INFLUENCE OF CONJOINT AND TRANSGENERATIONAL FAMILY THERAPIES ON DYSFUNCTIONAL FAMILIES IN KAFANCHAN, KADUNA STATE, NIGERIA.

BY

Chidimma Juliana OKOSUN

AUGUST, 2015

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Chidimma Juliana OKOSUN
N.C.E. 1992 (A.B.U.)
B.ED 1997 (A.B.U)
M.ED 2009 (A.B.U)
PhD/EDUC/8364/2010-2011

A THESIS SUBMITTED TO THE SCHOOL OF POSTGRADUATE STUDIES, AHMADU BELLO UNIVERSITY, ZARIA IN PARTIAL FULFILLMENT FOR THE REQUIREMENTS FOR THE AWARD OF DEGREE OF DOCTOR OF PHILOSOPHY IN HOME ECONOMICS

DEPARTMENT OF VOCATIONAL AND TECHNICAL EDUCATION
FACULTY OF EDUCATION
AHMADU BELLO UNIVERSITY, ZARIA, NIGERIA.

AUGUST, 2015

DECLARATION

I declare that the work in this dissertation titled 'Influence of Conjoint and Transgenerational Family Therapies on Dysfunctional Families in Kafanchan, Kaduna State' has been conducted by me in the Department of Vocational and Technical Education. The information derived from the literature has been duly acknowledged in the text and in the list of references provided. No part of this dissertation was previously presented for the award of degree or diploma at this or any other institution.

Chidimma Juliana OKOSUN _____ Signature _____ Date

CERTIFICATION

This dissertation titled "Influence of Conjoint and Transgenerational Family Therapies on Dysfunctional Families in Kafanchan, Kaduna State' by Chidimma, Juliana OKOSUN meets the regulations governing the award of the degree of Ph.D Home Economics of the Ahmadu Bello University, and is approved for its contributions to knowledge and literary presentation.

…….
Prof E. Ike **……..**
Chairperson, Supervisory Committee **Date**

……
Prof P.E Onuigbo **……..**
Member, Supervisory Committee **Date**

…….
Dr. E.E Adamu **……..**
Member, Supervisory Committee **Date**

……
Prof A.A. Udoh **……..**
Head of Department **Date**
Vocational and Technical Education

……..
Prof A.Z. Hassan **……..**
Dean, School of Postgraduate Studies **Date**

DEDICATION

This research work is dedicated to my hero, my late daddy, Chief Cletus C. Eneh,

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The researcher would like to humbly acknowledge her heavenly Father, the Most High God, for sparing her life to witness the end of this work, for, without His will, beginning and compilation of this piece of research study would not have been possible. May all praise glory, honour and adoration be ascribed unto His Holy name, Amen.

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ABSTRACT

Clinicians and researchers alike are turning attention to how families from different cultural and social backgrounds achieve positive ways of functioning in adapting to serious threats, crises or the strains of significant life changes. These have led to the emergence of some interventions aimed at helping families overcome their problems. Therefore, this study was conducted to establish the influence of Conjoint and Transgenerational family therapies on dysfunctional families in Kafanchan, Kaduna State. The main objective was to determine the influence of the therapies under study, that is , Conjoint and Transgenerational Family Therapies, on dysfunctional families in Kafanchan. Quasi experimental research design, using specifically the Nonequivalent control group design was employed for the study. A sample of twenty (20) dysfunctional families were used for the study. Fifteen families served as the experimental group while five families served as the control group. Questionnaire was used to obtain relevant data. Data collected were analyzed using frequencies, percentages, weighted mean, paired and independent t-test and ANOVA.F iv e null hypotheses were stated and all were tested at 0.05($P<0.05$) level of significance. The result of the findings revealed significant positive influence of Conjoint and Transgenerational or combination of both therapies on dysfunctional families. The result also revealed that there was no significant difference in the treatment outcome of both family therapies on dysfunctional families. Also the findings showed that there was significant difference in dysfunctional families treated with the family therapies studied and the control group. The study also showed addiction to alcohol by one or both parents and the use of threat and application of physical violence on children as the types of family dysfunction found in the area of study. It was also observed from the findings that authoritarian parenting is one of the causes of family dysfunction in the area where the research was carried out. Researcher's recommendations among others were that (1) religious bodies and NGO's should help with enlightenment campaigns by organizing seminars and workshops for married couples on parenting so that they will know the type of parenting that promote the types of dysfunction found in Kafanchan, (2) relationship education should be introduced into the senior secondary school curriculum and marital therapy in the tertiary institutions curriculum to help equip the young ones and also those already married with knowledge on relationships and marriage and prepare them for martial life or help them to live healthy marital life. The researcher concluded by stating that it was established that family dysfunction is found among some families in Kafanchan and the importance of Conjoint and Transgenerational Family Therapies in treating and bringing stability to dysfunctional families cannot be over emphasized. Therefore, Conjoint and Transgenerational Family Therapies had significant positive influence on dysfunctional families in Kafanchan.

OPERATIONAL DEFINITION OF TERMS

- **Family Therapy:** Treatment given to families and couples in intimate relationships to nurture change and development or treatment given to families to restore peace and normal family life.
- **Family Dysfunction:** Any condition that interferes with healthy family functioning or family living. This can also be seen as a family that has no peace not just for a moment but it lingers on. Happy family life is lacking.
- **Geneogram:** Is a detailed information about a family from past to present. It gives a visual diagram of the family structure.
- **Conjoint therapy:** Bringing all members of a nuclear family together in a bid to heal them of any dysfunction.
- **Couple**: This means one man with one wife.
- **Transgenerational therapy**-using the past history of a family to treat the dysfunction in the family.
- **Psychoanalysis** –method of understanding mental life of family members.
- **Triangulation** –a common way in which two persons under stress attempt to achieve stability in a third person
- **Psychotherapy** –treatment of mental disorders by psychological methods.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

In the context of human society, a family is a group of people affiliated by recognized birth, by marriage or co-residence and or shared consumption. In most societies, the family is the principal institution for the socialization of children. Family is a basic social unit consisting of parents and their children.

One of the primary functions of the family involves providing a framework for the production and reproduction of persons, biologically or socially. Members of the immediate family includes spouses, parents, brothers, sisters, son and daughters. Members of the extended family may include grandparents, aunts, uncles, cousins, nephews, nieces and siblings-in-law.

Sharing one's life with a happy healthy family is for many people, one of the most important goals. It is not secret that dysfunctional relationships and a chaotic family life are major contributors to social problems including juvenile delinquency, domestic abuse and addiction. However, there are some successful families who thrive, contribute to their communities, and nurture future generations to do the same. Characteristics of a happy and healthy family include, effective communication, appreciation, spending time together, commitment good coping skills, values and convictions. Some families for some reasons lack these qualities and this brings about a lot of friction in the home thereby leading to dysfunctionality.

All families have the potential for growth and adjustment in response to distress, trauma or crisis. Undoubtedly, some families, regardless of type, number of problems, ethnic or racial makeup, religion and spirituality, socio economic status, sexual orientation, or degree of education, are happier and more stable than others. They are more flexible in seeking solutions to problems, more purposeful in pursuing satisfaction than other families. Clinicians and researchers alike are turning attention to how families from different cultural and social background achieve positive ways of functioning in adapting to serious threats, crises or the strains of significant life changes. These have led to the emergence of some interventions aimed at helping families overcome their problems. Following the emergence of specialization in various societies, these interventions were often conducted by particular members of a community; for example, a chief, priest, physician, and so on, usually as an ancillary function. As these interventions became formalized, trained family therapists began to emerge each proposing somewhat different theoretical formulations and intervention technique.

Family therapy is used to classify psychological treatment with families. Family therapy differs from other psychological and environmental treatments in its perception of the family as an organism which is made up of individuals closely bound by their interaction, (Hart, 2007).Eliot and Norton (1989) defined family therapy as an ecological framework which assumes that the mutual relationship between family members and their environment is a pivotal area of intervention. This definition encompasses a seminal conceptual shift from the understanding of illness and pathology in individual psychological terms to that of the interactions

between individuals in close emotional relationship. There exists different approaches to family therapy among which are Conjoint and Transgenerational family therapies, (Kafka, 2008).

Conjoint family therapy aid in the identification and working through of distortions, helps hold transference and counter- transference in check, quickly brings mental conflicts into the open and into the counseling sessions and emphasizes current relationship problems, (Lowenstein and Spunk, 2010). According to Goldenberg and Goldenberg (2004), Conjoint family therapy is defined as an involvement of all members of a nuclear family in therapy with the intention of improving or establishing an open and honest manner of communication. Conjoint family therapy is not a panacea, however, it requires new skill of therapists and is demanding work.

Transgenerational family therapy is a dissection of the transmission of family culture in its broad sense from one generation to the next encompassing those patterns, styles, customs, secrets, myths, and problems which determine the uniqueness of a family,(Framo, 2005). Transgenerational therapy focuses on the dimension of time within family systems in an attempt to catalyze the present through the use of the past. According to Elliot and Norton (1989), Transgenerational family therapy is defined as that approach to family therapy that connects the present nuclear family quandary with the past as far back as four to five generations. Satir (1983) described the family as an interacting unit that strives to achieve balance in relationships through the use of repetitious, circular and predictable communication patterns. When this balance in relationship is absent, a

dysfunction arises. Family dysfunction is thus defined by Steven (2009) as lack of a sustainable environment which promotes emotional and physical health and psychological well-being of members in a family. Hart (2007) also stated that family dysfunction can also mean the family experienced violence, various kinds of abuse or alcohol and drug abuse.

Sigal, Rakoff and Epstein (1997), stated that the different schools of family therapy have in common a belief that regardless of the origin of the problems, and regardless of whether the clients consider it an "individual" or "family" issue, involving family members in the solution is often beneficial. This involvement of families is commonly accomplished by their direct participation in the therapy session. The skills of the therapist thus include the ability to influence conversations in a way that catalyses the strengths, wisdom and support of the wider system.

Understanding how a family works and interacts is the key objective of a therapist. During the last seven decades, the family therapy movement has tried to understand the mystery and beauty of the family. From psychoanalysis to the narrative school, every single school has discovered a new facet of the family.

Family dysfunction can be any condition that interferes with healthy family functioning. Most families have some period of times where functioning is impaired by stressful circumstances (death in the family, a parent's serious illness). Healthy families tend to return to normal functioning after the crises passes. In dysfunctional families, however, problems tend to be chronic and children do not consistently get their need met. Negative patterns of parental behavior tend to be dominant in their

children's lives, (Gil, 1993). A dysfunctional family is a family in which conflict, misbehavior and often child neglect or abuse on the part of individual members of the family occur continually and regularly, leading other members to accommodate such actions (Hart, 2013). Children sometimes grow up in such families with the understanding that such arrangement is normal. There are many types of dysfunction in families. Some parents under- function, leaving their children to fend for themselves. Other parents over- function, never allowing their children to grow up and be on their own. Others are inconsistent or violate basic boundaries of appropriate behavior. All these are the various types of dysfunction in families. The consequences of these is that the family now begin to experience serios crisis that are very much beyond their strength in handling. Family dysfunction can be found among the low, middle and high class families. It is not associated with any class of families, (Bass & Davis, 2008).

In truth, almost all families are dysfunctional,(Eric, 2009). In Nigeria, a lot of factors contribute to families being dysfunctional, examples are poverty and unemployment. In Kafanchan, a semi-urban town with majority of families in the low and middle class, many factors are contributing to the increase in dysfunctional families. For example, the researcher observed that there is high level of drunkenness among the people living in the town. Kafanchan is an ancient town located in the southern part of Kaduna state in Nigeria. The main occupation of people from this town is farming. The town has people from different tribes living in it. Despite the benefits of Conjoint and Transgenarational Family Therapies in the healing of dysfunctional families as opined by Hartline (2007) many families

cannot access it because they don't have knowledge of it, more so there are no formal family therapy units in Kafanchan. From the researcher's observation, most of the families do not even realize they are dysfunctional. They see whatever that is happening in their homes as part of family life, so why should they look for treatment.

It is in view of the foregoing that this study tends to identify some of the dysfunctional families in Kafanchan and treat them using the conjoint and Transgenerational Family Therapies. This is geared towards assessing the stability of families, identifying the challenges and causes of family dysfunction while using the therapies under study to create stability in families. This study cannot be more necessitated than at a time like this when the country is facing a lot of crisis. Undoubtedly the family is the bedrock of the nation. If families are not stable, surely the society will not be stable.

1.2 Statement of the problem

There is an outcry over the decline of moral standards in the society which obviously is coming from the family, (Ononuju, 2004). In September 2010, the Catholic Bishops of Nigeria cried out over the level of dysfunction among families, which has given rise to a lot of divorce. In a bid to tackle the problem, they mandated all churches to carry out a one week programme to sensitize married couples on issues concerning marriage, how to live healthy marital lives and the dangers of family dysfunction to both the family and society at large.

Daily Sun, Vanguard and The Nation newspapers of 10th February, 24th February and 3rd October 2013 respectively grab readers attention with reports of

spouse beatings, child abuse, sexual abuse, murder, drug-related crimes, and alcohol-related accidents. Many of these behaviors occur within the four walls of a family's home. Even when criminal behavior is absent, alcoholism and other obsessive and compulsive disorders dominate the emotional climate in many families. Many more experience constant arguing, runaway children, or emotional cutoff between family members. Why are so many families in turmoil? Why is there so much unhappiness and dissatisfaction expressed? Why do so many try to escape their life situation through compulsive behaviors of various kinds? These are questions that need to be answered.

The Nation newspaper of December 7th 2009, reported a case of a police man in Maiduguri who killed his wife and later shot himself because of a disagreement they had in connection with their son. The paper reported that the officer had become angry over the regular misbehavior of their son and the continuous support of his wife for the boy. This is a clear case of family dysfunction because from the story it is obvious that the family was not stable and the instability led to the crime since they could not manage their dysfunctional state. The researcher was particularly steered into this study because of a recent incidence in Kafanchan where a son had sex with the mother because both of them were under the influence of alcohol. When later they realized what they did, the boy ran away from home and vowed never to return. Also in the same town, a man who came home drunk killed his wife because of a little misunderstanding they had and his mother who was the only one around that could have saved the wife by raising an alarm could not do anything because she was equally drunk. Framo(2005) stated

that in every family dysfunction there is someone who is at the receiving end. It is obvious that the cases stated happened as a result of family dysfunction. One of the major causes of family dysfunction in Kafanchan is alcoholism. This has caused a lot of problems in many families. Another example was a case of a young boy who fought with the father at the place they both went to drink because they both had interest in the lady that own the place. There was another case of a family that disowned their teenage son who was always stealing the parents money and always came home drunk and has refused to do anything to be useful to himself. This particular case is being handled by the researcher. These are just few out of the numerous atrocities and crimes that are being committed by family members as a result of alcoholism..

Gail (2005) stated that people are in fact all from dysfunctional families. Everyone's parents made mistake, as did their parents and so on down the line. The difference is that in some families the mistakes are handled and corrected as quickly as possible to stop the dysfunctional state while in some the mistake persists and the family remains dysfunctional and at the end some may pay the price just like the cases stated above.

The rate at which families are becoming dysfunctional in Nigeria is really on the increase. This is as a result of the economic situation and moral decadence in the society, (Namka, 2008). Families where responsible individuals are expected to be formed and nurtured have become places where irresponsible acts are being carried out which in turn brings about undesired behavior in the individuals. In Anambra State, a man connived with his mistress to kill his wife and four children.

They succeeded in killing the children but the wife escaped, (Reporter, January 15th 2013). In Kafanchan, the story is the same. The painful aspect of it as observed by the researcher is that dysfunctional families are seen as normal families. Nobody seems to notice that there is a problem.

As earlier stated, dysfunctional families can be low, middle or higher class. The researcher came across a young boy one day in August 2012 in the church who was looking so depressed and confused. Upon enquiry, the boy said "my parents are not treating me well. I don't want to go home to them anymore" From the researchers observation the boy looked like someone from a middle class family. The researcher asked further to know what and how the parents were being unfair to the boy. He said "my parents have always had these big ambitions for me. They tell me what I should do all the time, what my career should be, who my friends should be and who I should date. It's like they expect me to be perfect but don't really believe I can blow my own nose. They compare me with my mates and keep reminding me of my failures. So, I don't want to go back home anymore so that they will not see me to command." This is a case of negative parenting which is one of the causes of dysfunctional families.

As a teacher in the pre-marriage class of the church, the researcher has encountered a lot of couples with different family problems. Having also served as a resource person in many workshops for married couples and singles, the researcher has realized that there are many dysfunctional families in Kafanchan and something needs to be done.

The researcher was able to get information on the level of family dysfunction in Kafanchan during the researchers internship experience at the welfare office in the town. Some of the problems stated were observed by the researcher during the preliminary study while others were reported at the office. The researcher carried out the preliminary study by visiting some families and during discussions picked out some of the problems.

These were the motivations for this study which is an investigation into the effect of Conjoint and Transgenerational Family Therapies on dysfunctional families in Kafanchan.

1.3 Objectives of the study

The major objective of the study was to investigate the use of Conjoint and Transgenerational Family Therapy on dysfunctional families in Kafanchan. The specific objectives were to:

1. identify the types of dysfunctional families in Kafanchan.
2. identify the causes of dysfunctional families in Kafanchan.
3. examine the influence of Conjoint Family Therapy on dysfunctional families
4. examine the influence of Transgenerational Family Therapy on dysfunctional families.
5. establish the difference in the treatment outcome of Conjoint Family Therapy and Transgenerational Family Therapy on dysfunctional families.
6. determine the influence of combined Conjoint and Transgenerational Therapies on dysfunctional families.

1.4 Research Questions

The research sought to answer the following research questions;

1. What are the types of family dysfunction found among the families in Kafanchan?
2. What are the causes of family dysfunction among families in Kafanchan.
3. What is the influence of Conjoint Family Therapy on dysfunctional families in Kafanchan?
4. What is the influence of Transgenerational Family Therapy on dysfunctional families in Kafanchan?
5. What is the difference in the treatment outcome of Conjoint Family Therapy and Transgenerational Therapy on dysfunctional families in Kafanchan?
6. What is the influence of combined Conjoint and Transgenerational Therapies on dysfunctional families in Kafanchan.

1.5 Research Hypotheses

1. There is no significant influence of Conjoint Family Therapy on dysfunctional families in Kafanchan.
2. There is no significant influence of Transgenarational Family Therapy on dysfunctional families in Kafanchan.
3. There is no significant difference between the treatment outcome of Conjoint Family Therapy and Transgenrational Family Therapy on dysfunctional families in Kafanchan.
4. There is no significant influence of combined Conjoint and Trangenerational Family Therapies on dysfunctional families in Kafanchan.

5. There is no significant difference in the influence of family therapies on dysfunctional families treated and the control group.

