

# Children of Alcoholics

A significant number of clients who seek the services of marriage and family therapists (MFTs) have been affected—directly and indirectly—by addiction. The role that substance abuse plays in the lives of clients is often undiagnosed, and at times, unacknowledged. The problems of families dealing with addiction can be exacerbated if there is a failure to recognize this tremendous impact.

In the last 20 years clinical and empirical research, combined with public education, has dramatically improved knowledge about family addiction. Professionals now know a lot about alcoholism and that growing up with an alcoholic parent can cause and contribute to significant problems. Living with addiction is a common and even a “normal” condition of family life, yet it is also one of the most difficult to diagnose and face directly, for both clinicians and families. Because the impact can be so severe, especially upon children, it is essential for therapists to rule out addiction early in the evaluation and treatment process. Making an accurate diagnosis of addiction is an important skill. The expanded knowledge base now makes it possible to individualize assessment, thus providing a better portrait of the impact of alcoholism within a particular family, and a better map for treatment planning.

Today, MFTs are on the frontlines for initial diagnosis and assessment as families seek help for a multitude of problems such as marital stress, childhood behavioral disorders or depression, school difficulties, or stress-related health disorders that may mask, or result from, parental addiction.

MFTs may work directly with addicted families in outpatient counseling, schools, or a variety of health settings, or they may refer members of a family to more specialized or intensive outpatient, residential and inpatient settings.

## Scope of the Problem: How Many?

The number of children of alcoholics is astounding. There are 18 million alcoholics in the U.S. according to the National Council on Alcoholism and Drug Dependence (2005). As a result, an estimated 26.8 million children are exposed, at varying degrees, to alcoholism in the immediate or extended family. These children are at higher risk for alcoholism and other drug abuse than are children of non-alcoholics, and are more likely to marry an alcoholic as well. Moreover, alcoholism tends to run in families. Research has shown that alcoholics are more likely than non-alcoholics to have an alcoholic relative, and almost one-third of any sample of alcoholics report having at least one parent who was an alcoholic (Eigen & Rowden, 1995).

## What MFTs Need to Know

The concept of Children of Alcoholics (COA) emerged 30 years ago as a way to describe the clinical phenomenon that presented for children who were growing up in families where alcohol was an organizing principle. The first research citations on COA emerged in the 1940s (Roe & Burks, 1945). Research expanded in the 1950s and 1960s with a focus on genetic transmission and psychopathology in children

(e.g., Fox, 1962; Nylander, 1960, 1963; Schuckit, Goodwin, & Winokur, 1972.) The impact of alcoholism on others was further recognized in the self-help arena with the birth of Al-Anon in the 1950s, followed by the introduction of Alateen shortly thereafter. Then, in the 1970s, COA were recognized as a treatment population by both chemical dependence and mental health professionals, and resulted in the rapid, global public acceptance of the new “adult COA,” and the popular social movement it launched.

The growth of this idea—that parental alcoholism has an impact on children—was unusual in its cross-disciplinary spread. It started in genetic and psychiatric research, was embraced by the self-help movement, and was then introduced into clinical settings as a treatment idea before a scientific research base was established. Clinicians provided the early knowledge base, describing the experience of growing up with an alcoholic parent—what it is like for a child—and suggesting schemas for understanding the consequences for children and adults (e.g., Black, 1981; Wegsheider, 1981).

Scientific researchers expanded the early emphasis on genetics and psychopathology in the late 1980s and through the 1990s. Initially questioning the validity of the social movement and clinical descriptions, empirical researchers ultimately confirmed the importance of parental addiction as an organizer in the child’s life. But instead of simplifying the knowledge base, research has added complexity. There is now virtual agreement among researchers across disciplines that the impact of

parental addiction is complex and heterogeneous.

## Research Reviews

Key review articles of COA began appearing in the 1960s (Chafetz, Blane, & Hill, 1967) and continue to the present (Brown & Schmid, 1999; Lieberman, 2000). Windle (1997) and Johnson (1999) provide particularly helpful summaries of the wide range of research topics, the differences among reviewers, and the complexity of differences in findings. Johnson also highlights the cross-disciplinary nature of research and its application to prevention, intervention and treatment.

