cohesion and adaptability with the rehabilitee's self-esteem, which means that the higher the addict's family cohesion and adaptability levels, the higher is the addict's self-esteem. The reverse applies as well where the lower the addict's family cohesion and adaptability levels, then the addict's self-esteem becomes lower too.

The implications from this research demonstrates that family institution is the root where family members' psychological problems are formed and therefore the family is also the place to turn to in resolving behavioral issues or problems, especially in children. A paradigm shift has to be initiated in the drive to resolve drug-addiction problems in Malaysia, where the family should play a significant role in any drug-rehabilitation programs in the country.

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