1.6 Significance of the Study

The findings from this study will be of immense help to parents, adolescent children, therapists, religious bodies, Non-governmental organization and the society at large. The results and findings will help to stabilize a lot of families that are dysfunctional, thereby reducing many irresponsible acts in the family and society. This means that both parents and children will understand their different roles in the family, appreciate family values and understand how to handle problems as they arise in the families and never allow any problem to be there unresolved.

It will help parents to appreciate the significant role that a therapist can play in their families whenever there is crisis. They will get to understand that there are some form of problems in the family that may require an expert to help them to overcome it and stop believing that as parents they know all and can handle all problems in the family. This means that parents will get to have good knowledge on issues concerning what makes a family dysfunctional and how to handle family dysfunctions. Religious bodies and NGO's will understand the importance of family therapy and family awareness campaigns and try to promote them.

The results of the study will help individuals to understand that family dysfunction affects, to a large extent the behavior of people, and so empathize and treat such individuals with love and care. This study can be used for family

awareness seminars and workshops for both couples and singles to sensitize them on the dangers of dysfunctional families and the need to have stable families. For example the therapies that have been designed can be used for family education programmes which is normally aimed at healing families with behaviour problems.

The study will also be useful to Home Economists because it will add to literature in the teaching of the course marital therapy and also help in achieving one of the objectives of home economics education at the tertiary level, which is to train and raise good home makers.

1.7 Basic Assumptions of the Study

The following assumptions were made in this study that;

1. All families are dysfunctional at different degrees.
2. All parents will admit that their families do have problems that a therapist can help in.
3. It is possible to get the cooperation of all family members during therapy sessions.

1.8 Delimitations of the Study

The study covered only families in Kafanchan in Jema'a Local Government Area of Kaduna State. Since family dysfunction cuts across states, tribes and religion, Kafanchan is suitable for the study because being an ancient town, all groups of people in Nigeria are represented. The work was delimited to the use of Conjoint and Transgenerational family Therapies on dysfunctional families because they are the two therapies under study. It was delimited to only couples that are not

polygamous in nature. This is because nuclear families are what were used for the therapy. It was also delimited to families that have adolescent children because the researcher wanted to find out the effect of family dysfunction on the social behavior of adolescent children. The study was experimental in nature.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

In this chapter, the researcher examined related literature, relevant to the topic. This will be discussed under the following sub-headings;

2.1 Theoretical framework

2.1.1 Theories of family therapy

2.1.2 Conjoint theory

2.1.3 Intergenerational theory

2.2 Conceptual framework.

2.2.1 History and meaning of family therapy.

2.2.2 Techniques of family therapy

2.2.3 Concept and goals of Conjoint family therapy

2.2.4 Beginning of treatment in Conjoint family therapy

2.2.5 Four areas of analysis in Conjoint family therapy

2.2.6 Main treatment efforts and criteria for assumption of completion of treatment under the Conjoint family therapy

2.2.7 Concept of Transgenerational family therapy

2.2.8 Eight key concepts of Transgenerational family therapy theory.

2.2.9 Meaning of family dysfunction

2.2.10 Characteristics of dysfunctional families

2.2.11 Types of dysfunctional families

2.2.12 Causes of family dysfunction

2.2.13 Effect of family dysfunction on children

2.2.14 Common characteristics of adult children of dysfunctional family

2.3 Empirical Studies

2.4 Summary of the Reviewed Literature

2.1 Theoretical framework

The researcher reviewed some theories that are of importance to the present study. The knowledge of these theories is important to the researcher because they have similar views with the two therapies under study on how therapies should be conducted. For example, they have the same view that the therapist role in therapy is an active and inventive one. They all believe also that the entire nuclear family should be involved in therapy sessions.

2.1.1 Theories of family therapy

Research and literature in the field of Family Therapy suggest that most current practice benefits from the rich infusion of conceptual material from a number of different teacher–theoreticians, (Ramon, 2008). The theories on which the present study is based include;

2.1.2 Conjoint theory

Conjoint Family Therapy propounded by Satir (1983) is based on a general systems theory. Satir stated that the theory describes a set of actions, reactions, and interactions among a set of variables essential to a single outcome and develops an order and a sequence among these variables to accomplish the desired outcome. The therapist's role is an active and inventive one in which he or she tries to aid family members make choices that increase self-esteem, provide

self-accountability and move members of the family towards congruent with one another. The present study is based on this theory because Conjoint family therapy is equally a therapeutic approach that treats the entire nuclear family.The premise of conjoint family therapy is that the client is the family. Focus is on improving family dynamics and self esteem that may be contributing to family dysfunction.

2.1.3 Intergenerational theory

Intergenerational Family Therapy is so closely identified with Murray Bowen (1976), it is sometimes known as Bowen–intergenerational Theory. Bowen believes that tension in the family system will be resolved by the presence of a neutral third person who can avoid emotional participation in the family system. The therapist usually works with one member utilizing the format of a multi – generational family map, or genogram. Family members are driven to achieve a balance of internal and external differentiation, causing anxiety, triangulation, and emotional cut off. Families are affected by nuclear family emotional processes, sibling positions and multigenerational transmission patterns resulting in an undifferentiated family ego mass. Intergenerational family therapy is based on this theory because here the therapist stands as the neutral third person who can avoid emotional participation in family problems. It is focused on the resolution of specific problems in the family using the past history of the family.

2.2 Conceptual framework

This has to do with the general knowledge of the concepts under study as they relate to the present study. Having knowledge on the concepts will help the

readers clear picture of what family therapy is and its usefulness in handling family problems or family dysfunction.

2.2.1 History and meaning of family therapy

Family therapy as a distinct professional practice within Western Cultures can be argued to have had its origins in the social work movement of the 19th century in England and the United States. As a branch of psychotherapy, its roots can be traced somewhat later to the 20th century with the emergence of the child guidance movement and marriage counseling, (Wetchler, 2003).

The formal development of family therapy dates to the 1940s and early 1950s with the founding in 1949 of the American Association of marriage counselors, and through the work of various independent clinicians and groups; who began seeing family members together for observation of therapy sessions, (Munichin and Fishman, 1981). There was initially a strong influence from psychoanalysis (most of the early founders of the filed had psychoanalytic backgrounds) and social psychiatry, and later from learning theory and behavior therapy, and significantly, these clinicians began to articulate various theories about the nature and functioning of the family as an entity that was more than a mere aggregation of individuals, (Nicholas, 1999). The movement received an important boost in the mid 1950s through the work of anthropologist, Bateson and colleagues like, Haley, Donald, Weakland, William and later, Sati and others, at Palo Alto in the United States, who introduced ideas from cybernetics and general systems theory into social psychology and psychotherapy, focusing in particular on the role of communication, (Minuchin, 1984).

By the mid – 1960s, a number of distinct schools of family therapy had emerged, (Nicholas, 1999). From those groups that were most strongly influenced by cybernetics and system theory, there came MRI Brief Therapy, and slightly later, strategic therapy, Minuchin's structural Family Therapy and the Milan systems model. Partly in reaction to some aspects of these systematic models, came the experiential approaches of Satir and Whitaker, which downplayed theoretical constructs, and emphasized subjective experience and unexpressed feelings, authentic, communication, spontaneity, creativity, total therapist engagement, and often included the extended family, (Nelson, 2003). Concurrently and somewhat independently, there emerged the various intergenerational therapies of Bowen, Ivan, Framo and Norman, which present different theories about the intergenerational transmission of health and dysfunction, but which all deal usually with at least three generations of a family, (Nelson, 2013) Multiple – family group therapy, a precursor of psychoeducational family intervention emerged, in part, as a pragmatic alternative form of intervention, especially as an adjunct to the treatment of serious mental disorders with a significant biological basis, such as schizophrenia, and represented something of a conceptual challenges to some of the "systemic" paradigms of pathogenesis that were implicit in many of the dominant models of family therapy. The late 1960s and early 1970s saw the development of network therapy which bears some resemblance to traditional practices, (Nicholas, 1999).

From the mid–1980s to the present, the field has been marked by a diversity of approaches that partly reflect the original schools, but which also draw on other

theories and methods from individual psychotherapy and elsewhere, (Thomas, 2003). Many practitioners claim to be "eclectic" using techniques from several areas, depending upon their own inclinations and or the needs of the clients , and there is a growing movement toward a single generic family therapy that seeks to incorporate the best of the accumulated knowledge in the field and which can be adapted to many different contexts, (Wetchler, 2003). However, there are still a significant number of therapists who adhere more or less strictly to a particular, or limited number of approach or approaches, (Robert, 2005).

Family Therapy focuses on relationships within the family unit and takes place with other family members present, (Thomas, 2003). Family Therapy also referred to as couple and family therapy, family systems therapy, and family counseling, is a branch of psychotherapy that works with families and couples in intimate relationships to nurture change and development, (Roberto, 2001). It tends to view change in terms of the systems of interaction between family members. It emphasizes family relationships as an important factor in psychological health, (Nelson, 2003).

Family Therapy helps to identify the ways that relationship and individual problems are caused and maintained by the family dynamics, (Golden berg and Goldenberg, 2004). For example, if a child is having academic and social problems, the focus will be on identifying the family patterns that have contributed to the child acting out, rather than on working intra-psychically with the child alone. Family therapy is used to approach a wide variety of therapeutic goals rather than viewing problems as owned and caused by a particular family member, (Thomas, 2003).

2.2.2 Family therapy techniques

Family therapy techniques are used with individuals and families to address the issues that affect the health of the family system. The techniques used will depend on what issues are causing the most problems for a family and on how well the family has learned to handle these issues. Strategic techniques are designed foe specific purposes within the treatment process.

Some of the techniques that can be used by a therapist as sated by Eric (2009) include;

Information- gathering techniques:

At the Start of therapy; information regarding the family's background and relationship dynamic is needed to identify potential issues and pebbles. The genogram is a technique used to create a family history or geneology. Both the family and therapist work to create this diagram. Having family members bring in meaningful photos is also a technique used to gather information as to how each member perceive the others (Lowenstein and Spunk, 2010). One other technique involve having family members draw up floor plans of their home. This exercise provides information on territorial issues, rules, and comfort zones between deferent members, (Sprenkle, 1994).

Family system techniques

A family operates like a system in that each member's role contributes to the patterns of behavior that make the system what it is. Certain therapy techniques are designed to reveal the patterns that make a family function the way it does. The tracking technique is a recording process where the therapist keeps notes on how

situations develop within the family system, (Eric, 2009). Interventions used to address family problems can be designed based on the patterns uncovered by thin technique. Family sculpting is another technique that is used to realign relationship patterns within the group. Members are asked to physically arrange where they want each member to be in relation to the others. This technique provides insight into relationship conflicts within the family, (Lowenstein and Spunk, 2010).

Communication techniques

More often than not, it's a family's communication patterns and styles that lead to conflict and division, (Eric, 2009). Communication techniques are used to build skills that allow for effective communication between family members. Some of these methods include reflecting, repeating and fair fighting, (Sprinkle, 1994). Reflecting involves having a member express her feelings and concerns, then having another member repeat back what he heard that person say. Repeating techniques involves having a member state how he feels, while another member repeats back what was said. Repeating and reflecting techniques allow members to better understand where the other is coming from and why she feels as she does. Fair fighting techniques focus on attentive listening and expressing feelings and concerns in a nonthreatening manner, (Sprinkle, 1994).

Intervention techniques

Intervention techniques are directives given by the therapist to guide a family's interactions toward more productive outcomes. Reframing is a method used to recast a particular conflict or situation in a less threatening light. A father who constantly pressures his son regarding his grades may be seen as a threatening

figure by the son. Reframing this conflict would involve focusing on the father's concern for his son's future and helping the son to "hear" his fathers concern instead of constant demands for improvement, (Eric,2009). Another technique has the therapist placing a particular conflict or situation under the family's control. What this means is, instead of a problem controlling how the family acts the family controls how the problem is handled, (Davis and Butter, 2004). This requires the therapist to give specific directives as to how long members are to discuss the problem, who they discuss it with, and how long these discussions should last. As members carry out these directives, they begin to develop a sense of control over the problem, which helps them to better deal with it effectively, (Lowenstein and Spunk, 2010).

2.2.3 Concept and goals of Conjoint Family Therapy

Conjoint Family Therapy an approach to family treatment was developed by Satir in mid 1960s in the United States of America. Most authors often classify this approach to family counseling within the family communications theory model, (Haber, 2002).Barmen (1986) defined Conjoint Family Therapy as a form of psychotherapy in which a therapist sees a single nuclear family and addresses the issues and problems raised by family members. Conjoint Family Therapy, however treats the entire family Simultaneously, (Kafka, 2008). The person who practices the therapy will only treat the family if all members are present. Sessions with missing members are typically rescheduled until everyone is there, (Hart, 2007). Premise of Conjoint Family Therapy (CFT) is that the client is the family. It is believed that the family will heal when problematic relationships are corrected.

For the therapist to understand and treat troubled family patterns, the relationship must be in the room with the therapist, they must be visible and accessible, (Kafka, 2008).

The Goals Conjoint Family Therapy

Satir, Barmen, Gerber and Gamoi (1991) stated the following as the major goals of Conjoint Family Therapy. They are;

1. To help raise family members self-esteem or self confidence in the course of therapy.
2. To help members to grow-up and to throw away the wrong models they have picked from their past.
3. To educate members on better ways of communicating with one another.
4. To teach members better ways of assenting themselves, their identity, what they believe, how they see things and what they like and dislike.
5. To enable members learn how best to settle their disagreements in the face of conflict of interest that do arise in practice.
6. To help members be able to detect the difference between the verbal and the non-verbal aspects of their communication and assist them to recognize how their usual verbalization, or their words can be contradicted by their feelings and gestures.
7. To help members to learn how to reach each others feelings where issues appear to divide.
8. To educate members on how to listen to one another.

9. To educate members on how to ask for clarification when there is confusion regarding what the other has communicated.

10 To help members to learn how to provide feedback to one another regarding their opinion on what is happening with them.

2.2.4 The beginning of treatment in conjoint family therapy

Doran (2009) stated the following as steps to be followed when beginning therapy in conjoint family therapy. Tylor (2010) affirmed this when he said that in order to have successful therapy sessions, the therapist must develop a good relationship with the family.

a. **Getting introduced to the family:** At the beginning of the therapeutic relationship, the conjoint therapist makes effort to start interaction with the family on a rather informal and threat-free atmosphere. To achieve this he begins with getting himself introduced to the family and tries to find out; who makes up the family, how many people are involved in the family; whether there are members of the family that live outside the family, or come in every now and then. He tries to find out too the ages of each family member; an avenue through which he will be able to determine where every member is supposed to be in their chronological maturity and the kind of parenting load the mates are carrying at the time.

b. **Setting the structure:** After getting to know about the members, he tries to structure the meaning of their meeting, by trying to explain how family therapy is organized, emphasizing the role of the husband and wife as the major architects of the family. This type of explanation helps to put the

members at ease and to get them effectively motivated to co-operate with the experience, (Tylor 2010).

c. **Requesting members to introduce the problem:** With the atmosphere so structured in this way, the conjoint therapist tries to find out from each member an idea of what the family wants and expects from treatment. This question he raises in order to briefly orient himself to the problem of the identified patient as the parents see it, (Satir, 1991). While trying to gain the parent's image of the nature of the identified patient's problem, the therapist should throw the following questions to the parents; namely: when did you notice this symptom. Have you discussed it among yourselves? What efforts have been made to get it controlled? And what happened after that, (Smith, 2002).

2.2.5 Four areas of analysis in conjoint family therapy.

There are usually four major areas of family analysis in conjoint family treatment.

According to Davis and Butler (2004) the four areas include the following:

a. Making analysis of the techniques used by each family member to handle the presence of differentness within the family: This part of the diagnostic process is undertaken to discover if the techniques of setting differences that may arise in the family is that of determining who is right (the war method) or of pretending that differentness does not exist (denial) in which case the therapist will conclude that there is existing in that family a potential for

pathological behavior on the part of any member of the family, more especially the children, (Hammond and Nicholas, 2008).

b. Making of a Role-Function Analysis:This is engaged in to discover how far the members of the family are unknowingly playing roles different from those which their position in the different family require that they play. (Baumen, 2006). Here such questions as the following are the basic issues that are raised. Is the husband seen by the wife as a husband or rather as her father or an omnipotent provider? Similarly, is the wife seen by the husband really as a wife or rather as his mother, daughter or indeed as a house maid, (Bitter, 2008). Answering such questions gives the therapist some clues about what is wrong in the family member's perception of who they are and the roles that are theirs to play in the family.

c. Making of self manifestation Analysis for each member of the family: What is assessed in this regard is to determine if what each member says or does under the therapeutic process fits or does not fit with the way he looks, sounds or acts or whether really he reports his wishes and feelings as belonging to someone else or as coming from somewhere else. In which case, it is to be concluded that he will not be able to produce reliable clues for any other person interacting with him, (Baumen, 2006).

d. Making a Model Analysis: One of the basic convictions of the conjoint therapist is that the marital relationship and the two persons that make up the marital pair are the architect of the family set up, (Sayles, 2002). The therapist in this model also believes that how the two mates behave in their

marriage is very well related to the kind of models that they happened to come across in their past, especially as regards the models met in the mate's families of origins, (Davis & Butler 2004). To find out the influence of such past models in the life of the marital pair, the therapist makes what Satir (1991) refers to as models analysis to find out how the early life of each members of the marital pair has affected his or her present way of behaving.

2.2.6 Main treatment efforts and criteria for assumption of completion of treatment under the Conjoint family therapy:

In developing intervention programmes to help the family to regain its health and equilibrium, the conjoint family therapist sees himself in the position of an educator with the duty to teach, clarify, correct and set a model to members regarding how to relate with, reach, approach, talk to, plan, live and work with one another, (Hammond, Nicholas 2008). Beaudry (2009) said that while in this position, the therapist,

1 Helps to equalize parental authorities

2 Strives to strengthen same – sex parent – child relationships.

3 Encourages mates to attend to each other more and to the children less.

4 Shows the identified patient how he looks to others and what he needs to do to change their perception.

6 Builds the self-esteem of members e.g. by labeling what is observed in the mates and the children.

7 Requests from each member what he can to bring pleasure to another member, and spells out double level messages and how they can be avoided.

8 Helps the children to understand their parents and to understand themselves as children.

Before ever the therapist can successfully arrive up to this stage in the family therapy process, he is expected to have started the initial therapy session by spelling out for all present the rules and norms that guide interaction in a typical Conjoint Family Therapy process, (Mc Goldrick and Cater, 2010).

Among the rules that must be spelt out in this connection include the following, namely that;

a. All family members ought to be present.

b. No one to interrupt while the other is speaking.

c. No one may act out or make it impossible to converse during the session.

d. No one is to be allowed to speak for another.

e. Everyone has to speak out clearly so he can be heard.