Johnson separated research on COAs into four major areas: 1) fetal alcohol syndrome; 2) transmission of alcoholism; 3) psychobiologic markers of vulnerability; and 4) psychosocial characteristics. The first three categories emphasize continuity in research from the earliest scientific focus in the 1940s and 1950s. These areas of focus also highlight the importance of medical specialties, such as pediatrics, as sites for intervention and treatment. Psychosocial studies are most recent and have the most direct impact on the clinical setting.

Johnson (1999) breaks psychosocial research into studies of family function, family violence, cognition, affect and behavior, and medical problems and physical health. Other researchers have emphasized the developmental impact of parental addiction on children’s attachment and identity formation (Brown, 1988) and the impact of addiction-related trauma (Hall & Webster, 2000) on all aspects of development.

The earliest research empha-



sizes the link between parental alcoholism and psychopathology. Many researchers found that children with alcoholic parents were more likely to experience symptoms of anxiety and/or depression, antisocial traits, relationship difficulties, behavioral problems, and/or alcohol abuse (Belliveau & Stoppard, 1995; Coleman & Frick, 1994; Kashubeck, 1994; Nordberg, Rydelius, & Zetterstrom, 1994).

Other studies of the early 1990s suggest that the link between alcoholism and psychopathology is not direct, nor automatic. The field of developmental psychopathology (Rolf et al., 1990) shifted the emphasis from discrete positive or negative outcomes to a continuum, recognizing that the consequences of living with parental alcoholism can be adaptive and maladaptive. Radke-Yarrow and Sherman's (1990) concept of "hard growing" illustrates this continuum. Hard growing suggests that it is the accumulation of risk factors, combined with fewer protective factors, that leads to maladaptive consequences. It is the relationship of risk and protective factors that will influence whether, and to what degree, the consequences of living with parental alcoholism will be a source of pathology or more positive adaptation. A further complication is that "positive" outcome does not necessarily mean "healthy." What is adaptive for a child may

become a problem later on. Many teens and adult children of alcoholics struggle to loosen psychological defenses or interpersonal ways of relating that were adaptive in childhood, but are maladaptive for adults.

Other researchers question the automatic assumption of psychopathology; that is, that all children living with an alcoholic parent will be harmed. Kashubeck (1994) asked why some people from alcoholic families have more serious difficulties than others. Johnson, Rolf, Tiegel and McDuff (1995) also emphasize the importance of determining risk factors. In their "challenge" model, Wolin and Wolin (1995) advocate a shift from a pathology perspective to a focus on strengths, resilience and coping. There is now a clear emphasis on assessing what is adaptive or maladaptive, what is damage and what is strength, and, importantly, what is psychopathology.

### **Recent Research and Its Relevance to Clinical Practice**

Several important review articles appeared around 1997 (Sher et al.; Windle). Since then, research continues to focus on the same major themes and issues, validating the importance of the concept of COA and confirming the complexity and heterogeneity of this population. These topics

include: 1) transmission of alcoholism from one generation to another; 2) the developmental impact of living with an alcoholic parent; including a distinction between hard growing adaptation and psychopathology; 3) coping and adaptation strategies of COA and their impact on the child; and 4) prevention, intervention and treatment strategies. The MFT will need to consider the direct and/or indirect influence of each of these areas in assessment and treatment.

- 1) Genetic, social and family transmission of alcoholism continues to be a focal area of research (King & Chassin 2004; Anda et al., 2002; Jacob & Windle, 2000; Schuckit et al., 2000; Dawson, 2000.) Clinicians must know that growing up with an alcoholic parent is a significant risk factor for becoming an alcoholic and use this knowledge in planning intervention, treatment and prevention strategies for the young COA.
- 2) Many researchers continue to explore the relationship between parental alcoholism and psychopathology. There is agreement that the link exists, but pinpointing it continues to be elusive. Studies (Fuller, 2003; Loukas, 2003; Furtado, 2002; Drucker & Greco, 2002) have demonstrated a higher incidence of

aggression, disruptive behavior and depression in COA. Other studies (Langeland et al., 2005; Christofferson & Soothill, 2003; Locke & Newcomb, 2004) suggest that living with parental alcoholism can predict later difficulties, such as phobic and anxiety disorders, PTSD, and suicidality. This focus on delayed problematic consequences adds difficulty to the assessment and treatment decisions MFTs will face in working with young children. Some kids may not yet demonstrate maladaptive consequences of living with parental alcoholism, so it's harder to determine what kinds of interventions would be most helpful. Some clinicians may wonder whether any intervention is necessary. These questions of whether to intervene, and what kind of intervention is appropriate, are areas of major controversy among clinicians and those in positions of child health and welfare across disciplines. It is also difficult and sometimes impossible to determine whether the problems a child is having are directly linked to parental alcoholism, separate, or a combination. The clinician must be open to all possibilities, gathering information to help make this determination.

A newer area of research (Kelley et al., 2004; Fals-Stewart et al., 2003; Cooke, 2004) focuses on differences in psychopathology between children of drug-abusing, alcohol-abusing and non-substance abusing fathers, finding the most significant problems among children of drug-abusing fathers. Elkins et al. (2004), further demonstrate that a parental history of alcohol dependence is associated with greater negative emotionality, aggression, stress disorder and alienation in both male and female children. With a parental history of drug disorder, children demonstrated lower constraint, control, harm avoidance and tradi-

tionalism, but higher social potency. These newer avenues of research accent the heterogeneity among COA and, again, the complicated task for MFTs of assessment and treatment.

3) Perhaps the most heterogeneous area of research is coping and adaptation. These studies, when linked to knowledge about risk and protective factors (Lieberman, 2000; Christiansen, 2000; Haugland, 2003), can provide guidelines for clinicians in assessment and intervention. In essence, protective factors contribute to positive coping and adaptation. For example, Werner and Johnson (2004) found that growing up with significant numbers of caring adults helped promote competence and effective coping with the trauma of parental alcoholism. The clinician looks for these caring figures in a child's history and looks for ways to provide these figures as part of a preventive or treatment intervention.

What is considered positive coping and adaptation in childhood may also mask recognition of the impact of parental alcoholism (Scharff et al., 2004). Here is a catch-22 for COAs. If positive coping masks underlying problems, it may hinder the COA in getting help as much as it also helps them.

4) Prevention, intervention and treatment were important areas in the early social movement of the 1980s and the first clinical descriptions provided at the same time. The National Association for Children of Alcoholics (NACOA) and the Children of Alcoholics Foundation were established to educate professionals about the idea of COA, along with guidelines for intervention, including diagnosis and assessment. Research and evaluation of these programs demonstrates positive influence on the well being of children through family therapy

(O'Farrell & Fals-Stewart, 2003) and small groups in schools and other community sites (Emshoff & Price, 1999).

This area of research highlights the cross-disciplinary focus that already exists for COAs. The MFT may be involved as an educator, therapist, child advocate or consultant across these domains.

Recently, researchers have identified another new area of focus, the alcoholic family in recovery (Brown & Lewis, 1999; Brown, Lewis, & Liotta, 2000; Hazelden films, 2005). The family in which one or both parents stops drinking can experience stages of growth that eventually lead to healthy individuals and a healthy family system. The recovery process is difficult and often so chaotic and out of control during the early months and years of abstinence that it can be called "the trauma of recovery." Family recovery can be as disruptive and tumultuous in the process of change as active addiction. Thus, MFTs must be just as knowledgeable about the process of family recovery as they are about the consequences of living with active addiction. They must also know that interventions for children in a recovering family may differ considerably. For example, the MFT recognizes that the chaos and anxiety experienced by a child whose mother is newly sober are normal. Intervention will involve education about what is expected and normal in the first weeks and months of recovery, along with guidance in providing safety and stability for the child.