Criteria for Assumption of Completion of Treatment under the Conjoint Family Therapy:

According to Satir (1999), treatment efforts under the Conjoint Family Therapy is assumed completed if the following conditions take place:

a. If family members have learnt how to complete transactions or check or ask questions.

b. If they have learnt how to interpret hostility.

c. If they can now see how others see them.

d. If they can see how they see themselves.

e. If each member has learnt how to tell another how he (the other) manifests himself.

f. If each family member can freely tell another what he hopes, fears and expects from him.

g. If the mates have learnt how to disagree.

If properly carried out by the therapist, Conjoint family therapy can go a long way in bringing stability to dysfunctional families. Transgenerational family therapy is another approach to family therapy used by family therapists. Though another type of family therapy, it still aims at the bringing stability to dysfunctional homes.

2.2.7 Concept of Transgenerational family therapy

Bowen (2009) opined that Transgenerationalists believe current family pattern are embedded in unresolved issue in the families of origin. That is not to say that these problems are caused by earlier generations, but rather they tend to be unsettled and thus persist in organs pattern that span generations. According to Roberto (1998) the family process in the transgenerational view may feed forward in chronological or spiraling fashion from emotionally influential events in the lives of great-grand parent onto children in the present. How today's family form attachments, manage intimacy, deal with power, resolve conflict and so on, many minor to a greater or lesser extent earlier family patterns. Unresolved issues in families may show up in symptomatic behaviours patterns in later generations. However, transgenerational approaches to family therapy have grown out of the work of such pioneers as Murray Boren, Ivan Boszor Menyi-Nagy, James Framo, Norman Paul and Donald Williamson.

Bowen began his training in a psychoanalytic model and some of his ideas can be traced to the background. In fairness, Bowen would have seen his approach operates on the premise that a family can best be three generational perspective, because a predictable pattern of interpersonal relationships connects the functioning of a family across generations.

According to Bowen, the cause of an individuals' problems can be understood only be viewing the roles of the family as an emotional unit. A basic assumption in Bowen's family therapy is that unresolved emotional fission (attachment to one's family must be addressed if one hopes to achieve a mature and unique personality.

As stated by Goldenberg (2004) Bowen's model framed the presenting problems within the past and present. Also, Bowen stressed how important the family relational patterns over decades affects the lives of a person and their family to the extent that noticing them is crucial in order to become a differentiated person. Furthermore, Boren (1975) believed that the absence of a clearly articulated theory had resulted in an unstructured state of chaos in family therapy. This approach offers a method for organizing data, explaining past events and predicting future events. It contributes to an understanding of both the causes and control of events.

2.2.8 Eight key concepts of Transgenerational family therapy

Bowen's theory and practice of family therapy grew out of his work with schizopheric individuals in families. He was much more interested in developing a theory of family systems therapy than in designing techniques for working with families. He identifies eight key concepts as being central to his theory. They are:

i. Differentiation of self

ii. Triangles

iii. Nuclear family emotional system

iv. Family projection process

v. Emotional cutoff

vi. Sibling position

vii. Societal regression

i Differentiation of self

Differentiation of self which occurs in an individual is the extent to which that person is able to distinguish between the intellectual process and the feeling process he or she is experiencing. That is, differentiation of self is demonstrated by the degree to which a person can think, and plan and follow his or her own values without having his or her behavior automatically driven by the emotional cues from others. Differentiated individuals are able to choose and guided by their thoughts rather than their feelings. Undifferentiated people have difficulty in separating themselves from others and tend to fuse with dominant emotional patterns in the family. These people are unable to take clear position on issues: they have a pseudo-self. Hence they are likely to be at the mercy of automatic or involuntary reactions and tend to become dysfunctional even under lave anxiety just as they are unable to differentiate though from feelings, such persons have trouble differentiating themselves from others and thus merge easily with whatever emotional attachments to one's family and remain intact (Bowen, 1978) e.g. people who are fused to their families origin tend to marry others to whom they can

become fused, that is, people at similar levels of differentiation tend to seek out and find each other when coupling.

ii. Triangles

Bowen (1976) noted that anxiety can easily develop within intimate relationships. Under stressful situations, two people may recruit a third person into the relationship to reduce the anxiety and gain stability. For example, anxiety within either husband or wife or both may arise, as they attempt to balance their needs for closeness with their needs or individuation. The greater the couple's fusion, the more difficult is the task of finding a stable balance satisfying to both. One way to defuse such anxious two-person relationship within a family is a triangulate i.e. (draw in a significant member to form a three-person interaction) Triangulation, then, is a common way in which two person system under stress attempt to achieve stability. According to Bowen (1978), the twosome may "reach out" and pull in the other person, the emotion may "overflow" to the third person or that person may be emotionally "programmed" to initiate involvement. This reduces the anxiety and more stable and flexible than two some. However, should anxiety in the triangle increase, one person may involve another outsider and so forth until a number of people are involved.

Triangulation does not always reduce tension .Ker and Bowen (1988) pointed out that triangulation has at least four possible outcome.

a. A stable twosome can be destabilized by the addition of a third person e.g. the birth of a child brings conflict to a harmonious marriage.

b. A stable twosome can be destabilized by the removal of a third person. E.g. a child leaves.

c. An unstable twosome can be stabilized by the addition of a third person (e.g. a conflictual marriage becomes more harmonious after the birth of a child)

d. An unstable twosome can be stabilized by the removal of a third person e.g. conflict is reduced by avoiding a third person who has consistently been taking sides.

iii. Nuclear family Emotional System

The nuclear emotional system describes the family's emotional system during a single generation. Boren (1978) contends that people choose mates with equivalent levels of differentiation to their own. Thus, the undifferentiated person will be attracted to a person who is equally fused to his/her family of origin. It is probable, that poorly differentiated people will also be highly fused and produce a family with same characteristics. The resulting nuclear family emotional system will then be unstable and will seek various ways to reduce tension and maintain stability. The most common way of dealing with this stress is emotional distance or emotional divorce. Three other methods of compensation are marital conflict, sickness or dysfunction in one of the spouses and projection of the problem into one of the children.

iv. Family Projection Process

The most common form of triangulation occurs when two parents with poor differentiation fuse leading to conflict, anxiety and ultimately the involvement of a child in an attempt to regain stability. When a parent lacks differentiation and

confidence in his or her role with the child, the child also becomes fuse and emotionally reactive. The child is now declared to "have a problem; and the other parent is often in the position of calming and supporting the distraught child. Such a triangle produces a kind of pseudo stability for a while; the emotional instability in the couple seems to be diminished, but it has only been projected onto the child.

This family projection process makes the level of differentiation worse with each subsequent generation (Papero, 2000). An exemplary scenario was described by Singleton (1982), the child responds anxiously to the mother's anxiety, she being the principal caretaker, becomes alarmed at what she perceived as the child's problem and becomes over protective.

This cycle is established as the mothers cares for the child and the father is the third leg of the triangle and frightened by the wife's anxiety calms her down without dealing with issues but plays a supportive role in her dealing with the child. The parents have now stabilized their relationship around a "disturbed" child, and in the process perpetuated the family triangle. That person will be less able to function autonomously in future.

v. Emotional cutoff

Children involved in family projection process may try various strategies upon reaching adulthood, or even before. They may attempt to isolate themselves from the family by moving to another state, through the use of psychological barriers by ceasing to talking to parents. This is called emotional cutoff, i.e. not emotional distancing in order to break emotional ties and not true emancipation,

cutoff often occur in families in which there is a high level of anxiety and emotional dependence.

As anxiety increases and greater family cohesiveness is expected, conflicts between family members may be disguised and hidden. When the fussion reaches an unbearable stage, some members may seek greater distance, emotionally, socially, perhaps physically for self – preservation.

However, Bowen (1995) believes "The person who runs away from his family of origin is an emotionally dependent as the one who never leaves home". The runaway needs emotional contact but negatively reacts to it. Running away will become a coping pattern in future relationship, such as marriage.

vi. Multigenerational Transmission Process

When a child leaves the family of origin with unresolved emotional attachment, whether they are expressed in emotional fission or emotional cutoff, they will tend to couple and create a family in which these unresolved issues can be re – enacted. Family projection process has now become the foundation for multigenerational transmission.

vii. Sibling Position

Bowen adopted Toman's (1993) research on the relationship between birth order and personality with clarifying his own thinking regarding the influence of sibling position in the nuclear family emotional process.

Toman believed that position determined power relationships and gender experience determined one's ability to get along with the other sex. In addition to noting the unique positions of only children and twins, Toman focused on ten

power / sex positions: the oldest brother of brothers; the youngest brother of brothers; the oldest brother of sisters; the youngest brothers of sisters, the male only child and the same five configurations for females in relation to sisters and brothers. Under this conceptualization, the best possible marriage, for example, is hypothesized to be the oldest brother's sisters marrying he youngest sister of brothers. In this arrangement both parties would enter the marriage with similar expectations about power and gender relationships. Conversely, the worst marriage would occur between the oldest brother and the oldest sister of sisters. In this case, both parties would seek and want powers positions and neither would have had enough childhood experience with the other sex to have adequate gender relationships.

viii. Societal Regression

Here, Bowen extended his thinking to society's emotional functioning. He believed that under circumstances of chronic, societal stress, public anxiety would increase and government leadership abandon rational considerations in favour of emotional driver decisions designed to bring about short term relief. The most common process would involve two groups joining together to preserve their own positions at the expense of a third (Papero, 2000). Such societal projection processes tend to result in laws that do little to affect the chronic problem, bring relief to very few, and generate helplessness in many. The result of this is a societal regression. However, Bowen called for better differentiation between intellect and emotion in order for society to make rational decisions rather than act on the basis of feelings and for short term band and solutions.

2.2.9 Meaning of family dysfunction

Many people hope that once they leave home, they will leave their family and childhood problems behind. However, many find that they experience similar problems, as well as similar feelings and relationship problems, long after they have left the family environment. Ideally, children grow up in family environments which help them feel worthwhile and valuable. They learn that their feelings and needs are important and can be expressed. Children growing up in such supportive environments are likely to form healthy open relationships in adulthood, (Halpem, 2007). However, families may fail to provide for many of their children's emotional and physical needs. In addition, the families communication patterns may severely limit the child's expressions of feelings and needs. Children growing up in such families are likely to develop low self esteem and feel that their needs are not important or perhaps should not be taken seriously by others. As a result, they may form unsatisfying relationships as adults, (Osterkamp 2002).

Often, the disturbance that upsets the balance of a family occurs within the family system itself. The presence of an alcoholic, for example, produces change in the behavior patterns of the other family members. The focus of the family becomes the alcoholism, (Bradshaw, 2007). A family member experiencing a chronic illness or a mental problem can also throw a family out of balance. Such unbalanced families do not function well: they are dysfunctional, (Robert, 2007).

Family dysfunction can be any condition that interferes with healthy family functioning, (Vinnicelli, 1999). Most families have some periods of time where functioning is impaired by stressful circumstances (death in the family, a parents

serious illness etc). Healthy families tend to return to normal functioning after the crisis passes, (Forward, 1989). In dysfunctional families, however, problems tend to be chronic and children do not consistently get their needs met, (Cathey. 2008). A dysfunctional family is a family in which conflict, misbehavior, and often child neglect or abuse on the part of individual parents occur continually and regularly, leading other members to accommodate such actions, (Geringer, 2005). Children sometimes grow up in such families with the understanding that such an arrangement is normal. Dysfunctional families are primarily a result of co – dependent adults, and may also be affected by additions, such as substance abuse (alcohol, drugs etc), or sometimes an untreated mental illness, (Carolyn, 2007). Dysfunctional parents may emulate or over – correct from their own dysfunctional parents; (Steven, 2009).

2.2.10 Characteristics of dysfunctional families

While the term "dysfunctional family" is thrown around somewhat carelessly nowdays, there are certain hallmark characteristics of dysfunctional families that are common, (Carolyn, 2007). The question is, does a family that has one of the these characteristics automatically qualify as "dysfunction" of course, it depends on the severity of the problem and the way in which it cascades to cause other problems, (Messina, 2009). Steven (2009) enumerated some of the most common characteristics of a dysfunctional family. These include:

1. **Addiction:** one of the most prominent characteristics of a dysfunctional family is addiction on the part of one or more of its members. This addiction need not be to drugs or alcohol, but it typically manifests itself by

making it difficult for family members to communicate, and may affect the family financially, (Carolyn, 2007). Typically addiction is a problem suffered by the adults in the family, though adult children and teenagers may suffer from addictions in various forms, (Hunt, 2012).

2. **Control:** another hallmark characteristic of dysfunctional families is control. Control means that one member of the family exerts his or her will on some or all of the other family members. This may manifest itself, for example, as a husband not permitting his wife to see male friends, or as a parent not allowing their child to go to reasonable school events, such as football games and dances. Control usually occurs from spouse to spouse or from parent to child in a dysfunctional family, (Nancy, 1990) This control usually results in emotional "stunting" and may make people feel as if they are not entitled to an opinion or to a life of their own, (David and James, 2007). Control may be overt, or it may be in the form of causing people to feel guilty for wanting to "step outside the box", (Hunt, 2012).

3. **Unpredictability and Fear:** these are two common signs of a dysfunctional family. Typically, fear results from the unpredictability of a single or multiple members, (Messina, 2009). This may be unpredictability with regard to financial matters, emotional state, or reactions to novel situations. This affects a family by making its members fearful of the actions of a single or multiple members, (Hunt, 2012).

4. **Conflict:** a more obvious indicator of a dysfunctional family is conflict. While a certain amount of conflict is expected in a normal family, constant,

heated conflict is not, (Steven, 2009). If a serious argument erupts over slight misunderstandings on frequent and unyielding basis, there is a good chance that there is a certain level of dysfunction within the family, (Nancy, 1990). Likewise, undertones of conflicts and resentment can also be an indicator of a dysfunctional family. The conflict may also take place in passive – aggressive terms. Conflict may occur between any member of a family, and affects the family by increasing tension and resentment among its members, (Lee, 2000).

5. **Abuse:** abuse, whether physical or emotional, is another characteristic of a dysfunctional family. The way in which abuse affects a family is obvious, as it punishes and diminishes a single or multiple family members. Abuse typically occurs from one spouse to the other, or from a parent to a child. Sometimes children also abuse each other, whether through physical or emotional means, (Blair and Rita, 1990).

6. **Perfectionism:** this can be a reflection of unrealistic expectations towards other family members, and may also be an indicator of the areas in which the perfectionist family member feels that he or she is inadequate, (Carolyn, 2007). Perfectionism may result in low self – esteem in other family members, and may be self – perpetuating, (Lee, 2005). Typically, perfectionism occurs in parents towards their offspring.

7. **Poor Communication:** poor communication is another hallmark of a dysfunctional family. Communication may be strained, ineffective, or nonexistent. Family members may have difficulty communicating their

wants and needs to other members, which can result in misunderstandings and little self – expressions. Poor communication often occurs throughout the entire dysfunctional family, (David and James, 2007).

8 **Lack of Diversity:** a lack of diversity in a family is a sign that a family may be dysfunctional. Diversity, in this instance, refers primarily to differences in interests and beliefs between family members, (Hunt, 2012). If all of the family members share the same interest and beliefs, there is a high probability that one member of the family is acting to control and manipulate others, (Nancy, 1990). An example of this would be several children from a family that all have the same interests and aspirations as one of their parents. A lack of diversity usually occurs in families where there are children, though some people may be emotionally quashed in romantic relationships to the point where they adopt all of the interests of their partner, (Steven, 2009).

2.2.11 Types of dysfunctional families

There is a great deal of variability in how often dysfunctional interactions and behaviours occur in families, and in the kinds and the severity of their dysfunction. However, when patterns like the ones stated below are the norm rather than the exception, they systematically foster abuse and or neglect. According to Halpern (2007), the following are some examples of patterns that frequently occur in dysfunctional families,

1. One or both parents have addictions or compulsions (e.g drugs, alcohol, promiscuity, gambling) that have strong influences on family members.

2. One or both parents use the threat or application of physical violence as the primary means of control. Children may have to witness violence, may be forced to participate in punishing siblings, or may live in fear of explosive outbursts, (Blair and Rita, 1990).
3. One or both parents exploit the children and treat them as possessions whose primary purpose is to respond to the physical and or emotional needs of adults (e.g. protecting a parent or cheering up one who is depressed).
4. One or both parents are unable to provide or threaten to withdraw financial or basic physical care for their children. Similarly, one or both parents fail to provide their children with adequate emotional support.
5. One or both parents exert a strong authoritarian control over the children. Often these families rigidly adhere to a particular belief. Compliance with role expectations and with rules is expected without any flexibility, (Lee, 2005).

2.2.12 Causes of family dysfunction

Gil (1993) stated that there are many reasons why families become dysfunctional, but the four common causes of family dysfunction include;

Deficient parents: Deficient parents hurt their children more by omission than by commission. Frequently, chronic mental illness or a disabling physical illness contributes to parental inadequacy. Children tend to take on adult responsibilities from a young age in these families, (Beattie, 2007). Parental emotional needs tend to take precedence, and children are often asked to be their parents caretakers. Children are robbed of their own children, and they learn to ignore their own needs

and feelings, (Bass and Davis, 1998). Because these children are simply unable to play an adult role and take care of their parents, they often feel inadequate and guilty. These feelings continue into adulthood, (Lee, 2005).

Controlling Parents: Unlike the deficient parents, controlling parents fail to allow their children to assume responsibilities appropriate for their age. These parents continue dominating and making decisions for their children well beyond the age at which this is necessary, (Kaslow, 2001). Controlling parents are often driven by a fear of becoming unnecessary to their children. This fear leaves them feeling betrayed and abandoned when their children become independent (Forward, 1999). On the other hand these children frequently feel resentful, inadequate and powerless. Transitions into adult roles are quite difficult, as these adults frequently have difficulties making decisions independent from their parents. When they act independently these adults feel very guilty, as if growing up were a serious act of disloyalty (Janet, 2006).

Alcoholic Parents: Alcoholic families tend to be chaotic and unpredictable. Rules that apply one day don't apply the next. Promises are neither kept nor remembered. Expectations vary from one day to the next (Keer and Bowen, 2000). Parents may be strict at times and indifferent at others. In addition, emotional expression is frequently forbidden and discussion about the alcohol use or related family problems is usually nonexistent. Family members are usually expected to keep problems a secret, thus preventing anyone from seeking help. All of these factors leave children feeling insecure, frustrated and angry, (Janet 2006).

Abusive Parents: Abuse can be verbal, physical or sexual. Verbal abuse – such as frequent belittling criticism, can have lasting effects, particularly when it comes from those entrusted with the child's care. Physical abuse vary widely. Many parents, at one time or another, have felt the urge to strike their child. With physically abusive parents, the urge is frequent and little effort is made to control this impulse (Whitfield, 2002).