**Diagnosis**

There is no official diagnosis for "children of alcoholics" or for alcoholism as a family disease. Yet these terms are widely accepted in cultural and clinical vocabularies and widely used clinically as if they were diagnoses. COA is a relational description. It names the reality of parental alcoholism and accents the role of parental

alcoholism as an organizer in the family's life and the child's development. The term "COA" may accurately link the source of a child's presenting problems directly to parental alcoholism, or, the term COA may be but one part of a child's difficulties. Many of the children MFTs see will not present as COA. The therapist will determine whether to diagnose parental alcoholism, and then assess the nature and the impact of its organizing role for the child.

MFTs may readily diagnose a childhood behavior disorder, depression, anxiety, or learning difficulties (for example) as presenting problems, then determine if a child is living with parental alcoholism or perhaps with a parent in recovery. The MFT can continually assess the relationship of the child's individual diagnosis within the framework of DSM-IV TR—behavioral disorder, depression, anxiety—to the child's experience of living with what may likely be the trauma of parental alcoholism or recovery. Thus, many children may correctly warrant a diagnosis of PTSD, including hypervigilance, sleep disturbance, or anxiety (although this is not recognized either as a diagnosis that acknowledges the direct consequences of parental alcoholism). It is nevertheless, a useful concept for the therapist in the clinical setting.

It may be difficult for therapists to make a diagnosis of parental alcoholism when they do not see the child's family or caretakers. Or, clinicians will be discouraged from making a diagnosis of parental alcoholism as an important part of a child's presenting difficulties. Perhaps the family resists recognizing alcoholism or the therapist struggles with the complications of diagnosis for the child. Despite the hurdles, it is important for the therapist to assess, as best as possible, the family circumstances that may contribute to the child's individual problems. The therapist always maintains a double focus: the child as an individual and in relation to the family.

Therefore, diagnosis and assessment of the child must include a portrait of family life that illuminates parental drinking. This is often a difficult and challenging task. The therapist includes direct questions about the use of alcohol, indirect questions, and elaborations that may also function as interventions. Because alcoholism is so often denied by all members of the family, the therapist must do more than simply inquire.

**Assessment: Establishing a Portrait of Family Life that Illuminates Parental Addiction**

The therapist knows that alcoholism affects the drinking individual physically, behaviorally, cognitively, and emotionally. It can affect family members in all the same ways. Yet, it is often difficult for the family, and even the therapist, to acknowledge the impact that alcoholism can have. It may be the central organizing principle of family life, causing trauma and shaping individual development, yet family members will work hard to deny this reality.

In order to live with active addiction, the family often denies that it exists and focuses on other things as the "real problem." Thus, family members conclude to deny the reality of drinking and attribute problems to other causes. Helping professionals, friends and family can get caught up in the explanations that maintain denial of the reality of drinking.

Therapists should ask direct questions about drinking and establish a portrait of family life to better understand how the family is organized around drinking. What are the cues and clues that drinking is an important part of family life? For example, do family arguments always occur following cocktail time? Who drinks? When? How much? What happens when someone is drinking? What happens before and after? The therapist should listen for evidence that alcohol is

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a central organizing principle of family life and clarify how the family may distort this reality.

The therapist may then introduce the notion that drinking is important in the family and wonder how the family sees it. This intervention helps further assess degrees of denial and the kinds of other defenses and explanations that maintain the status quo. Here the therapist may learn that family members all identify stress as the culprit. Perhaps they acknowledge that Dad drinks, but that's not the problem. If it weren't for the demands on him at work, he wouldn't need to drink so much. Kids may also hear that parental drinking is their fault. If they didn't fight so much, if they got better grades or didn't whine, Mom wouldn't need to drink.

The therapist elaborates the portrait, names the drinking directly and invites the family to think about it. Eventually the therapist may say directly that drinking is an organizer in the family. It is extremely important for the therapist to be willing to name alcoholism as a family systems disease. Each person has a relationship to alcohol and to the family that organizes around it. Assessment of family life may also provide important information about coping: are there important positive caretaking figures involved with a child? Who are they? How do these figures serve a protective function?

The therapist may also need to diagnose, assess and intervene on issues related to family recovery, though the clinician may wonder what could be problematic about recovery. This is such a new area of research that therapists may still erroneously believe that "recovery" is the good outcome everyone wanted, and therefore, the end of the "problem." Therapists may even urge the family to be supportive of the alcoholic/addict early in recovery and to deny the reality of the dramatic and often upsetting changes that are occurring. It is important to continue to pay attention to the impact of active

addiction and recovery on the children. They may feel the pain and resentment of having had to cope with an addicted parent and of all the radical changes of recovery. Children may still not be receiving the appropriate attention they need.

The literature on psychopathology and risk and protective factors has provided further guidelines for assessment that help the clinician determine which children are at the highest risk for severe consequences such as active addiction, conduct disorders, emotional disturbance, school problems and all manner of social and interpersonal difficulties. Brown and Sunshine (1982) suggest that the factors related to emotional outcome include the child's age at onset of parental alcoholism, the relationship with the alcoholic parent independent of the drinking behavior, the child's resources outside the family, the availability of and interaction with the nonalcoholic parent (if there is one), as well as the child's innate endowment. Giglio and Kaufman (1990) highlight the following variables: birth order, gender of child, type of family system, which parent was alcoholic, and temporal locus of parental drinking (past, present, or both). In addition, Cermak (1990) included the following: temperament of the child, genetic predisposition to alcoholism, presence of traumatic events, levels of stress in childhood, absence of normative experiences, necessity for denying the truth, and presence of other psychiatric conditions in the child.

The literature on risk and protective factors illustrates the heterogeneity of COAs in their childhood experiences and adaptations, and highlights the complexities of assessment. Werner and Smith (1992) suggested that the majority of COAs become productive adults, a statement that heightened the difficulty in determining which kids need treatment when they are young. Skeptics who question whether living with parental

alcoholism needs any attention at all can point to this research to deny the need for education and professional intervention. This is another catch-22 for kids who do well: does it mean that they do not need help? This question does not have an answer and may never be answered.

The questions of who needs treatment, when, and for what reasons are not "either-or" propositions. They should be answered by the variety of helping professionals and clinicians who are in contact with COAs. But the complexities of assessment do make the MFT's job more difficult. It is not helpful to kids living with parental alcoholism if the only children who receive help are those who present with greater risk factors and more readily diagnosable psychopathology.

Many COAs have strengths and resilience. The qualities that Werner believes make the difference are: social competence, problem solving skills, the development of autonomy, and a sense of purpose and future. Werner found that resilient children believed they had control over their lives, as opposed to feeling controlled by external factors. They were self-reliant, yet able to ask for help when they needed it. What is right with these children? She expands on these qualities as follows:

1. An active, evocative approach toward solving life's problems, enabling the children to successfully navigate an abundance of emotionally hazardous experiences.
2. A tendency to perceive their experiences constructively, even if they cause pain suffering.
3. The ability to gain other people's positive attention from infancy on.
4. A strong ability to use faith in order to maintain a positive vision of a meaningful life.

In assessing which children need treatment, what kind and when, it is important to assess as best as possible the kinds of difficulties children are experiencing and the degree to which

their adaptations are problematic and require intervention. Again, it may not be clear whether a child's methods of coping are on the side of resilience and strength or maladaptation and pathology. When it is not clear if the child needs help, the therapist should consider available education opportunities and small groups as an introduction to treatment and further evaluation. As research demonstrates, intervention for kids living with active addiction is helpful. Ironically, children with the greatest strengths and resilience may also be able to make excellent use of support and therapy.