Satir (1983) viewed family communication as one of the major causes of dysfunctional families. Although, there is no one right path to psychological healing, CFT is one of the best options for troubled children, (Smith, 2002). For Satir, (1991) there are indeed a lot of other crisis outside that of communication difficulties which can lead to family pathology. Hence before any serious attempt can be made to highlight the treatment process under the Conjoint Family Therapy model, prior effort need be made to say something more specific regarding what Satir has said on the factors that can lead to family dysfunction. According to Satir (1991), dysfunctional families can arise from any of the following group of circumstances;

a. Low self-esteem and immature mate selection consideration.
b. Immature method of negotiating personal differences and disagreements.
c. Influences of wrong models from the members past.
d. Faulty communication.

a. **Low self-esteem and immature mate selection:** Satir (1991) is of the view that a person with low self-esteem has a great sense of anxiety and uncertainty about himself. Influenced by this condition, such a person tends

to disguise in order to give impression of a self confident man. One major problem about this person is that he hopes too much on what others can do for him, at the same time he harbors a lot of fears on whether these hopes will actually be fulfilled, (Hart, 2007). He distrusts people generally. When such a person marries, he does so to "get" but invariably fears that in the main he will ordinarily be disappointed. During the process of mate selection, he tries to hide his true colours, thereby giving the intending mate false ideas of who he is and what he can offer to the marriage. After marriage, when the true colours starts showing up sharp and clear, problem will arise in the family, (Satir, Stachowiak&Taschman, 1995).

b. **Marital Disappointment and self-centered parenting:** The eventual discovery of the couple's true selves by themselves later on in marriage leads to frustration and marital disappointments. However, when after marriage these walls of defenses finally begin to breakdown, the child in the marriage is the first person to feel the effect, (Satir, 1991). When parents get disappointed in each other, they begin to see the child as the only one who can represent their worth. They also desire to think that the child likes them,(Taylor, 2002). If by the child's behavior he shows that he disapproves of them, they are then disappointed once more. And when this becomes the case, disciplining the child becomes difficult. Satir (1991) is of the view that when parents lose confidence in each other, they turn to the child as the only opportunity they have for hanging their life and aspiration. The same sex-parent will see the child as potentially belonging to him/her more than he

does to the other and the other parent will start entertaining fears of losing the child, so each parent starts making efforts to woo the child to himself or herself.

c. **Faulty Communication:** A child is induced unconsciously to the point of becoming a parent because of double-level message in the parents communication style. Such double-level messages are manifested where the speaker's word and expressions are disparate, that is, where he says one thing while he means the other by his voice or gestures. Such message of course does not always lead to maladaptive behavior. It is only when it takes place in the presence of the child and often a long period of time, (Hart, 2007).

d. Immature method of negotiating personal differences and interpersonal disagreement

Satir, Stachowiak and Taschman, (1995) are of the opinion that most marriages breakdown together with their families because the issue of differences which leads to a conflict of interest (disagreement in value and preferences) is seen as an insult and as evidence of being uninvolved. This problem is further compounded by the fact that the two parents have not been able to strike a balance within their current marital experience as regard, what each other wants, what each does best, what each thinks about and how each is to carry his responsibilities.

e. **Influence of past wrong models:** Satir, (1991) believes that the problem of low-self esteem is a learnt phenomenon, since no child has been known to

come into the world with a particular level of esteem ascribed to him or her. Rather, it is assumed that all he does in life, he learnt it. This is Satirs normal routine in family treatment, to begin by asking the mates to describe for her how things looked like in their family of origin. This information helps the therapist to decide whether or not the mate's parents have given him or her inadequate models or methods of communicating conflicting signals about what behavior is appropriate.

Regardless of the kind of dysfunction or abuse, effects vary widely across individuals. Support from other healthy adults, success in other areas, or positive changes in the family can help prevent or minimize negative effects (Kaslow, 2001).

2.2.13 Effect of family dysfunction on children

As stated by Keer and Bowen (2000) children of dysfunctional families, either at the time or as they grow older may also;

i. Lack the ability to be playful, or childlike, and may "grow up too fast", conversely they may grow up too slowly or be in a mixed mode, well behaved, but unable to care for themselves.

2. Have moderate to severe mental health issue, including possible depression, anxiety and suicidal thoughts.

3. Become addicted to smoking, alcohol and drugs especially if parents or friends have done the same.

4. Bully or harass others, or be an easy victim thereof.

5 Be in denial regarding the severity of the family's situation.

6 Have mixed feeling of love – hate towards certain family members.

7 Have difficulty forming healthy relationships within their peer group (usually due to shyness or a personality disorder).

8 Feel angry, anxious, depressed, isolated from others or unlovable.

9 Become a juvenile delinquent and turn to a life of crime.

10 Have low self – esteem or a poor self image with difficulty expressing emotions.

11 Have a little self – discipline when parents are not around.

2.2.14 Common characteristics of adolescent children of dysfunctional family

According to Janet (2006) adult children of dysfunctional families normally show the following characteristics:

1 They guess at what normal is.

2 They have difficulty in following a project through from beginning to end.

3 They lie when it would be just easy to tell the truth.

4 They judge themselves without mercy.

5 They have difficulty having fun.

6 They take themselves very seriously.

7 They have difficulty with intimate relationships.

8 They over react to changes over which they have no control.

9 They constantly seek approval and affirmation.

10 They feel that they are different from other people.

11 They are either super responsible or super irresponsible.

12 They are extremely loyal, even in the face of evidence that the loyalty is underserved.

13 They are impulsive.

1. They guess at what normal is

There is no frame of reference for what it is like to be in a normal household. You also have no frame of reference for what is okay to say and feel. In a more typical situation, one does not have to walk on eggs all the time. Because you did, you became confused. Many things from the past contributed to your having to guess at what normal is.

2. They have difficulty in following a project through from beginning to end.

In a functional family, the child has this behavior and attitude to model. They child observes the process and the child may even ask questions along the way. The learning may be more indirect than direct, but it is present. Since the child's experience was so vastly different, it should be no surprise that he has a problem with following a project through from beginning to end, (Beattie 2007).

3. They lie when it would be just easy to tell the truth

Lying is basic to the family system affected by alcohol. It masquerades in part as an overt denial of unpleasant realities, cover ups, broken promises and inconsistencies. Lying as the norm in your house became part of what you knew and what could be useful to you. At times, I made life much more comfortable. If you lied about getting your work done, you could get away with being lazy for a while. It seemed to make life simpler for everybody, (Gil (1993).

4. They judge themselves without mercy

Your judgment of others is not nearly as harsh as your judgment of yourself, although it is hard for you to see other people's behavior in terms of a continuum either. Black and white, good or bad, are typically the way you look at things. You know what it feels like to be bad, and how those feeling make you behave. And then if you are good there is always the risk that it won't last. So either way you set yourself up, (Gil, 1993).

5. They have difficulty having fun and adult children take themselves very seriously

These two characteristics are closely linked.

You didn't hear your parents laughing and joking and fooling around. Life was a very serious, angry business. The tone in your house put a damper on your fun. Eventually, you just went along with everybody else. Having fun just was not fun. The spontaneous child within was quashed, (Gil, 1993).

6. They have difficulty with intimate relationships.

The feelings of being insecure or having difficulty in trusting, and of questions about whether or not you are going to get hurt are not exclusive to adult children. These are problems most people have. It is simply a matter of degree, your being a child of an alcoholic caused the ordinary difficulties to become more severe, (Nancy, 1990).

7. They over- react to changes over which they have no control

The young child of an alcoholic was not in control. The alcoholics' life was inflicted on him/her, as was his/her environment. In order to survive when growing

up, he/she needed to begin taking charge of his/her environment. This became important and remains so. The child of the alcoholic learns to trust him/herself more than anyone else when it is impossible to rely on someone else's judgment, (Beattie 2007).

8. They constantly seek approval and affirmation.

The message you got as a child was very confused. It was not unconditional love. The definitions were not clear and the messages were mixed. "Yes, no, I love you, go away." So you grew up with some confusion about yourself. The affirmations you did not get on a day – to – day basis as a child, you interpret as negative, (Nancy, 1990).

9. They feel that they are different from other people

Feeling different is something you have had with you since childhood and even if the circumstance does not warrant it, the feeling prevails. Other children have had the opportunity to be children. You did not. You were very much concerned with what was going on at home. You could never be completely comfortable playing with other children. You could not be fully there. Your concerns about your home problems clouded everything else in your life, (Janet, 2006).

10. They are either super responsible or super irresponsible

Either you take it all on or you give it all up. There is no middle ground. You tried to please you parents, doing more and more, or you reached the point where you recognized it did not matter, so did nothing, (Gil, 1993).

11. They are extremely loyal, even in the face of evidence that the loyalty is undeserved

The alcoholic home appears to be very loyal place. Family members hang in long after reasons dictate that they should leave. The so – called "loyalty" is more the result of fear and insecurity than anything else, nevertheless, the behavior that is modeled is one where no one walks away just because the going gets rough. This sense enables the adult child to remain in involvements that are better dissolved, (Janet, 2006).

12. They are impulsive

They tend to lock themselves into a course of action without giving serious consideration to alternative behaviours or possible consequences. This impulsivity leads to confusion, self – loathing, and loss of control over their environment. In addition, they spend an excessive amount of energy cleaning up the mess, (Janet, 2006).

2.3 Empirical Studies on Conjoint and Transgenerational Family Therapies on Dysfunctional Families

The researcher reviewed journal articles, thesis and research related reports and came up with the following on the topic.

Zygarlicki and Smith (1992) investigated the effect of Conjoint Family Therapy in the treatment of alcoholism among couples with unstable marriages in America. The aim of the study was to find out whether Conjoint Family Therapy could be used in the treatment of such problem in a bid to restore stability of marriages among the couples. The researchers used the experimental research

design. The sample size for the study comprised of 10 couples who were randomly selected from the population. Zygarlick and Smith had therapy sessions with the couples for a period of two months, (two hours session per week). Research instrument used was the questionnaire which was administered at the end of the therapy. There was no control group.

The findings revealed that there was tremendous increase in the stability of marriages. Some of the couples had to quit alcohol taking completely.

Zygarlick and Smith study has similarities with the present study because the present study used couples and experimental research design. The differences are in the fact that Zygarlicki and Smith used 10 couples, while the present study used 20 families out of which 5 families were used for the Conjoint Family Therapy. Zygarlicki and Smith had no control group but the present study had a control group.

In the researchers opinion, conducting therapy for only the couples without the children by Zygarlicki and Smith was not a good idea since alcoholic parents cause problems not only to themselves but the entire family members.

Tamura and Lau (2011) conducted a research on applicability of conjoint Family Therapy on dysfunctional Japanese families. The main objective was to find out if culture has any effect on the applicability of western model of family therapy (conjoint Family Therapy) on Japanese families. Experimental research design was used. A total of twelve (12) families (couples) were treated. The instrument used for the research was the interview. The therapy lasted for just one month with two sessions per week. At the end of the therapy, the areas where the western model of

family therapy is not compatible was identified and modifications to fit the Japanese culture made. At the same time, the therapy had great effects because western family therapy is currently a topic of growing interest in Japan.

Tamura and Lau's study differ a bit from the present study in the sense that Tamura and Lau delimited their study to culture while the present study researched into all round causes of family dysfunction. Another difference is that Tamura and Lau used interview as their instrument, while the present study also used the questionnaire. The similarity lies in the fact that both studies are experimental.

Another study was carried out by Stuart (2002) on a 32 year – old female banker who was suffering from unremitting bouts of crying following her second marriage to a colleague. Her symptoms included waves of fearfulness, poor sleep and appetite and feelings of worthlessness. She complained of losing her independence since after marriage, lack of trust in her second husband, a poor sexual relationship and constant rejection which was mutually felt. The therapist aim was to find out why the lady felt that way towards her husband which was greatly affecting the family. Therapy session was for one month with three sessions per week. Only the family was treated. At the end of the therapy the genogram revealed that for three generations her aunts, sisters, mother and grandmother had all been unable to maintain stable relationships. The woman's mother had been divorced six times and was seen by her as an incompetent woman needing men to structure her life. Grandmother had left her husband, had never re – married and was seen as independent and resourceful. The patient had been partly raised by her mother, partly by her grandmother. She had a poor marital choice in her first

marriage and was now wondering if she had done the same a second time. The final analysis was that the patient was the product of a transgenerational history of poor marital relations. Her conflict was, in family terms, whether to emulate grandmother, independent and resourcefulness with no need of men, or to be like mother, inadequate and dependent tied to unsatisfactory relationships with men. Her need to fulfill a woman's role of sexual and family life conflicted with the need to be an independent person.

The therapist explained the analysis to the patient who then recounted that her symptoms had begin when her husband, after two months of marriage, had decided not to have children contrary to their pre – marital understanding. The explanation of the transgenerational history and its effects on current internal conflict led the patient to become more independent from her second husband. A conscious decision was made by her to integrate the best from both mother and grandmother. The relationship with her husband improved steadily and by the final session the family had become stable.

Stuart's study has something in common with the present study. Stuart treated a family and used the geneogram to be able to come up with the patients problems . The present study was carried out using the Transgenerational Family Therapy. Just like Stuart's study, the present study also used geneograms during the therapy to establish the root causes of the problems.

Another study was also carried out by Russell and Dare (1997) using a combined therapy of conjoint and Transgenerational Family Therapies. The aim of the study was to build up a family's feeling of identity and involvement and reduce

tension in a family that was anorexic. It was a family of four. The session began with all four family members tense and angry. Discussion about the patient and her diet and eating habits heightened the hostility with the parents joining together angrily against their daughter while their 20 year – old son withdrew into silence. The geneogram was introduced into the session. The details revealed that the marriage between the patients parents was a stormy lrish – English union. The marital home was a battleground. This led to their daughter starving herself and losing weight. The effect of uncovering of this in the session was to draw brother and sister closer together, while their parents acknowledged for the first time their deep marital division. The tension and anger was significantly reduced between all parties. From this point the parents agreed to a joint marital sessions while the identified patient their daughter was treated on several conjoint sessions. By the end of the sessions, she was no longer losing weight and showed a visibly lowered sensitivity to her parents arguments.

The similarities between Russell and Dare's study with then present study lies in the fact that Russel and Dare used a combined therapy of Conjoint and Transgenerational which the present study used. Russell and Dare had all family members present and that is how the present study carried out the combined therapy. The difference is that Russell and Dare used only one family while the present study used five families.

Sigal, Rakoff and Epstein (2006) also conducted a research on the therapeutic outcome of conjoint Family Therapy on dysfunctional families. The aim of the research was to describe the patterns of collaboration of the families they

were treating at predetermined intervals during the course of therapy. Twenty (20) families were used for the study and the 20 families were selected based on the following criteria, the family had to be intact, the identified patient has to be at least 7 years and not overtly psycholic, and the family had to be sufficiently fluent in English for treatment to be carried on in that language. These criteria had to be met because some of the measurement techniques used in some aspects of the study could otherwise not have been applied. To be included in the study they had to attend two conjoint therapy sessions at the beginning of treatment. The first 20 families meeting these criteria were selected. These families have a mean socioeconomic level of 3.8 (upper – lower class), 15 were Jewish and the remainder Protestant and Catholic. With one exception, all came originally to seek help with one child, the remaining family came because there was lack of understanding and cooperation at home. The mean age of the identified patient was 11.5 years for the 14 boys and 15.5 years for the 6 girls. The mean age of the siblings was 12.2 years. The mean age of the fathers was 43.4 years and that of the mothers was 40.4. Not all families remained in treatment for the whole period of study. One family backed out after 5 sessions and two left after 8 sessions. At the end of the study with the remaining 17 families, the researchers recorded tremendous change in the families. The instrument that was used to collect data was the questionnaire.

Sigal, Rakoff and Epstein's study is similar to the present study because they used the questionnaire and treated the whole family just as the present study was carried out. The differences lies in the fact that while Sigal, Rakoff and Epistin

included children of about 7 years in their studies, the present study included children that were up to adolescence age.

Masters and Johnson (2007) carried out another study with the aim of finding out why couples referred specifically for sexual dysfunction treatment have major relationship problems concomitantly which were affecting their lives. They used just a couple for the study. The woman, a thirty – five year old social worker was referred for marital therapy with her husband. She had been previously been admitted on many occasions of suffering from phobic anxiety, chronic depression and had made multiple suicide attempts. The ward staff and her psychiatrist had reached the limits of their skill and patience. Her referral was in the hope that a family approach might help.

It was noted in her medical history that she had three surgical vaginal dilations for vaginal constriction. The couple had a poor sex life due to painful intercourse according to the history. The marital therapy was undertaken and her symptoms were traced to their transgenerational source. Geneograms were used in several marital sessions in which the husband's contribution to her symptoms was explored. One family session with the woman and her husband were so undertaken. Both she and her husband were so naïve about sexual matters that they had assumed the marriage was consummated. Infact, they had not actually experienced penetration during their four years of marriage. The transgenrational influence from both sides was one of intense naivety and secrecy regarding sexual matters. The researchers had a total of 20 sessions with the couple. The instrument used was interview. During the sessions a lot of explaining on vaginal tightening and

anatomy lessons were given using diagrams and photographs. By the end of the sessions penetrations was successfully achieved. Much of the marital disharmony disappeared as it became clear that they both felt cheated of a normal married life and the possibility of having children which had not materialized. The woman was able to continue with her work and required no further treatment. No further psychiatric and therapeutic interventions have been necessary and as at the time the study was published, she was pregnant.

The study has similarities with the present study because the present study followed almost the same steps like the study, i.e. making a genogram first before administering therapy. The difference is that while Master and Johnson used interview as their instrument, the present study used questionnaire.

Another study was carried out on four adolescent children whose parents had some family problems. The aim of the study was to determine how family dysfunction was affecting the children and the effect of the therapy on them. The therapy lasted for a period of five weeks. The first week the geneogram was introduced and the details revealed that the children have been having some problems with their social behavior especially in school with the authority. They were also having problems in the way they relate with one another and also friends. The therapist based on the findings first had a transgenerational therapy with them during which the specific problem was treated. Thereafter, Gil had a Conjoint session with them. The children showed a visible change in their social behavior after the therapy.

The similarities between Gil's study and present study is that Gil used a combined Conjoint and Transgenerational Family Therapy which the present study also used. The difference lies in the fact that therapy was carried out on the adolescent children only but the present study used both the adolescent and their parents.

In the researchers view, most of the studies used very small samples but the present study used a larger sample of 15 families. In all the studies also there were no pre-test only treatment then post-test. In the present study the researcher carried out the pre-test, treatment then a post test on all the sampled families.