In making the link between individual diagnosis of a child within the structure of DSM IV, and an assessment of his or her relationship to family addiction, clinicians have also suggested criteria for assessment (Brown, 1991; Brown & Lewis, 1999; Brown, Lewis & Liotta, 2000). They describe the environment, the family system, and the impact on individual development as important domains of childhood experience. The therapist continues to establish a portrait of family life, making a detailed assessment of each of these domains.

## The Environment

Early clinical descriptions provided guidelines for assessing the experience of each child in the alcoholic family. The environment—what it is like to be in the family; context of a child's experience—is often characterized by chaos, uncertainty, and a changing reality (Black, 1981; Brown, 1988; Cermak, 1986; 1988), as well as inconsistent discipline, emotional and physical neglect, arguments, marital instability, disorganization, violence and/or physical and sexual abuse (Giglio & Kaufman, 1990). The COA may endure emptiness, loneliness, and terror of repeated abandonment or the witnessing of violence or abuse to others. The atmosphere is characterized by tension, fear,



and shame, feelings that become fused with the child's sense of self. At least one person in the family has lost control of drinking and its consequences, which throws the whole family out of control; the hallmark of the environment is a basic lack of safety. The therapist assesses the nature of the environment of this particular family, listening for signs of overt danger (which could require a CPS report), to the underlying chronic, covert sense of threat that exists for everyone. The therapist may begin to make links to the kinds of problems kids are having—sleep disturbances, hyperactivity, depression, school phobias—or other difficulties such as hypervigilance, or a parentified child.

Trauma theory can provide a vital theoretical frame to understand the impact of parental alcoholism developmentally and psychodynamically, and it offers a bridge between the mental health and addiction fields. Acute trauma is one or more discrete events that threaten the integrity of the self or family, and is so overwhelming that it cannot be integrated into one's sense of self. Chronic trauma is the normalization of repeated unpredictable, inconsistent, dangerous circumstances or events and relationship patterns (Krystal, 1978; Khan, 1963.) Chronic trauma often leads to depression and anxiety. Children who have been traumatized by primary caregivers can demonstrate overreactivity, poor tolerance of anxiety, frozen watchfulness, and an unusual sensitivity to parents' needs. Living with alcoholism almost always involves acute and chronic trauma.

### The Family System

The alcoholic family system is an adaptation to the ongoing trauma created by drinking and a chief source of maintaining the trauma at the same time. The family is dominated by the alcoholic whose changing moods, out-of-control behavior, and failure to fulfill major roles must be

compensated for if the family is to survive. Most alcoholic families have a "story" about the drinking. It includes the explanations and core beliefs that allow drinking behavior to be maintained, denied, and explained at the same time (Brown & Lewis, 1999).

Like other families organized around trauma, alcoholic families likely experience disorders of rules, hierarchies and boundaries. Rules are often arbitrary and inconsistent. They dictate how the alcoholism will be denied and explained in a way that allows it to be maintained. Such rules set irrational thinking, based on skewed or reversed cause and effect, as a cornerstone of family membership. Often families will have two different sets of rules: one that applies when the alcoholic is dry and another that applies when the alcoholic is drinking (Steinglas et al., 1987).

### The Individual

Children living with trauma may develop a sense of self that is equated with defense (Brown, 1993; Brown & Schmid, 1999). These defenses are designed to keep the enemy out, to minimize anxiety, fear and the threat of humiliation. The "defensive self" or "false self" creates a deep sense of inauthenticity and a barrier to connectedness with others that exacerbates isolation and loneliness. The defensive mantle tends to be brittle, inflexible, and self-reinforcing, with the potential to break down under stress. These defenses become hardened in the adult (ACOA), the way of knowing oneself in relationship.

COAs have little or no choice but to adapt to the environment and the system of the family in which they are raised. The ACOA will bring these defensive adaptations to their adult relationships and families. In alcoholic families, adaptation to the traumatic environment and distorted system interferes with healthy individual development and can produce pathology. The child who must be vigilant to potential danger or

who focuses on filling the family's needs is distracted from the normal academic, social and psychological tasks of childhood. The necessity for constant defense in a traumatic environment creates a personality based on defense rather than on self-development (Miller, 1994; Brown, 1995). In addition, the abusive and neglectful behavior of adults in alcoholic systems can lead to serious damage to the child's capacity for healthy emotional attachment.