2.4 Summary of the Literature Review

Summarily, this chapter started by clarifying the theoretical framework upon which this study was based. The study was predicted on Conjoint and Transgenerational Family Theories. The theories emphasized that Conjoint and Transgenerational Family Therapies are very important in bringing about stability in the unstable families. The therapist role is an active and inventive one in which he or she tries to aid family members make choices that increase self-esteem, self-accountability and move members of the nuclear family towards congruent with one another. On the other hand Transgenerational family theory believes that tension in the family system will be resolved by the presence of a neutral third person, who can avoid emotional participation in the family system. It emphasizes on past history of the family as a necessary information in treating the family of any form of dysfunction. The study therefore emphasized on the influence of these therapies on dysfunctional families.

Accordingly, the chapter reviewed literature on the concept of the two therapies that were studied, concept of family dysfunction and the relevance of the therapies in healing dysfunction. A number of empirical studies related to the influence of Conjoint and Transgenerational family Therapies were reviewed. All the empirical studies reviewed were conducted by foreign authors and in each case, treating only a particular type of family dysfunction, thus narrowing the scope while the present study was more comprehensive.

Despite the fact that much has been written about the Conjoint and Transgenerational Family Therapies by several scholars outside Nigeria, the literature, however, revealed that little or no research has been carried out on this topic at any level in Nigeria, Kafanchan in particular. This study therefore, served to fill up the missing gap in the aspect of literature. The review also revealed the method, techniques and what should be the aim of the therapist when carrying out the therapy. The review failed to state how a therapist can identify a dysfunctional family so as to offer help. This study therefore came up with a method that can be used to identify dysfunctional families thereby filling up this missing gap in literature.

Consequently, this study was intended to close the above gaps by providing formal therapies, that is, Conjoint and Transgenerational Family Therapies which were used in treating dysfunctional families in Kafanchan.

CHAPTER THREE

RESEARCH METHODOLOGY

This chapter described the methodology and procedures used for the study under the following sub-headings:

3.1 Research design

3.2 Population for the Study

3.3 Sample size and Sampling Procedure

3.4 Instrument for Data Collection

3.4.1 Validity of the Instrument

3.4.2 Pilot Study

3.4.3 Reliability of the Instrument

3.5 Procedure for Data Collection

3.6 Procedure for Data analysis

3.1 Research design

The research design used for this study is the experimental research design, specifically the quasi experimental design. Experimental research design is a type of design that is concerned with cause – effect relationships, so as to find out any effect the independent variables have on the dependent variables. Within the realm of experimental design there are different types of experimental design but for this study, the Nonequivalent control group design was used. This is a type of quasi-experimental design (Trochim, 2006).The researcher was involved in the actual manipulation of conditions in order to determine relations. The researcher selected

samples using some criteria from the target population so as to get the experimental and control groups. This was carried out in phases.

Phase one:

The researcher conducted a one day marriage seminar for couples, thereafter participants were divided into groups for group discussion. The aim of the group discussion was to get couples together for more intimate discussions. The researcher met with different groups on different days. This lasted for five days. After every group discussion the baseline questionnaire was distributed. The participants filled, added up their scores and returned it to the researcher.

Phase Two:

Using the diagnoses which was meant to show families that were dysfunctional, (appendix iii), the researcher based on the scores of the couples selected all the couples that were from dysfunctional families from where samples were taken. After the selection, the researcher invited the selected families for therapy. Before starting the therapy, a pretest was given to them using the instrument for data collection and thereafter the therapy.

Phase Three:

The therapy lasted for a period of six weeks. After that, the researcher allowed a period of four weeks before carrying out the posttest. Posttest was carried out using the same instrument for data collection. It was given to the groups to ascertain the effect of therapy on the subjects that were measured.

3.2 The Population

The first stage of the population comprised of all families in Kafanchan. The total number of families in kafanchan or household as being called by the population commission was eleven thousand, two hundred and forty-seven(11,247) households, (Jema'a Local Government Population Center, 2006) .The second stage of the population comprised of all families that attended the seminar. The total number was one thousand and fifty three families. The third stage was the population of dysfunctional families in Kafanchan. This population was gotten after the baseline study has been carried out as explained in the research design. The total number of dysfunctional families was five hundred and ten(510).

3.3 Sample Size and Sampling Procedure

Kwasau (2002) stated that sampling of a population is an indispensable factor in research work. He opined that in almost all instances in educational research, it is impossible to study a whole population and therefore, portions (samples) of it are usually studied. For the purpose of this study, sampling was carried out in the following phases:

Phase one: after carrying out the baseline study, families that were dysfunctional were selected using the diagnosis for determining which family was dysfunctional. Samples were randomly selected from the population after the seminar using purposive random sampling. Purposive sampling was used because the researcher wanted to select only dysfunctional families that were literate because they are the

ones that would understand the therapy, families that were nuclear in nature and families that both couples accepted that they had problems .

Phase two : From the sampled population, twenty dysfunctional families were purposely selected. The researcher used what they scored during the baseline study to select. That is to say, the first twenty (20) families with the lowest scores were selected because from the diagnoses the lower the total score, the more dysfunctional is the family.

Phase three: From the twenty (20) families that were sampled, Conjoint family therapy was used on five (5) families, Transgenerational family therapy equally had five (5) families, another five (5) families were used for the combined therapy while the remaining five (5) were used as the control group. This is line with Gay and Diehl (1992) recommendation that about 10 subjects are ideal for an experimental research. This was done using the hat drawn method.

3.4 Instrument for Data Collection

The instrument that was used to collect data for the study was the questionnaire. The questionnaire was chosen for the research because it is relatively effective to administer and score. The questionnaire was in two forms.

Phase one: the first questionnaire was used for the baseline study, (appendix iii). The purpose was to enable the researcher select the families that were dysfunctional. It was close ended questions. The answers were rated as follows; 1-undecided, 2-never true,3-sometimes true, 4-most times true and 5-always true. At the end there was diagnoses indicating which group each couple fell into. That is

,those that needed therapy and those that did not. But the diagnoses was for the researcher's consumption only. The baseline study questionnaire was adapted from Oyawoye (2004).

Phase two; The second questionnaire was used for the pre-test and post-test to elicit data for the study (appendix ii). It was designed to obtain information and data on the research objectives and research questions raised for the study. It was adapted from Zygarlick and Smith (1992), Tamaura and Lau,(2011) and Stuart, (2002). It was closed-ended questions with answers rated thus, 1- undecided, 2- never, 3- sometimes, 4- most times, 5- always. It was meant for the couple only. Section A of the questionnaire was on the bio-data of the respondents. Section B and C answered research questions one and two respectively, while section D was on general issues about family dysfunction which took care of research questions four, five, six and seven and also the stated hypotheses. The parents test instrument consisted of 3 bio data variables and 40 questions divided into sections.

3.4.1 Validity of the instrument

In order to make sure that the final copy of the test instrument was valid for the study, the researcher employed the services of some Postgraduates in the Department of Vocational and Technical Education, Home Economic Section during the construction of the test instrument. Based on the input of the students and lecturers, a draft of the test instrument was submitted to the supervisors, experts and statistician for face validation. On the basis of their expert inputs, the test instrument for data collection was raised. The instrument used for the baseline study

was a standard questionnaire for determining dysfunctional families and so was not validated.

3.4.2 Pilot Study

Pilot study was carried out to determine the reliability of the designed instrument. A total of six (6) dysfunctional families selected from Zonkwa, a town also in the southern part of Kaduna state were used. Zonkwa was used for the pilot study because it has similar characteristics with Kafanchan. Two families each were used for both the conjoint, transgenerational and combined therapies. To get the dysfunctional families, the researcher first carried out a one day marriage seminar for couples. All participants were given codes. At the end of the seminar, the couples were shared into groups for group discussions. After the group discussions, the baseline study questionnaire was distributed and each participant filled and returned it to the researcher. They wrote the codes given to them on the questionnaire. The researcher quickly carried out the diagnoses and called out the selected families using the codes. Those called were asked to see the researcher at the end of the seminar but the reason was not publicly made known. The selected families were then invited for therapy sessions. This lasted for a period of one month. Before starting the therapy sessions, a pre-test was conducted and at the end, the post-test using the same instrument meant for data collection. The pilot study was carried out just to obtain data that was used in testing the reliability of the instrument. The data collected were analyzed by a statistician using the Cronbach's alpha statistics.

3.4.3 Reliability of the instrument

The data collected from the pilot study were statistically analysed for purpose of reliability co-efficient. Cronbach's alpha reliability coefficient method was used to analyze data collected. Consequently, reliability co-efficient of alpha level of 0.79 was obtained for the parents test instrument. These reliability co-efficient was considered adequate for the internal consistencies of the instrument. This was a confirmation of test of reliability by Spiegel (1992) and. Stevens, (1986). According to them an instrument is considered reliable if it lies between 0 and 1, and that the closer the calculated reliability coefficient is to zero, the less reliable is the instrument, and the closer the calculated reliability co-efficient is to 1, the more reliable is the instrument. This therefore confirms the reliability of the data collection instrument used as fit for the main work.

3.8 Procedure for data collection

Data was collected from couples in the dysfunctional families that were used for the therapies. For the sake of clarifications, the procedure for data collection is presented in stages;

STAGE 1

The researcher collected data for the study by first organizing a one day marriage seminar for couples in Kafanchan. At the end of the seminar, the participants were divided into groups for group discussions. The group discussions was carried out at different locations and time. The purpose of the group discussion was to enable the researcher familiarize with the participants so that they can freely and honestly

speak out. After each group discussion, the first questionnaire was administered to the group. They filled and returned it immediately to the researcher. The couples filled the questionnaire independently. This exercise lasted for one week.

STAGE 2

Using the diagnoses for selection of dysfunctional families(appendix iii), the researcher then selected the families that fall within the range of families that are dysfunctional as explained in the research design and sampling procedure.. Couples that their responses did not tally were not selected because it means they were not in agreement about their situation. From the identified dysfunctional families, twenty (20) families were selected as sample for the study. That is to say, each therapy was assigned five families. That is Conjoint therapy five (5) dysfunctional families, Transgenerational five (5) dysfunctional families, combined therapy five (5) and control group five (5) dysfunctional families. The researcher used the codes on the questionnaire and the couple's phone numbers to contact and invite them for therapy sessions.

STAGE 3

On the first day each family came in for therapy, a pre-test was conducted after general introduction. After the pretest, the therapy sessions started. The therapy lasted for six (6) weeks, and it was conducted in the evenings starting from 4pm. The days for therapy were Mondays, Tuesdays, Wednesdays, Fridays and Saturdays. Thursday was not included because it is a major market day in the town. Each family had one session per week and a session lasted for just an hour so that the families would not become less interested in the therapy. For Conjoint Family

Therapy, the therapy was on general issues on marriage and this was conducted as follows;

Week 1……general introduction.

Topic……. What makes marriage work.

Week 2: …… Sexual relationship in marriage

Week 3: …..Communication in marriage.

Week 4:…….Marriage and self-esteem.

Week 5:…….Parenting.

Week 6:……Managing family finances.

The Trangenerational Family Therapy was conducted based on the presenting problem. Based on what the problem was, the researcher first of all drew up the genogram of the family to know how the past is affecting their present situation. The researcher then treated only that problem that was manifesting in the family. For example, if the researcher discovered that the problem in the family was as a result of finances, the therapy would be on that. The first two weeks was used for the genogram while the remaining four weeks were used for the treatment.

The combined therapy was carried out by combining the two therapies. That is to say, the Conjoint Family Therapy and the Transgenerational Family Therapy were conducted on the same family using the methods stated above. The Transgenerational Family Therapy was conducted first for three weeks and Conjoint was conducted for another three weeks. Full text of the therapy used is attached as appendix one.

STAGE 4

After the therapy sessions, the researcher gave a space of four weeks before administering the post-test. The families were invited once more just for the exercise. They filled and returned the questionnaire to the researcher immediately. From the pretest to posttest, questionnaire was filled independently by family members. It is important to state here that the researcher in order to get the correct responses from the parents on question 5-10 in section B of the parents questionnaire, engaged them in one on one discussion before and after the therapy. While the discussion was going on, the researcher from the responses they gave ticked the responses on the questionnaire. The researcher did not collect any letter of introduction from the department or use research assistants for the sake of confidentiality. This is because whatever transpires between the therapist and the family is never to be made known by the therapist to any other person. It is based on that trust that families reveal every bit of their secret to the therapist.

3.9 Procedure for data analysis

The study made use of a number of statistical procedures which helped in data analysis and interpretation. These are percentages, and frequency count, which were used to present information on the personal data. Weighted mean scores and standard deviation were used to analyze data collected for research questions one and two, while mean scores, standard deviation and standard error were used to analyze data collected for research questions three, four, five and six. Paired t-test was used to test hypotheses one, two and four. While the independent t-test was used for hypothesis three. ANOVA was used to test null hypothesis five. Both

variables (pre-test and post-test) are quantitative and in order to determine differences between the two, the paired sampled and independent t-test and ANOVA were used at 0.05 level of significance for rejecting or accepting the null hypothesis in each case.

CHAPTER FOUR

PRESENTATION AND ANALYSIS OF DATA

This chapter primarily presents the analysis of the data collected for the research titled Influence of Conjoint and Transgenerational Family Therapies on Dysfunctional Families in Kafanchan, Kaduna State, Nigeria. The chapter is presented under the following sub-headings:

4.1 Analysis of bio-data of respondents

4.2 Answers to Research Questions

4.3 Testing of Hypotheses

4.4 Summary of major findings

4.5 Discussion of Findings

4.1 Analysis of Bio-data of Respondents

Table showing the Distribution of groups of Parents Respondents.

. **Table 4.1.1 Distribution of the parents respondents into different groups**

	Frequency	Percent
Conjoint	10	25.0
Transgenerational	10	25.0
Combined Conjoint & Transgenerational	10	25.0
Control	10	25.0
Total	40	100.0

According to table 4.1.1 the parents were divided into four groups. The first 25.0% (10) were exposed to Conjoint therapy, the next 25.0% (10) were exposed to Transgenerational therapy while the next 25.0% (10) were exposed to Combined Conjoint & Transgenerational Therapies and the rest 25% (10) were control that were not exposed to any family therapy.

The Bio-data of Respondents

Table 4.1.2: Distribution of parents' respondents according to their Bio-data

Item	**Frequency**	**Percentage**
Sex		
Male	20	50
Female	20	50
Age		
36-40	21	52.5
41-45	19	47.5
Qualification		
SSCE	18	45.0
NCE	11	27.5
First Degree	11	27.5

The gender of the parents respondents showed that 50% (20) were males and also 50% (20) were female. This implies that the number of both the male and female respondents were equal.

The parents respondents age showed that 52.5% (21) were aged between 36-40 years while the rest 47.5% (19) were aged between 41 – 45 years.

On the educational qualification of parents 45.0% (18) possess SSCE qualification as against 25.5% (11) that possess NCE and the rest 27.5% (11) possess first degree. Thus most of the respondents had SSCE certificate.

4.2 Answers to Research Questions.

Research question 1: What are the Types of family dysfunction found among families in Kafanchan, Kaduna state?

The analysis of data generated to find out the types of family dysfunction found among families in Kafanchan is presented in table 4.2.1.

Table 4.2.1: Types of family dysfunction among families in Kafanchan, Kaduna state

S/no	The following are types of family dysfunctions.	Response categories					Mean Score	Std.dev
		Always (5)	Most times (4)	Sometimes (3)	Never (2)	Undecided (1)		
1	Do you see it as your duty to provide for the children rather than the children providing for you?	70	32	30	12	2	3.6	**.210**
2	If your child fails to take up adult roles do you see him/her as a failure?	50	60	15	8	6	3.4	**.320**
3	Do the children bring money to the family through trading or labour?	75	56	12	12	1	3.9	**.502**
4	Have you ever withdrawn financial or basic physical care for any child in your family just because the child did wrong?	40	56	30	10	3	3.4	**.321**
5	Drugs like cocaine or marijuana sometimes help people feel high, have you ever tried it.	35	40	9	16	12	2.8	**.921**
6	Drinking of alcohol is seen as a way of relaxing by people, have you ever taken alcohol in excess.	75	60	12	10	1	3.9	**.502**
7	Men and women do have desire for a person who is not their spouse, have you ever felt that way.	40	32	12	18	11	2.8	**.409**
8	Gambling is something that attracts people and they actually go for it, have you been doing it?	20	20	18	40	5	2.5	**.443**
9	African culture permits husbands to beat their wives when they misbehave, have you ever done it.	25	28	9	42	4	2.7	**.612**
10	It is believed that the severe the punishment the more children can be corrected, do you believe in that.	100	40	15	8	1	4.1	**.339**
	Cumulative Mean						**3.3**	

Decision mean: 3.0

Table 4.2.1 shows in summary that the respondents were in agreement with most of the items as the cumulative mean of 3.3 is higher than the decision mean of 3.0. Specifically, the respondents believed in severe punishment for children as a means of correcting them. This item scored 164 with a weighted mean of 4.1. The table also shows that majority of the parents engage in excessive alcohol. This item has a total score of 158 with a weighted mean of 3.9. The table also shows that item three indicated that majority of the parents allow their children to bring money to the family through trading or labour as this item had a total score of 156 with a weighted mean of 3.9. Also the table shows that parents believe their children should equally provide for them as this item had a weighted mean score of 3.6. and they also withdraw financial assistance or other basis care because the item had a weighted mean score of 3.4.This implies that the parents engage in severe punishment for children , they take alcohol a lot and also abuse their children by engaging them in one form of trade or labour and denying them some basic care. . From the results, it is evident that family dysfunction is prevalent in Kafanchan because the result showed the types of family dysfunction that are found in the town. Details of the items and the type of dysfunction each represent is in appendix iv.

Research question 2: What are the Causes of family dysfunction among families in Kafanchan, Kaduna state?

Table 4.2.2 : Causes of family dysfunction among families in Kafanchan, Kaduna state.