### Treatment Considerations

If diagnosis is a problem, and assessment involves descriptions of experience in multiple domains, how does the MFT determine who it is and what it is that requires treatment? How is treatment to be defined and what should it be? These are questions that have long been faced by professionals; however, now it is possible to form guidelines for education, intervention, and treatment. The AAMFT's Core Competencies are a step in this direction, as these guidelines provide a detailed map for MFTs in diagnosis, assessment, intervention and treatment, particularly in clinical settings.

*The Initial Period of Contact.* Some therapists will first see a child in their offices, with a single presenting problem of childhood behavioral disorder, depression, anxiety or another mental health difficulty. Other therapists might see the same child some time later with the same presenting problem, plus an acknowledgment of parental alcoholism. Other MFTs might see this child in the school counseling office, or in the medical clinic on referral from a pediatrician.

Historically, there has been a clear distinction between intervention and treatment. Clinical intervention tended to be crisis-oriented and short term. Treatment tended to be longer and have an in-depth focus. While these differences between intervention and treatment still exist, they are often lost com-

pletely in the initial contacts with COAs. Intervention often is treatment and treatment often involves intervention. Traditional long-term treatment may still be possible and desirable for COAs, but it usually will not be the focus of treatment at initial contact. Other issues come first.

The first focus of assessment is physical safety. Is the child in danger? Is there evidence of physical or sexual abuse? If yes, follow intervention guidelines that are well established for providing immediate interruption of the dangerous situation and safety for the child. This intervention may involve notifying CPS, the police, or altering living arrangements temporarily or long term.

Whether or not there is a need for direct intervention, the therapist always works to establish safety within the therapeutic setting. This is extremely important because safety cannot always be insured in the home, even if a child is in treatment. Safety involves creating a therapeutic environment in which the therapist can recognize the reality of parental alcoholism, assess its impact on the child, and maintain a climate in which the child can come to acknowledge this reality. Some kids recognize it immediately when it is named by a trusted adult. Other kids cannot acknowledge it for a long time, a resistance that the therapist must consider and protect.

The second line of assessment is "making it real." All intervention and treatment involves telling the truth about what is really happening, or what really happened in the past, for children whose parents are still in active addiction or in recovery. As the child is able to see and comprehend more about what is happening in the home, the therapist works to give the child tools to cope and works directly to promote a child's capacity to take action. This focus helps the child move from denial to recognition, to a sense of agency. The child learns how to seek help and what actions to take for immediate protection.

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## How Group Therapy Helps

If available, the therapist may additionally refer a child to an educational or therapy group for COAs. This is particularly beneficial early in the process of identifying parental alcoholism, or when parents are also seeking treatment themselves. The addiction field has long advocated for the value of group therapy and has provided prevention and treatment materials to guide the therapist (Celebrating Families, 2005). Most of these principles will apply to individual and family therapy as well.

The therapy group is a powerful support for children

because of the peer support it offers. A child can maintain his or her defenses for as long as necessary while listening to the experiences of other children. Sharing in a safe group environment facilitates the erosion of denial, the beginnings of "making it real," and the basic work of trauma intervention and healing.

Jerry Moe recommends five principles that create a safe setting for trusting, talking and feeling. These include:

1. Enter the child's world.
2. Create a safe and nurturing environment.
3. Move beyond words with experiential learning: drawing, play and games.
4. Acknowledge children's dif-

ferent learning styles with varied activities.

5. Have fun.

In addition to physical safety, a safe environment means clear rules, consistency and predictability, and a place where children can learn about alcoholism and its effects on all the family.