S/no	Causes of Family Dysfunction	Response categories					Mean	Std.dev
		Always (5)	Most times (4)	Sometimes (3)	Never (2)	Undecided (1)		
1	Do you feel happy when the children ignore their own needs and feelings just to satisfy your needs?	45	32	9	24	8	2.9	**.417**
2	Do you choose friends for your children?	50	44	30	6	6	3.4	**.521**
3	Do you feel it is important for your teenage child to own an account and manage it the way he/she feels?	25	16	33	22	9	2.6	**.181**
4	As an adult do you think you can take alcohol the way you feel even in excess sometimes since it is believed to help people relieve tension and 'relax'.	20	40	63	10	0	3.3	**.401**
5	Do you flog rather than talk to your child at every offence he/she commits?	55	40	9	18	5	3.1	**.012**
6	Do you seek for your children's opinion on some family issues especially the ones that affect them?	40	32	27	28	1	3.2	**.810**
7	Do you exert a strong authoritarian control over the children?	90	32	24	8	2	3.9	**.155**
8	Are your words final in any decisions in the family?	65	40	24	12	2	3.5	**.418**
9	Are you consistent with your rules and regulations in the home or rules that apply one day may not apply the next day?	35	24	33	28		3.0	**.215**
10	Do you feel it is necessary to keep promises made to any member of the family	25	12	15	40	2	2.3	**.332**
	Cumulative Mean						**3.1**	

Decision mean: 3.0

Table 4.2.2 above shows the causes of family dysfunction among families in Kafanchan, Kaduna state. The result indicated a cumulative mean response of 3.1 which is higher than the decision mean of 3.0, meaning that majority of the respondents were in agreement with the question items used to collect data. The table shows that some parents exert a strong authoritarian control over the children. This item scored 156 with a weighted mean score of 3.9. It was also shown that some parents words are final in any family decision, as this item scored 143 with a weighted mean response of 3.5.The result also shows that the respondents believe that an adult is free to take alcohol the way he or she feels even in excess. This item had a total score of 133 with a weighted mean score of 3.3. The result equally indicated that parents believe they should choose friends for their children as this item had a weighted mean score of 3.4. The item mean scores of the items are higher than the decision mean which is an indication that the items are causes of family dysfunction in the study area .In view of this the researcher concluded that the main causes of family dysfunction in Kafanchan is the authoritarian behavior by the parents and alcohol taking. Details of the items and what each represent as causes of family dysfunction is in appendix v.

Research Question 3 :What Is the influence of Conjoint Family Therapy on dysfunctional families in Kafanchan, Kaduna state?

The analysis of data generated to determine the influence of Coinjoint Family Therapy on Dysfunctional Families in Kafanchan, Kaduna State is presented in table 4.2.3.

Table 4.2.3 Influence of Conjoint Family Therapy on dysfunctional families in Kafanchan, Kaduna state.

Dysfunctional scores	N	$\overline{X}$ scores	Std.dev	Std.err
Pre test dysfunctional mean scores	10	139.3000	6.821	2.16050
Post test dysfunctional mean scores	10	124.1000	4.62961	1.46401

The descriptive statistics table 4.2.4 revealed the mean dysfunction scores before and after Conjoint Family Therapy was administered to subjects in this group. Their mean dysfunction scores before therapy (pretest) was 139.3000 and after therapy (posttest) was 124.1000. This implies that there has been remarkable positive influence of Conjoint Family Therapy on dysfunctional families in Kafanchan, Kaduna state. This is because when the mean score of posttest result is lower than the mean score of pretest result, it means there is a positive influence of treatment on subjects.

Research question four: What is the influence of Transgenerational Family Therapy on dysfunctional families in Kafanchan, Kaduna state.

The analysis of data generated to determine the influence of Transgenerational Family Therapy on Dysfunctional Families in Kafanchan, Kaduna State is presented in table 4.2.4.

Table 4.2.4 Descriptive statistics on influence of Transgenerational Family Therapy on dysfunctional families in Kafanchan, Kaduna state

Trans generational Dysfunctional scores	**N**	$\overline{X}$ **scores**	**Std.dev**	**Std.err**
Pre test dysfunctional mean scores	10	141.8000	4.02216	1.27192
Post test dysfunctional mean scores	10	119.7000	7.43938	2.3525

The summary of data used to answer the research question five is presented in table 4.2.5. The result of the table shows that the mean score before Transgenerational Therapy was administered on the subjects was 141.8000 and 119.7000 mean score after the therapy. It means that the mean score before therapy was higher than the mean score after therapy indicating that there was great positive influence of Trangenerational Family Therapy on dysfunctional families in Kafanchan.

Research question five: What is the difference in the treatment outcome of Conjoint Family Therapy and Transgenerational Ffamily Therapy on dysfunctional families in Kafanchan , Kaduna state?

The analysis of data generated to determine the difference in the treatment outcome of Conjoint Family Therapy and Transgenerational Family Therapy on Dysfunctional Families in Kafanchan, Kaduna State is presented in table 4.2.5.

Table 4.2.5 Descriptive statistics on the difference in treatment outcome between the mean scores of families treated with Conjoint family therapy and those treated with Transgenerational Family Therapy in Kafanchan, Kaduna state.

Variable	Group	N	$\overline{X}$ scores	Std.dev	Std.err
Family dysfunction scores	Conjoint	10	131.7000	4.0221	1.27192
	Transgenerational	10	130.7500	2.7512	.87003

Table 4.2.6 presents the results of data used to answer research question six. Results of table 4.2.6 revealed that there is no difference in the treatment outcome of Conjoint Family Therapy and Transgenerational Family Therapy among dysfunctional families in Kafanchan, Kaduna state. The table shows calculated mean scores were 131.7000 and 130.7500 by Families exposed to Conjoint Therapy and those exposed to Transgenerational Therapy respectively. This implies that the two therapies are both good in the treatment of families that are dysfunctional. The difference in the mean scores is so small that none can be said to be better than the other.

Research Question six: What is the influence of combined Conjoint and Transgenerational Family Therapies on dysfunctional families in Kafanchan, Kaduna state?

The analysis of data generated to determine the influence of combined Conjoint Family Therapy and Transgenerational Family Therapy on Dysfunctional Families in Kafanchan, Kaduna State is presented in table 4.2.6.

Table 4.2.6: Descriptive statistics between the mean dysfunction scores of families who were exposed to combined Conjoint and Transgenerational Family Therapies in Kafanchan, Kaduna state.

Variable	Group	N	$\overline{X}$ scores	Std.dev	Std.err
Family dysfunction	Pretest mean scores	10	130.7500	2.75126	.87003
	Posttest mean scores	10	107.8500	17.13030	5.41708

According to the descriptive statistics table 4.2.7, there is positive influence in the use of combined Conjoint and Transgenerational Family Therapies among dysfunctional families in Kafanchan, Kaduna state. The table shows that the calculated mean dysfunctional scores were 130.7500 and 107.850 from the pretest and posttest respectively, implying that there is significant positive influence as a result of the application of the combined family therapy on dysfunctional families in Kafanchan Kaduna state.

4.3 Testing of Research Hypotheses:

Hypothesis 1: The null hypothesis states that, there is no significant influence of Conjoint Family Therapy on dysfunctional families in Kafanchan, Kaduna state

To test this hypothesis, the pretest and post test of **Conjoint** *dysfunctional mean scores among families in the experimental group were compared.*

4.3.1: Paired Sample t-test statistics on the Influence of Conjoint Family Therapy on dysfunctional families in Kafanchan, Kaduna state

Conjoint Scores	N	$\overline{X}$ Scores	STD.DEV	Std.err	df	T cal	T crit	P (sig)
Pre test dysfunctional mean scores	10	139.3000	6.83211	2.16050	9	5.684	1.96	0.000
Post test dysfunctional mean scores	10	124.1000	4.62961	1.46401				

P calculated < 0.05 t calculated > 1.96 at df 9

Table 4.3.1 shows the result of the test of hypothesis one. The result on the table shows significant positive influence in the mean score of Conjoint Family Therapy on dysfunctional families in Kafanchan, Kaduna state . This is due to the fact that the calculated p value of 0.000 is less than the 0.05 alpha level of significance and the calculated t value of 5.684 is higher than the t critical value of 1.96 at df 9. The mean Conjoint dysfunction scores before and after therapy were 139.3000 and 124.1000 respectively. Therefore the null hypothesis which state that there is no significant influence of Conjoint Family Therapy on dysfunctional

families in Kafanchan, Kaduna state, was rejected because the results showed that Conjoint Family Therapy had positive significant influence on subjects treated.

Hypothesis 2: The null hypothesis stated that There is no significant influence of Transgenerational Family Therapy on dysfunctional families in Kafanchan, Kaduna state.

To test this hypothesis, the pretest and post test of Transgenerational family mean scores among famailies in the experimental group were compared.

4.3.2: Paired Sample t-test statistics on influence of Transgenerational Family Therapy on dysfunctional families in Kafanchan, Kaduna state.

Trans generational Dysfunctional scores	N	$\overline{X}$ Scores	Std.dev	Std.err	df	T cal	T crit	P (sig)
Pre test dysfunctional mean scores	10	141.8000	4.02216	1.27192	9	6.581	1.96	0.000
Post test dysfunctional mean scores	10	119.7000	7.43938	2.35254				

P calculated < 0.05 t calculated > 1.96 at df 9

The result of the data used to determine the influence of Transgenerational Family Therapy on dysfunctional families shows a mean score of 141.8000 before treatment and mean score of 119.7000 after treatment. The paired sample statistics table 4.3.2 shows that the calculated p value of 0.000 is less than the 0.05 alpha level of significance and the calculated t value of 6.581 is higher than the t critical value of 1.96 at df 9. This implies that there was positive influence of Trangenerational Family Therapy on dysfunctional families treated. Therefore the

null hypothesis which states that there is no significant influence of Transgenerational Family Therapy on dysfunctional families in Kafanchan, Kaduna state, was rejected.

Hypothesis 3: The null hypothesis state that there is no significant difference in the treatment outcome of Conjoint and Transgenerational Family Therapies among dysfunctional families in Kafanchan, Kaduna state.

Table 4.3.3: Independent t test between Conjoint family therapy and Transgenerational family therapy among dysfunctional families in Kafanchan, Kaduna state.

Variable	Group	N	$\overline{X}$	std.dev	std.err	df	T Cal	t crit	Sig (p)
Family dysfunction	Conjoint	10	131.7000	4.0221	1.27192	**18**	.616	1.96	0.545
	Transgenerational	10	130.7500	2.7512	.87003				

Calculated p > 0.05, calculated t < 1.96 at df 18

Results of table 4.3.3 independent t-test statistics showed that there is no significant difference in the treatment outcome of Conjoint Family Therapy and Transgenerational Family Therapy on dysfunctional families in Kafanchan Kaduna state. Reason being that the calculated p value of 0.545 is higher than the 0.05 level of significance while the calculated t value of 0.616 is lower than the 1.96 critical t value at df 18. Their calculated mean scores were 131.7000 and 130.7500 by families exposed to Conjoint and those exposed to Transgenerational Therapies respectively. This implies that the two treatments are equally good therapies for the reduction of dysfunctional traits as a result of the application of family therapy on dysfunctional families in Kafanchan, Kaduna state. Therefore,

the null hypothesis which state that there is no significant difference in the treatment outcome of Conjoint Family Therapy and Transgenerational Family Therapy among dysfunctional families in Kafanchan Kaduna state, was accepted.

Hypothesis 4: The null hypothesis stated that There is no significant influence of Combined Conjoint and Transgenerational Family Therapies on dysfunctional families in Kafanchan, Kaduna state

To test this hypothesis, the pretest and post test of **combined Conjoint and Transgenerational** *therapy mean scores among families in the experimental group were compared*

Table 4.3.4: Paired Sample t-test statistics on the influence of the mean effect of Combined Conjoint and Transgenerational Family Therapies on dysfunctional families in Kafanchan, Kaduna state.

Combined Conjoint and Transgenerational.	N	$\overline{X}$ Scores	Std.dev	Std.err	Df	T cal	T crit	P (sig)
Pre test dysfunctional mean scores	10	117.2000	3.99444	1.26315	9	6.547	1.96	0.000
Post test dysfunctional mean scores	10	98.5000	36.07477	11.40784				

P calculated < 0.05 t calculated > 1.96 at df 9

According to the paired sample statistics table 4.3.4 , significant positive influence exist among families treated with the combined therapies . This is due to the fact that the calculated p value of 0.000 is less than the 0.05 alpha level of significance and the calculated t value of 6.547 is higher than the t critical value of 1.96 at df 9. Their mean scores before and after therapy were 117.2000 and 98.5000

respectively. Therefore the null hypothesis which states that there is no significant influence of combined Conjoint and Transgenerational Family Therapies on dysfunctional families in Kafanchan, Kaduna state, is hereby rejected because there is significant positive influence of the therapy on dysfunctional families.

Null Hypothesis 5: The null hypothesis state that there is no significant differences in the influence of family therapies on dysfunctional families treated and the control group (Conjoint, Transgenerational, Combined Therapy and Control)

Table 4.3.5 (a)

Variation	Sum of Squares	df	Mean Square	F	F critical	Sig.
Between Groups	16214.500	3	5404.833	115.262	2.60	.000
Within Groups	1688.100	36	46.892			
Total	17902.600	39				

Table 4.3.5 (b) Descriptive statistics on the mean differences in the influence of family therapies on account of the subjects groups (Conjoint, Trans generational, Combined and Control)

Treatment Group	N	Mean	Std. Deviation	Std. Error
COJOINT (EXP1)	10	131.7000	4.02216	1.27192
TRANSGENERATIONAL (EXP)	10	129.8000	4.23740	1.33998
CONBINED (EXP)	10	88.5000	9.08295	2.87228
CONTROL	10	140.6000	8.42219	2.66333
Total	40	122.6500	21.42524	3.38763

Table 4.3.6 (a and b) shows the result of the test of hypothesis six.

The Analysis of variance (ANOVA) statistics showed that there is significant mean differences in the effect of family therapies on account of the subjects groups (Conjoint, Transgenerational, Combined Therapies and Control group). This is because the calculated P (sig) value of 0.000 is lower than the 0.05 alpha level of significance, while the calculated F value of 115.262 is higher than the 2.60 F critical. The descriptive statistics showed that the mean dysfunctional traits is 131.70000, 129.8000, 88.5000 and 140.6000 by subjects exposed to therapies of Conjoint, Transgenerational, Combined Conjoint & Transgenerational Therapies and those in control groups respectively. This implies that the combined therapy had the best effect among the therapies, then Transgenerational and Conjoint. The control group had the worst dysfunctional mean traits than the other three groups that were exposed to the treatments. This means that there is significant difference in the experimental groups treated with the therapies and the control group. Therefore the null hypothesis which stated that there is no significant difference in the influence of family therapies on dysfunctional families treated and the control group is hereby rejected.

Table 4.3.5 (c) Post Hoc Multiple Analysis using LSD on the mean differences in the effect of family therapies on account of the subjects groups (Conjoint, Transgeneration, Combined and Control group)

(I) GROUP	(J) GROUP	Mean Difference (I-J)	Std. Error	Sig.
COJOINT (EXP)	TRANSGENERATIONAL (EXP)	1.90000	3.06241	.539
	COMBINED (EXP)	43.20000*	3.06241	.000
	CONTROL	-8.90000*	3.06241	.006
TRANSGENERATIONAL (EXP)	COJOINT (EXP1)	-1.90000	3.06241	.539
	COMBINED (EXP)	41.30000*	3.06241	.000
	CONTROL	-10.80000*	3.06241	.001
COMBINED (EXP)	COJOINT (EXP1)	-43.20000*	3.06241	.000
	TRANSGENERATIONAL (EXP)	-41.30000*	3.06241	.000
	CONTROL	-52.10000*	3.06241	.000
CONTROL	COJOINT (EXP1)	8.90000*	3.06241	.006
	TRANSGENERATIONAL (EXP)	10.80000*	3.06241	.001
	COMBINED (EXP)	52.10000*	3.06241	.000

*. The mean difference is significant at the 0.05 level.

The post Hoc analysis using LSD (Least Significant Differences) in a pair wise comparison shows that significant differences exist in the effect of Conjoint therapy and Combined therapy and also those in control. But there is no significant differences in the effect of Conjoint and Transgenerational Therapies and vice versa. The reason is that in each of the pair wise comparison and vice versa, the calculated significance level is lower than 0.05 where significant differences was reported and higher than the 0.05 alpha where there was no significant differences. It showed that in dysfunction mean reduction level, Combined Therapy has the

least mean dysfunction level, followed by Transgenerational , then Conjoint and highest are those in control who were not exposed to any treatment.

4.4 Summary of Major Findings

From the results of the analysis presented, the major findings of this study are summarized thus:

1. The result of objective one (research question one) indicated that physical violence on children, alcohol addiction and abusive parents are the types of family dysfunction found in Kafanchan.
2. The result of objective two (research question two) revealed that family dysfunction in Kafanchan is caused mostly by controlling parents and alcoholic parents.
3. The results of null hypothesis one revealed that Conjoint family therapy was found to have significant positive influence on dysfunctional families as families treated showed improvement and were able to move out of their dysfunctional state. In view of this, the null hypothesis was rejected.
4. The study further revealed that there was significant positive influence of Transgenerational family therapy on dysfunctional families because families treated using the therapy were able to live normal family life where peace and love reigns. Therefore, null hypothesis two was rejected.
5. The result of the findings equally revealed that there was no difference in the treatment outcome of Conjoint and Transgenerational family therapies on dysfunctional families. Therefore, null hypothesis three was accepted.

6. Result of hypothesis four showed that combined therapy of Conjoint and Transgenerational family therapies had positive influence on dysfunctional families. Therefore, null hypothesis four was rejected.

7. The result of null hypothesis six revealed that there was significant difference in dysfunctional families treated with the therapies studied and the control group.

4.5 Discussion of Findings

The analysis of the data collected for this study provided some insight into the main objectives of the study, which was to examine the Influence of Conjoint and Transgenerational Family Therapies on dysfunctional families in Kafanchan, Kaduna State.

The first part used different tables to answer the descriptive part involving frequency and percentages of the different variables that are related to the research topic.

The study in Table 4.2.1 revealed that the type of family dysfunction commonly found in Kafanchan is physical violence on children, alcohol addiction and abusive parents. The finding concurred with what was obtained by other researchers like Halpern (2007) who opined that when one or both parents have addictions or compulsions such as alcohol, the family is dysfunctional. Also Blair and Rita (1990) observed that when one or both parents use threat or application of physical violence on the children as a means of control and also abuse the children, the family is dysfunctional.

The result of Table 4.2.2 shows that family dysfunction in Kafanchan is caused mostly by controlling parents (i.e. authoritarian parenting) and alcoholic parents. The findings agreed with the result obtained from Gil (1993) which showed that controlling parents are often driven by a fear of becoming unnecessary to their children, so they tend to control both the children and any other person in the family in a manner that becomes a problem to the family, thereby causing dysfunction in the family .Also, from the result gotten in table 4.2.1 which showed that one of the types of family dysfunction found in Kafanchan is alcohol addiction, it is obvious that one of the causes of family dysfunction in Kafanchan is as a result of alcoholic parents. This is in line with what Keer and Bowen (2000) said that if the type of dysfunction in a family is alcohol addiction it is because the family has alcoholic parents. Alcoholic families are chaotic and unpredictable, (Janet, 2006).

Table 4.2.3 and 4.3.1 shows that Conjoint family therapy has influence on dysfunctional families treated using the therapy. This findings agreed with the result obtained from Zygarlicki and Smith (1992) who observed that there was tremendous increase in the stability of marriage when Conjoint Family therapy was administered. Satir, Barmen, Gerber and Gamoi (1991) supported this view and noted that Conjoint family therapy helps family members learn how best to settle their disagreements and differences in the face of conflict at home.

The study in Table 4.2.4 and 4.3.2 revealed that Transgenerational family therapy has positive influence on dysfunctional families after they have been treated using the therapy. The findings of Stuart (2002) confirms the findings in this study because Stuart (2002) revealed through a research finding that dysfunctional

families can better be healed when the presenting problem is traced back to the past history of the family and then the problem is treated. She had earlier indicated that the family geonogram is the best thing that can reveal the source of any problem in a family.

Furthermore, the research work on Table 4.2.5 and 4.3.3 shows that there is no difference in the treatment outcome of Conjoint and Transgenerational family therapies on dysfunctional families. This means that each of the therapy is good and can be effectively used in the treatment of family dysfunction. This goes in agreement with the work of Ken, (2010) who was a Narrative therapist but came up with the finding that irrespective of the type of therapy used, family therapy is aimed at healing a family of its dysfunctional state. Therefore any therapy used is geared towards this, so no therapy can be said to be better than the other. All family therapies are good.

Table 4.2.6 and 4.3.4 revealed that combined Conjoint and Transgenerational family therapy has positive influence on dysfunctional families. The work of Russell and Dave (1997) had earlier shown that there was positive influence of combined Conjoint and Transgenerational family therapies on dysfunctional families. Hammond and Nicholas (2008) added that combined therapies are more effective than single therapies. Corrales (2008) maintained that since the family faces different problems in their dysfunctional state, it is better to use combined therapies so as to be able to effectively handle the dysfunction in the family.

According to the empirical results of the study, significant positive influence exist in mean responses of dysfunctional families treated with the different family therapies that were studied. This means that both Conjoint and Transgenerational family therapies have positive influence on unstable families thereby bringing about stability. By this particular analysis, the findings is in agreement with Sigal, Rakoff and Eptein (2006) who conducted a research on the therapeutic outcome of Conjoint family therapy on dysfunctional families. Their findings revealed tremendous change in the families. In the same vein, Masters and Johnson (2007) carried out another study on dysfunctional families using Transgenerational family therapy. The results showed that dysfunctional families were equally healed after the therapy.

In addition, the study equally revealed that there is no significant difference in the treatment outcome of the different therapies that were used for the study. The lack of differences in the treatment outcome was not surprising because all therapies have the potential of healing a dysfunctional family, (Kerr, 2010). The result of the findings corroborated the study by Davis and Butter (2004) who maintained after working on dysfunctional families using four different therapies that every therapy is as good as the other but can be affected by some factors such as the skill of therapist.

The fifth hypothesis states that there is no significant difference in the influence of family therapies on dysfunctional families treated and the control group. The result of the findings is seen on table 4.3.5a and 4.3.5b. This hypothesis was rejected, meaning that significant difference exists among the two groups, that

is, experimental and control groups. This agreed with the positions of Zygarlicki and Smith (1992), Tamura and Lau (2011), Stuart, (2002) Masters and Johnson (2007) who observed that family therapy is an indispensable tool in the healing of family dysfunction.

Their studies revealed that there was tremendous increase in the stability of marriages after therapy was administered.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter contains the summary, conclusion and recommendations of the study. The conclusions are based on the results of the research findings. Recommendations are made on how to improve on the use of family therapies in healing family dysfunction. The chapter is presented under the following sub-headings:

5.1 Summary

5.2 Conclusions

5.3 Recommendations

5.4 Suggestions for further studies

5.1 Summary

The purpose of the study was to investigate the influence of Conjoint and Transgenerational Family Therapies on dysfunctional families in Kafanchan, Kaduna State, Nigeria. The study had seven objectives, among which is to ascertain the influence of Conjoint family therapy on dysfunctional families in Kafanchan, likewise Transgenerational family therapy. Also, seven research questions and six null hypotheses were formulated. Past literature relating to the study were also reviewed. The research adopted experimental research design. The population for the study comprised of all families in Kafanchan. Thus, the total respondents for this study were 20 families, comprising of 40 parents. The instrument used for the study was the questionnaire. The questionnaire was in two parts, one for the

baseline study and another for data collection. The five null hypotheses formulated in the study were tested using paired t- test, independent t-test and ANOVA at 0.05 level of significance. Out of the five hypotheses stated in null form, four were rejected and only one was retained. Findings of the study revealed that:

1. Physical violence on children, alcohol addiction and abusive parents are the types of family dysfunction found in Kafanchan.
2. Controlling parents and alcoholic parents are the major causes of family dysfunction in Kafanchan.
3. Conjoint family therapy was found to have significant positive influence on dysfunctional families in Kafanchan.
4. Transgenerational family therapy had significant positive influence on dysfunctional families in Kafanchan..
5. There was no significant difference in the treatment outcome of Conjoint and Transgenerational family therapies on dysfunctional families because each was found to be as good as the other in treating dysfunctional families.
6. Combined Conjoint and Transgenerational Family Therapies had significant positive influence on dysfunctional families in Kafanchan.

5.2 Conclusion

Based on the findings of the study the following conclusions were drawn, that:

The rate of alcohol consumption among dysfunctional families in Kafanchan is high and this has caused a lot of families to have alcoholic parent. The implications of having alcoholic parents is that they end up becoming abusive parents that are capable of carrying out physical violence on children.

Family dysfunctions in Kafanchan is as a result of alcoholic parents and controlling parents. These causes of family dysfunction if not checked will bring about increase in family dysfunction in the town.

Conjoint family therapy can be used with success in treating dysfunctional families in Kafanchan.

Also Transgenerational family therapy can equally be used in treating dysfunctional families in Kafanchan.

The efficacy of the influence of combined Conjoint and Transgenerational family therapies on dysfunction families in Kafanchan cannot be stressed so far. It was obvious that the outcome of this therapy yielded better result.

When compared with the control group, dysfunctional families in Kafanchan treated with Conjoint and Transgenerational family therapies showed positive influence of the therapies on the stability of their families than the control groups who were not treated.

5.3 Recommendations

In view of the research results and the conclusions drawn, the following recommendations were made to improve on the use of Conjoint and Transgenerational family therapies in treating dysfunctional families in Kafanchan.

1. Religious institutions and NGO's should from time to time organize seminars/workshops on parenting to enlighten parents on the different types of parenting so that they will know the type of parenting that promote the type of dysfunction that are found in Kafanchan.
2. Alcoholism is one major cause of family dysfunction therefore; religious institutions should help in preaching about the social ills associated with alcoholism. Government at all levels and non-governmental organizations should organize health talks to sensitize members of the family on health risk involved in high alcohol consumption.
3. Non-governmental organizations should offer help by training some of their staff on how to administer Conjoint family therapy so that they can gain knowledge on the technique of the therapy and provide assistance to dysfunctional families in the society.
4. The recommendation above also applies to Transgenerational family therapy. It is worth nothing that acquiring the basic skills and techniques necessary in administering the therapies is important. When this is done, the therapist will be able to carry out his/her duties properly with the sole aim of restoring stability to dysfunctional homes.

5. The department of home Economics in all tertiary institution should introduce family therapy course so that students can be trained on the different methods, approaches and types of family therapies. This is because Home Economic is a course that deals with family living, therefore training experts who can assist families live healthy family life will surely be a welcomed idea.
6. Relationship education should be introduced into the senior secondary schools and also made a general course in the tertiary institutions. This is important because it will help in equipping our young ones with sound knowledge on relationships and prepare them better for marital life.
7. Religious institutions and Non-Governmental organization should organize regularly seminars/ workshops to create awareness among couples on the danger of family dysfunction to the family and society at large. Awareness should also be created on the importance of family therapy so as to encourage families that are dysfunctional to go far help. Also the various groups mentioned should endeavor to establish family therapy units and make it affordable to families who may wish to go for therapy.

5.4 Suggestions for further studies

1. A replica of this study should be conducted in similar towns in other parts of the country since family dysfunction cuts across every tribe and race. It will also serve as a basis for comparison of the findings of the study.

2. A replica of this study should be conducted in other towns using other family therapy methods or approaches like Narrative family therapy.
3. A similar study should be conducted on the influence of socio-cultural indices on family therapy methods.

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APPENDIX 1

THE THERAPY

INTRODUCTION

In developing intervention programmes to help the family to regain its health and equilibrium, the therapist is in the position of an educator with the duty to teach, clarify, correct and set a model to members regarding how to relate with, reach, approach, talk to, plan, live and work with one another.

OBJECTIVES

The therapist should be able to

- Help equalize parental authorities
- Encourage mates to attend to each other more and to the children less.
- Show the identified patient how he looks to others and what he needs to do to change their perception.
- Build the self – esteem of members
- Help the children to understand their parents and to understand themselves as children.

THE STRUCTURE OF SESSIONS

In the structure of the sessions, the researcher will include timing, location and content. In timing family sessions, flexibility is required. Although the researcher would prefer weekly sessions lasting one and a half hours, the length of session will depend on the needs of family members and the tasks ahead of them. Some sessions may last for thirty minutes wile others might extend for two hours.

Location – the location will be in the researchers home, a three bed room flat. There is enough room for individuals, couples or small family groups. Home visits may be done at any time during the therapy.

Content – the structure of the sessions will also be classified by their content. The researcher will divide the emphasis of content into investigative, planning, activity or reflective sessions.

TECHNIQUES TO BE USED DURING SESSIONS

The researcher will use the following techniques during sessions.

* Reversal technique – this is a technique used to alter family patterns by asking that one family member reverses the way in which he deals with another family member. For example, a man who responds to his wife's quarrelling by withdrawing from the argument and physically leaving the house may be asked to have a reversal of his behavior so that he began to argue rather than retreat.
* The use of Humor – a humorless relationship or family is an unhappy one and the introduction of humor into sessions may serve a valuable function. It will help to ease tension.
* Experiential Techniques – this defer from the parts of sessions in which words are used as the main therapeutic tools. The use of action teaches the family the value of experiential learning in establishing new behavior, emphasizes non – verbal communications between family members, as well as providing new experiences through doing rather than talking about doing.
* Home Visits – this may be time consuming but they are equally essential. The researcher will use this when she become puzzled by the discrepancy between reported behavior and behavior which she will experience in the session.

TRAINING PROGRAMMES DURING CONJOINT THERAPY SESSIONS

Opening Session

The therapist seeks to clarify the nature of the problem and to identify the family's goals. The therapist asks each family member the same sort of open-ended questions typically used in therapy. For example

- What you would like to see happen here?
- What would you like to work on?
- What is your goal in coming here?
- The therapist educates the family in what is needed to participate effectively in the therapeutic process.
- The therapist provides feedback to the family on what was said, demonstrating whose goal are similar or different.

- The therapist can then move on to prioritizing directions for change or, if the direction is sufficiently clear, start work.

Note: It is important to know that family therapy is different from other family education programmes because in family therapy, the therapist tends to address family issues as it is presented by the family or by the identified patient. Therefore, the therapists is not a slave to the format presented below as he/she can adopt another means of achieving the aim of therapy. All sessions are interactive in nature. Below is a step-by-step account of how the researcher conducted the therapy.

Week 1: In creating a condusive atmosphere, the researcher ensured that everyone was relaxed by trying to bring down the tension in the family members.

Objective: At the end of the session for the week, members of the family especially the couples, will understand better what is marriage and reasons why people marry.

b. After the general introduction, the researcher gave room for the family members to speak their minds on the different things that happen in their family. The researcher and family members at this point discussed some of the problems the family was facing. Since it was a conjoint therapy, the researcher took them on general issues that affects families.

c. Topic: All about marriage

Marriage: Marriage is the union of a man and a woman who make a permanent and exclusive commitment to each other of the type that is naturally fulfilled by bearing and rearing children together.

Why do people marry

- To meet the needs of man's fellowship, comfort and joy, i.e. companionship, Genesis 2:18.
- To carry out the biological function of bearing and rearing children, i.e. procreation, Genesis 1:28.
- For protection, 1 Timothy 2:14
- For providence, 1 Timothy 5:8

Myths of Marriage

- Myth: Something that many people believe but that does not exist or is false.
- Marriage is 50/50
- Passion is love and love is passion.
- Love is a cure all

- I can change him/her after we are married.

What Makes Marriage Works

- Communication
- Commitment and common values
- Spirituality and faith

Communication- the researcher explained how a normal communication should be carried out in families to avoid conflict.

The researcher explained the importance of commitment in marriage and regard for common values in the home. Some of the values include, religion, how time is spent together, traditions, interaction with relatives etc.

Also spirituality and faith as factors that help marriage to work was extensively discussed.

Conclusion

God ordained marriage for some special reasons. Knowing these reasons and other things relating to marriage helps in having a successful marriage. Therefore, husband and wives should constantly and continuously learn the issues of marriage.

Week 2: Sexual Relationship in Marriage

The researcher introduced the session by refreshing the family members memories on what was discussed during the last session. This particular session was conducted only for the couples. Other members of the family were excluded.

Objective: The objective of this session was to help the couples know more about sex in marriage and know the twofold purpose of sex in marriage.

Sex in Marriage:

- Learn to talk about sex in marriage
- Sexual intimacy
- Sexual integrity (fidelity)
- Tips for a healthy sexual marital relationship

Purpose of Sex in Marriage:

- For pleasure
- For procreation

Conclusion

Of all God's creatures, only humans have sex face to face. This means that for mankind sex is an intimate act of love, not just an act of procreation.

Week 3: Communication in Marriage

Objective: The therapist ensures that at the end of the session family members should be able to communicate effectively in the home.

- Communication means to give or exchange thoughts, feelings and information.
- It is the means by which people develop a collective view of the tasks that face them.
- It is a mutual exchange of ideas with understanding by an effective means.

  There are two types of communication

  * Verbal communication
  * Non-verbal communication

Verbal Communication

- It involves talking or speaking to each other about something that happened in either home, place of work, market etc.
- It involves the use of words which individual expresses to another.
- Verbal communication is spoken verbally or orally.

Ways of Having Effective Verbal Communication in Marriage

- Mutual openness and honesty should be observed when talking to each other.
- Exercise self control.
- Respect your spouse when talking
- Show interest in what your spouse is saying
- Avoid distraction
- Speak gently and politely
- Learn to say sorry to each other
- Talk about things that make you laugh and simile
- Learn to praise your spouse when talking
- Do not insult or criticize
- Speak on the positive side
- Describe the problem without laying blame

Non-Verbal Communication

It is the use of facial expressions, body language or gestures, visual communication (the use of images or pictures). Non verbal messages sometimes tell people more than

actual words. It conveys relationship more adequately. This is expressed in the following ways:

i. Eye contact
ii. Body posture
iii. Facial expressions
iv. Touching, tapping the shoulder to get attention
v. Signals or command

Barriers to Good Communication

- System design
- Ambiguity of word or phrases
- Physical barriers
- Attitudinal barriers

Causes of Communication Problems in a Marriage

- Selfishness
- Yelling at spouse
- Having a competitive attitude

Importance of good communication in Marriage

- It brings about positive development in the family
- It reduces suspicion in the family
- It strengthens the marriage and develop strong bonds.
- It brings peace and harmony in the family

Conclusion

The researcher encourages family member to practice what they have learned during the session.

Week 4: Topic: Marriage and Self-esteem

Objective: To help family members to know more about self esteem and how it can affect family life.

What is Self-Esteem?

- Is a term in psychology to reflect a person's overall evaluation or appraisal of his or her own north.
- Confidence and satisfaction in oneself: Self respect.

COMPONENTS OF SELF-ESTEEM

- Self-esteem is an essential human need that is vital for survival and normal, healthy development.
- Self-esteem arises automatically from within based upon a person's beliefs and consciousness.
- Self-esteem occurs in conjunction with a persons thoughts, behaviours, feeling and actions.

LOW SELF-ESTEEM

A person with low self-esteem may show some of the following characteristics:

- Heavy self-criticism and dissatisfaction
- Hypersensitivity to criticism with resentment against critics and feelings of being attacked.
- Chronic indecision and an exaggerated fear of mistakes.
- Excessive will to please and unwillingness to displease any petitioner.
- Neurotic guilt, dwelling on and exaggerating the magnitude of past mistakes.

CAUSES OF LOW SELF-ESTEEM IN MARRIAGE:

There are many indications in the context of marriage that can help you understand if someone lacks self-esteem. The most common are:

- The childhood of your partner was full of parental rejection and ignorance or even worse he/she was a victim of physical violence.
- Your partner has a fear of opening himself to others and being himself, he is very sensitive to others.
- Your partner is early discouraged.
- Your partner has no self confidence especially when it comes to taking decisions.
- Your partner hardly admits mistakes.
- He/she gets angry and upset very easily

BUILDING SELF-ESTEEM:

Self-esteem comes from self-dominion. Some of the ways of building self-esteem includes:

- Confidence in our abilities
- Create a compelling vision
- Socialize

- Do something that scares you
- Do something you are good at

SELF-ESTEEM EXERCISES FOR A GOOD MARRIAGE

Self-esteem is a major factor for the success of a marriage. It is the reason of success or the cause of disaster of a relationship. Self-esteem exercises are ways that can help you improve yours and your partner's self-esteem that will eventually lead to a successful relationship and marriage. Below are self-esteem exercises that can be followed by a couple to improve each other's self-esteem.

- The unconditional acceptance
- Forget the past
- Be careful on what you say.
- Be supportive in the difficult moments
- Free your partner from the feelings of failure
- Say "thank you" more often

A POSITIVE SELF-ESTEEM:

People with a healthy level of self-esteem

- Firmly believe in certain values and principles and are ready to defend them even when finding opposition.
- are able to act according to what they thing to be the best choice
- Do not lose time worrying excessively about what happened in the past, nor about what could happen in the future.
- Fully trust in their capacity to solve problems, not hesitating after failures and difficulties.
- Consider themselves equal in dignity to others, rather than inferior or superior, while accepting differences in certain talents.
- Are sensitive to feelings and needs of others.

Conclusion

Self-esteem comes from self-dominion. The more power you have in getting yourself to take the right actions, the more self-esteem you will have. Your level of self-esteem affects your happiness and everything you do.

Week 5: Topic-Parenting

Objective: Family members should know at the end of the session what is parenting, styles of parenting and parenting skills.

The researcher starts this session by asking family questions based on what they learnt in the last session. The researcher introduces the topic by asking the parents to state some of the ways they handle their children at home.

What is Parenting?

- Parenting or child rearing is the process of promoting and supporting the physical, emotional, social, financial and intellectual development of a child from infancy to adulthood.
- Parenting refers to the aspects of raising a child aside from the biological relationship.

Factors that affect parenting

- Social class
- Wealth
- Culture
- Income

Parenting Styles

A parenting style is the overall emotional climate in the home. There are four parenting styles, they are

- Authoritative
- Authoritarian
- Permissive
- Uninvolvet

These four styles of parenting involve combinations of acceptance and responsiveness on the one hand and demand and control on the other.

Parenting Skills

- Communicate honestly about events ors discussions
- Stay consistent

- Utilize resources available to them
- Take more interest in the child educational needs and early development.
- Keep open communication and staying educated on what the child is learning and doing and how it is affecting him/her.