Since young children believe their thoughts and feelings are all-powerful, they imagine that they cause bad things. COAs may assume their parents drink because of them. A parent may even encourage this belief with remarks like "Who wouldn't drink with a family like this!" So, leaving the bicycle in the driveway, getting bad grades, or thinking bad thoughts, can lead, in the

child's mind, to a parent drinking. One of the most important messages children can learn in group is that the alcoholism is not their fault. It is not possible to create alcoholism in another person. This is a message that the other adults in the family may need to hear too.

Because addiction in the family is embarrassing, children are taught by word and example not to talk about it. Therefore one of the tasks in the support group is to encourage discussion. Family therapists are familiar with the importance of breaking no-talk rules, and it is particularly important for families with alcoholism. Since this is difficult for the child, therapists can break the rule

## CONSUMER UPDATE BROCHURE



Here is a sample of the Consumer Update brochure on Children of Alcoholics. This brochure is designed to educate consumers and to market your services, with space on the back to imprint your name and contact information.

### MARKETING TIPS

To market your services to individuals and families who may be faced with this issue, distribute copies of the *Consumer Update* brochure to:

- Physicians and nurse practitioners in family practice
- Local hospitals and urgent care facilities
- Churches, synagogues and temples
- Community resource centers
- School and university counseling programs
- Mental health agencies and health fairs

### HOW TO ORDER

These brochures are available for purchase in packs of 25. The cost per pack is \$8.75 for members and \$11.25 for non-members. Contact AAMFT Member Services by e-mail at [central@aamft.org](mailto:central@aamft.org) or by phone at 703-838-9808. Order online at [www.aamft.org](http://www.aamft.org)

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- Bipolar Disorder
- Bipolar Disorder in Children and Adolescents
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- Parental Grief
- Panic Disorder
- Postpartum Depression
- Post-Traumatic Stress Disorder
- Schizophrenia
- Substance Abuse and Intimate Relationships
- Suicidal Ideation and Behavior
- Suicide in the Elderly
- When Your Adolescent Acts Out Sexually

themselves by demonstrating an understanding of how parental alcoholism affects the child (Morehouse, 1984.) This can be done verbally or with reading materials, or such visual aids as movies and pictures. By stating, "Here are some of the concerns of other children who have parents who drink too much sometimes," the therapist normalizes the feelings.

Living with active alcoholism is high stress for the family. One survival mechanism is to feel as little as possible. If a family member can manage not to notice, react, and have feelings, it is easier to get through traumatic days, weeks, or years. When asked how she coped with her parents' fighting, a child in group put her hand over her ears and closed her eyes. Several other kids covered their ears in agreement. One said, "You try not to listen. You don't see it. Then there's nothing to feel."

Artwork is one way for COAs to express what is going on in their families and how the child feels about it. Claudia Black writes, "There is hope for the addicted person and those affected by their addiction. We, the children, do not have to remain confused and silent" (1997). She quotes a six-year-old whose father was in treatment for alcoholism who was asked if she knew why he was in a program. She answered, "My Dad loves me, but my dad has a disease." The answer inspired the name of her workbook for young children, which focuses on art to help kids express their feelings and to give words to them. This child has come to feel safer and she has learned to "make it real."

## Principles for Support and Change

Important messages of support include:

1. You are not alone. There are many other children with alcoholic parents who experience what you experience and feel like you do.
2. You are not responsible for

your parent's alcoholism, behavior or recovery.

3. You can get help for yourself so things will be better.
4. There are people who can help you.

These messages will be internalized by the child over time and become the positive outcomes of intervention and treatment. The child becomes safe and learns how to get help to maintain that safety. The child has "made it real" and can continue to know and speak the truth. The child is better able to cope. The principles of initial support that become positive outcome and change are summarized by what Al-Anon calls the Seven Cs:

1. I didn't cause it.
2. I can't control it.
3. I can't cure it.
4. But I can learn to take care of myself by...
5. ...Communicating my feelings
6. ...Making healthy choices and
7. ...Celebrating myself.



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See the AAMFT's Clinical Updates on Alcohol Use Disorders, by M. Duncan Stanton, and Substance Abuse and Intimate Relationships, by William Fals-Steward.

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