Week 6: Topic Managing Family finances

Objective: At the end of the week members of the family should be able to know how to adequately manage family finances.

What is money/financial management: This is the process of managing money including investments, budgeting, banking and taxes.

- The process of budgeting, saving, investing, spending or otherwise in overseeing the cash usage of an individual or group.
- Rules for developing a good financial system: It may take families sometime to develop a financial system that works for them. Some of the rules that can help them include:
    * Make a realistic budget and stick with it
    * As much as possible, avoid debt
    * Attend a financial management seminar
    * Save

Debt Trap

- This is simply creating a n indebtedness that will take years to undo.
- Learning to do within and struggling together is a good way of avoiding debt trap.

Budgeting

- Family budget is a plan for future expenditure of a given household.
- Family budget is a plan that is drawn by members of a family consisting of the total income that the family gets every mouth and also the total expenditure that the family incurs every mouth.

In making a family budget focus on two things:

- Planned amounts – What you think your income and expenses will be
- Actual amounts – what the income and expenditure actually were.

Money- His/Hers/Ours:

- Couples should learn to live on one salary and save the other if both are working.
- If possible, couples should keep a joint account.

Conclusion

The researcher reviews the whole exercise once again and gives the couples four weeks to live out what they have learnt. After the four weeks, the post-test was carried out.

TRANSGENERATIONAL THERAPY

In transgeneational therapy, the use of the family geneogram is an important instrument in the elucidation of family structure and dynamics. Geneogram is a detailed, schematic diagram of the family tree. The family is considered a system and is the primary unit of treatment.

The identified patient is considered a "symptom bearer of the family's dysfunction.

CONSTRUCTION OF THE GENEOGRAM

A geneogram is a visual diagram of family structure, which may be used to elicit family patterns. It incorporates family relatedness, age, sex, life events such as births, marriages, divorces and deaths, and may include profession, family role and emotional bonds.

The genneogram is used in a family session to build the family structure in front of the family, involving all of them in the process. It can also be used for individual treatment. By particular attention to emotionally charged events, specific areas of family disturbance are covered systematically and thoroughly in a mental context which helps the family to deal with the emotionally charged material. The systematic nature of the process allows family secrets and family myths to be revealed. Attempts at concealment can be inferred from conflicting statements or any associated reluctance to speak freely.

The technique is used as follows: the family is invited to respond to questions and the data is written either on a blackboard or on a paper for all to see. Information which is repressed or unknown is noticed by its absence, and the family is asked to discover the missing facts and bring them to the next session. During therapy, the therapist asks a lot of questions on the family's history, from past questions to the present. He / she will ask questions on family relatedness, age, sex, life event such as births, marriages, divorces and deaths, family roles, profession etc so as to know the cause of the present problem in the family. From the geneogram

gotten from the family analysis will be made. A plan will be devised on how to change and educate the family about the presenting problem with the intention of getting them out of the problem, (Stuant, 1999, Journal of Family Therapy).

AN EXAMPLE OF A GENEOGRAM

Mr. and Mrs. H. were referred for marital treatment because she had been treated for five years for chronic anxiety and depression, but had become extremely anxious and depressed since the ending of a lesbian affair with a much younger woman at work. Her husband was a genial inoffensive man whose outward acceptance was viewed by his wife as indifference. He was genuinely puzzled by his wife's disturbance. She expressed strong guilt and disgust that were not dispelled by medications or psychotherapy, and marital relations had become tense.

Duration of the therapy – the therapy lasted for four weeks, having two sessions per week.

A marital session in which a geneogram was constructed revealed that Mrs. H. was the oldest and only daughter of a mother who was sexually promiscuous. She was married three times, the first of which was ended after she gave birth to a child whose father was her husband's brother. Her mother's brothers and sisters had all had sexual problems. These were related to Mrs. H.'s grandmother who died of carcinoma of the uterus. Her grandfather re – married soon afterwards, but the children were fostered for several years in their early teens. No discussion was ever allowed about the death of their mother on their return to the parental home.

Mrs. H. related the facts about her mother's sexual abuses with the same disgust and guilt she reserved for her catalogue of her lesbian relationship. She angrily denounced her mother and her husband confirmed that his wife's guiding principle was to avoid being in any way similar to her own mother. Mr. H. came from a stable family background in which he was the youngest of six sons. He admitted his naiveté on sexual matters and his lack of experience with women. Mr. and Mrs. H. had two children, both girls.

ANALYSIS

The lesbian affair had three meanings, first, a loss of sexual control; second, a similarity with mother, a hated object; and third, a hidden love for mother. The resultant conflict led to the symptoms of guilt, disgust, anxiety and depression. The family theme of sexual difficulties were directly traced to grandmother's disease, death and it's aftermath. Fear for the effects of her own indiscretion on her children was an unconscious acknowledgment of the familial pattern. Her husband's family background provided him with little experience in dealing with women and their problems.

From this analysis, a plan was devised to (1) change Mrs. H.'s view of and relationship with her mother; (2) educate Mr. and Mrs H. about sexual matters and (3) bring Mrs H. more closely into her own family life, reducing her fear of her influence on the children. The effect of the accomplishment of these tasks was to remove all symptoms and strengthen the marital bond.

AN EXAMPLE OF THE GENEOGRAM COTTON FROM ONE OF THE FAMILIES TREATED

Mrs. B. a 32 year old banker was having problems with her second marriage to a colleague. Her symptoms included waves of tearfulness, poor sleep and loss of appetite and feelings of worthlessness. She said to the researcher 'I've lost my independence since marriage to my second husband'. She complained of lack of trust in her second husband, a poor sexual relationship and constant rejection which was mutually felt. Her husband had agreed to the therapy but she was the one treated because she was the identified patient. Her geneogram revealed that for three generations her aunts, sisters, mother and grandmother had all been unable to maintain stable marital relationships.

Mrs. B's mother has been divorced twice and was seen by her as an incompetent woman needing men to structure her life. Grandmother had left her

husband, had never re-married and was seen as independent and resourceful. The patient had been partly raised by her mother, partly by her grandmother. Mrs. B. had made a poor marital choice in her first marriage and was now wondering if she had done the same a second time.

Analysis

The patient was the product of a transgenerational history of poor marital relations. Her conflict was, in family terms, whether to emulate grandmother, independent and resourceful with no need for men, or to be like mother, inadequate and dependent tied to unsatisfactory relationships with men. Her need to fulfill a woman's role of sexual and family life conflicted with the need to be an independent person.

The analysis was explained to Mrs. B. who then recounted that her symptoms had begun when her husband, after two months of marriage, had decided that she would give up her work at the bank and take up another job that would allow her time for other things especially domestic work. After the therapy, her relationship with her husband improved steadily because she took a conscious decision to integrate the best from both mother and grandmother.

APPENDIX II

QUESTIONNAIRE

Home Economics Section
Department of Vocational and Tech Education,
Faculty of Education,
A.B.U Zaria.

Dear Respondents,

REQUEST TO COMPLETE QUESTIONNAIRE

I am a postgraduate student of the Department and Institution stated above. This questionnaire has been designed as one of the research tools for collecting data on Conjoint and Transgenerational Family Therapies on dysfunctional families in Kafanchan, Kaduna state. Your honest cooperation in completing this questionnaire is indispensable to the success of the study. It is hoped that the outcome of the study will help in bringing about stable families in the society. You can best be assured that your responses will be treated confidentially and will only be used for the purpose of research.

Thanks for your cooperation.

Yours faithfully,

Okosun Chidimma Juliana

PRE-TEST/POST-TEST QUESTIONNAIRE FOR PARENTS

SECTION A: BIO- DATA.

INSTRUCTION : Please tick where appropriate.

1. Gender (a) male [ ] (b) Female [ ]
2. Age in years
   (a) 30-35[ ] (b) 36 -40 [ ] (c) 41-45 [ ] (d) 46-50 [ ]
3. Educational Qualification
   (a) NCE [ ] (b) HND [ ] (c) First Degree [ ]

SECTION B : Types of family dysfunction.

Using the scale below, answer the questions that follow as it affects you in your relationship with your spouse and members of your nuclear family.

UNDECIDED……1
NEVER……..2
SOMETIMES…….3
MOST TIMES…….4
ALWAYS……...5

		Undecided	Never	Sometimes	Most times	Always
1	Do you see it as your duty to provide for the children rather than the children providing for you?					
2	If your child fails to take up adult roles do you see him/her as a failure?					
3	Do the children bring money to the family through trading or labour?					
4	Have you ever withdrew financial or basic physical care for any child in your family just because the child did wrong?					

		Undecided	Never	Sometimes	Most times	Always
5	Drug like cocaine or marijuana sometimes help people feel high have you ever tried it					
6.	Gambling is something that attracts people and they actually go for it, have you being doing it?					
7.	African culture permits husbands to beat their wives when they misbehave, have you ever done it?					
8.	Men and women do have desire for a person who is not their spouse, have you ever felt that way					
9.	It is believed that the severe the punishment the more children can be corrected, do you believe in that					
10.	Drinking of alcohol is seen as a way of relaxing by people, have you ever taken alcohol in excess					

SECTION C : Causes of family dysfunction.

		Undecided	**Never**	**Sometimes**	**Most times**	**Always**
1	Do you feel happy when the children ignore their own needs and feelings just to satisfy your needs?					
2	Do you choose friends for your children?					
3	Do you feel it is important for your teenage child to own an account and mange it the way he/she feels?					
4	As an adult do you think you can take alcohol the way you feel like even in excess sometimes since it is believed to help people relieve tension and "relax".					
5	Do you flog rather					

	than talk to your child at every offence he/she commits?					
6	Do you seek for your children's opinion on some family issues especially the ones that affect them?					
7	Do you exert a strong authoritarian control over the children?					
8	Are your words final in any decisions in the family?					
9	Are you consistent with your rules and regulations in the home or rules that apply one day may not apply the next day?					
10	Do you feel it is necessary to keep promises made to any member of the family?					

SECTION D : General issues on family dysfunction.

		Undecided	**Never**	**Sometimes**	**Most times**	**Always**
1	Do you have freedom of expression in your family?					
2	Is it difficult for you to maintain intimate relationship with your spouse?					
3	Is money one of the sources of conflict in your marriage?					
4	Are you a spender than a saver compared to your spouse?					
5	Do you have a monthly or annual budget?					
6	Do you find it difficult to trust others?					
7	Do you tend to avoid or ignore responsibilities?					
8	Do you find it					

	particularly difficult to deal with anger or criticism?					
9	Do you always involve your spouse in taking decisions concerning the family?					
10	Do you make out time to sit and discuss with everyone in the family?					
11	Do you willingly accept your spouse for sex any time he/she want it ?					
12	Do you see sex as a punishment rather than fun?					
13	Do you at the close of work visit a “cool joint” where you drink and relax and thereafter get home late?					
14	Do you send the children to hawk					

	around or do other jobs to earn money for the family upkeep while you stay at home?					
15	Would you prefer that your spouse spends most of the days travelling and being away from the home rather than being there at home always?					

(Zygarlick and Smith 1992, Tamaura and Lau, 2011, and Stuart, 2002).

Using the scale below, mark as appropriate the following character traits as it relates to you in your relationship with your spouse.

SCALE

Needs improvement -1

Improving -2

Satisfactory -3

Very good -4

Awesome -5

Character traits

16 Communication [ ]

17 Handling anger [ ]

18 Resolving conflict [ ]

19 Encouragement [ ]

20 Commitment [ ]

21 Humor [ ]

22 Goal setting [ ]

23 Spiritual intimacy [ ]

24 Sexual intimacy [ ]

25 Friendship [ ]

(Masters and Johnson, 2007) (Zygarlick and Smith 1992, Tamaura and Lau, 2011, and Stuart, 2002).

APPENDIX III
BASELINE STUDY QUESTIONNAIRE

Please choose one option only by entering the appropriate score in the box after the question. The purpose of this exercise is only for classification of families. Thank you.

UNDECIDED…….1

NEVER TRUE……2

SOMETIMES TRUE……3

MOST TIMES TRUE……4

ALWAYS TRUE……5

1 . I am submissive to my husband/ I love my wife [ ]

2. My husband / wife respects me [ ]

3. My husband / wife respects me [ ]

4. We are close spiritually [ ]

5. We pray together as a couple [ ]

6. I show appreciation to my partner [ ]

7. I would sacrifice an official meeting to be with my spouse if it means so much to him/her [ ]

8. I work to resolve conflict with my spouse in a way that is productive, not hurtful [ ]

9. My spouse and I touch each other regularly [ ]

10. I look into my spouse eyes and say I love you [ ]

11. I do not seek to control my spouse [ ]

12. I think of little ways to surprise my spouse, to make his/her day better[ ]

13. I listen more than I talk [ ]

14. I always apologize after a quarrel [ ]

15. I share a hobby with my partner [ ]

16. I trust my spouse [ ]

17. I confess my fault to my partner [ ]
18. There is feeling of appreciation to God when we make love [ ]
19. I show my partner frequent caring gestures throughout the day [ ]
20. I believe there is value in the rough spots of our life [ ]
21. My partner and I take time to get away from our usual surroundings together [ ]
22. I accept my partner just as he/she is [ ]
23. My partner and I have strong connections with extended family [ ]
24. The struggles in our marriage bring us closer together [ ]
25. I look forward to seeing my spouse each day [ ]
26. I easily forgive and forget [ ]
27. I share almost everything and live free of territory [ ]
28. We sit quietly with one another just being together without watching television or doing other personal things of interest [ ]
29. We make love much more than we argue [ ]
30. I do not let work come between a time together that the two of us had planned in advance [ ]
31. I do not let dispute over children, friends or activities come between us [ ]
32. I do not let a hobby or other interest consume so much time that my spouse feels neglected [ ]
33. I agree with my spouse on spiritual matters [ ]
34. I play an active role in the affairs of my church [ ]
35. Our family and the world is better because of our relationship [ ]

Now add up your score .

DIAGNOSIS

35-69…… Your marriage requires immediate attention. You need immediate therapy.

70-104…. Your marriage needs attention to maintain reasonably healthy marriage. You need to review your priorities and give your marriage the attention it deserves.

105-122…. Your marriage is prone to problems. See a therapist. I t requires more commitment on your part.

123-139…. Your marriage is sound but sometimes threatened by problems. Stop apportioning blame when things go wrong. As long as it depends on you, seek to do good all the time and make peace even when you are aggrieved.

140-157….. You appear to pay special attention to your marriage and that has kept it healthy. Please keep it up.

158-175….. Your marriage is in great health. Please share the secret with other couples.

(Oyawoye, 2004).

APPENDIX IV

TYPES OF FAMILY DYSFUNCTION

Item	Types of Dysfunction
1.	Deficient Parents
2.	Refusing to accept personality differences in children
3.	Abusive parents
4.	Denying of needs
5.	Drug addiction
6.	Alcohol addiction
7.	Unfaithfulness
8	Gambling by parents
9.	Wife battering
10.	Severe punishment for children

APPENDIX V

CAUSES OF FAMILY DYSFUNCTION

Item	Causes of family dysfunction
1.	Deficient parents
2.	Controlling parents
3.	Controlling parents
4.	Alcoholic parents
5.	Abusive parents
6.	Controlling parents
7.	Controlling parents
8.	Controlling parents
9.	Deficient parents
10.	Deficient parents

APPENDIX VII

SAMPLE OF INVITATION CARD FOR THE SEMINAR

SEMINAR! SEMINAR! SEMINAR

The unique sisters invite you to a one day Marriage Seminar which will take place as follows:

Date: Saturday 5th July 2014

Venue: Kaduna State College of Education Staff School, Kafanchan

God bless you as you come.

Signed:

Organizers

APPENDIX VI

RELIABILITY ANALYSIS

Reliability

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	12	100.0
	Excluded[a]	0	.0
	Total	12	100.0

a. List wise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.704	.794	36

Item Statistics

	Mean	Std. Deviation	N
do you see it as your duty to provide for the children rather than the children providing for you	1.7500	.45227	12
if your child fails to take up adult roles do you see him/her as a failure	1.4167	.51493	12
do you feel happy when the children ignore their own needs and feelings just to satisfy your needs	1.2500	.45227	12
do you choose friends for your children	1.2500	.45227	12
do you feel it is important for your teenage child to own an account and manage it the way he/she feels	1.2500	.45227	12
would you give your child the opportunity to select who to marry	1.7500	.45227	12
do you at the close of work visit a cool joint where you drink and relax and there after get home late	1.1667	.38925	12
do you flog rather than talk to your child at every offence he/she commits	1.5000	.52223	12

ever engaged in or seen any parent around engaged in: drug:	1.3333	.49237	12
ever engaged in or seen any parent around engaged in: Alcohol	1.5000	.52223	12
ever engaged in or seen any parent around engaged in: Promiscuity	1.3333	.49237	12
ever engaged in or seen any parent around engaged in: Gambling	1.2500	.45227	12
ever engaged in or seen any parent around engaged in: wife beating	1.4167	.51493	12
ever engaged in or seen any parent around engaged in: physical violence on a child	1.2500	.45227	12
do you send children to hawk around or do other jobs to earn money for the family upkeep while you stay at home	1.1667	.38925	12
have you ever withdrawn financial or basic physical care for any child in your family	1.3333	.49237	12
do you seek for youer children opinion on some family issues especially the ones that affect them	1.6667	.49237	12
do you exert a strong authoritarian control over the children	1.3333	.49237	12

Are your words final in any decision in the family	1.1667	.38925	12
is it wrong to take a little alcohol	1.7500	.45227	12
does any member of your family take drugs	1.2500	.45227	12
is he/she addicted to it	1.1667	.38925	12
have you ever engaged yourself in any form of gambling	1.0833	.28868	12
do you have freedom of expression in your family	1.7500	.45227	12
is it difficult for you to maintain intimate relationship with your spouse	1.2500	.45227	12
is money one of the sources of conflict in your marriage	1.5833	.51493	12
are you a spender than a saver compared to your spouse	1.2500	.45227	12
do you have a monthly or annual budget	1.8333	.38925	12
do you find it difficult to trust others	1.4167	.51493	12
do you tend to avoid or ignore responsibilities	1.5000	.52223	12
do you find it particularly difficult to deal with anger or criticism	1.2500	.45227	12
do you always involve your spouse in taking decisions concerning the family	1.7500	.45227	12

do you make out time to sit and discuss with everyone in the family	1.6667	.49237	12
do you willingly accept your spouse for sex any time he/she wants it	1.4167	.51493	12
do you see se as a punishment rather than fun	1.2500	.45227	12
would you prefer that your spouse spends most of the days travelling and being away from the home rather than being there at home always	1.2500	.45227	12

Summary Item Statistics

	Mean	Minimum	Maximum	Range	Maximum / Minimum	Variance	N of Items
Item Means	1.403	1.083	1.833	.750	1.692	.045	36