

**Breaking the Chain:  
Making Prevention Programs Work  
for Children of Addicted Families**

*Prepared by the  
Illinois Prevention Resource Center*

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*When I was growing up in an alcoholic home I was acutely aware that when I felt sad, or angry, or panicked, or hurt, there was no place—and no one—where I was safe enough to talk about how I felt.*

*I also noticed something else: that when the adults in my life had the same feelings, they did something to make those feelings go away. They used a chemical, they used food, they used “busy-ness,” they used control and management of themselves, others, and situations.*

*I really believed that noise and upsetting and making people uncomfortable was what made things so bad in my house. So I spent my life trying never to make noise and always to be good, and never making anyone uncomfortable. And it didn’t work.*

*Then I found alcohol, and it worked.*

*It’s amazing how well that stuff works. I spent 11 years of my life without it, and at 11, I put it in my body and I became who I had wanted to be. It was amazing, and it was free. Alcohol was the only thing that made a great deal of sense to me. Had you been there to try to talk me out of using alcohol, I want to assure you that you would have been ignored and probably ridiculed.*

*But had you been there to tell me you cared what I was feeling, you might have made all the difference. Had you been there to tell me you might even know a little bit of what I was feeling, I might have believed that there was some human being in the world I could count on.*

Cathleen Brooks

## **Author's Note**

This document is a result of the prevention field's growing recognition that any real success in preventing alcohol and other drug abuse will have to include real success in understanding and meeting the needs of children of addicted families.

One of the most exciting trends in prevention is an increasing willingness to study family systems theory and the wealth of information that's been developed in the addictions/recovery field, and to acknowledge that we need to incorporate much of that information in order to do our work effectively.

Choices about alcohol and other drugs—for adults or for children—aren't made in a vacuum. Within each person a complex set of fears, pain, trauma, expectations, learned responses, inherited tendencies, compulsivity, and confusion adds momentum to each decision. For children of addicted families, the momentum toward dangerous choices can be far too strong to be stopped by even the most persuasive argument.

Study of addicted families and their effects on children has convinced me that we can't simply divide the world between "people who don't yet have problems" and "people who do have problems." The silent, hidden trauma that many children of addicted families carry—often under "perfect" exteriors—is a serious problem long before these children even think about drinking or using. Alcohol and other drugs are not the essence of their problems; they are a reflection. We don't have to wait for those symptoms to show before we offer help that will mean something to them.

In producing this document, I've been fortunate to have the help and collaboration of Guest Editor Cathleen Brooks, an international leader in the field that works to help children of addicted families. We gratefully acknowledge her contribution of ideas, practical suggestions, guidance, inspiration, and encouragement throughout the writing and editing process. I've also included information from nine other leaders in that field, and we thank each for his/her knowledge, insights, and commitment.

We hope this effort helps to increase the collaboration, and the sharing of information and hope, among the many fields that care about these children.

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## Foreword and Acknowledgements

This Guide is written for people who want to help children who live in addicted families. It talks about how these children's needs and realities differ from those of other children, and ways of making programs and practices more relevant and sensitive to their needs. It is intended to help intervene in the cycle of addictive behavior passing from parents to children, and on to **their** children. Its object is to help break the generational chain of alcoholism and other drug addiction.

### Terminology

The term “addicted family” has been chosen for use here primarily because of its general and inclusive nature. In most cases, the families it refers to have one or more parents addicted to alcohol or other drugs—although the key addict might be a sibling, grandparent, or other significant adult, rather than a parent.

The word “addicted” itself usually refers to addiction to alcohol or other drugs, but it's also being used more and more to include “process addictions” like compulsive overeating, gambling, working, worrying, etc. And the word “family” widens the emphasis to include the entire family system, where every member is affected, and most are caught up in addictive patterns of emotion, thought, or behavior.

When we talk about “prevention”—particularly as it relates to children of addicted families—we don't limit it to the prevention of alcohol and other drug abuse. We recognize that in these families children develop a complex assortment of survival and coping responses. These responses may protect children in the family context, but they often become counterproductive or destructive in the outside world, and in adolescent and adult life. Alcohol and other drug abuse is certainly one of the most destructive coping strategies children and adults can employ, but it isn't the only one that gives cause for concern.

### Audience

This Guide is for prevention volunteers and professionals, youth outreach workers, teachers, counselors, therapists, administrators, health care personnel, and others who care.

There are many children who need help, and often their needs are significant. They need the help of anyone—in any capacity—who is willing to listen and learn about their needs and realities. People might use this document in starting new programs for children of alcoholic and other drug-dependent families, or in working to make existing programs more responsive to their needs.

## **Approach**

Although this Guide rests on the body of knowledge that has grown up around children of alcoholics in the past two decades, its approach is also rooted in the prevention philosophy that has evolved during the same time.

Research in prevention has determined that the most effective programs are those which engage people over time, instead of limiting their impact to one or two information/persuasion sessions. Successful programs also involve many areas of people's lives, and use a variety of strategies. Five prevention strategies have been developed to have the most comprehensive and effective impact on people's lives:

- *Involving and Training impactors* (so that programs will grow and continue);
- *Providing Information* (to help people understand and make informed choices);
- *Developing Life Skills* (to give people healthy ways of coping with life);  
*Providing Alternatives* (drug-free activities that help them practice these skill; and
- *Influencing Social Policy* (to shape environments that promote healthy choice).

A driving force behind this Guide is the growing conviction in the prevention field that our main purpose is not simply to “impart knowledge” to adults, children, or communities. We need to concentrate first on understanding their experience, based on what they say as the true “experts” on that subject. Only then can we slowly earn the trust and rapport necessary to synthesize our knowledge and skills with theirs.

## **Format**

This Guide presents both conceptual information to help people understand the experience and the needs of these children, and practical suggestions that can be used in a wide variety of programs (presented in special pages called “Suggestion Boxes”)

The challenge in this document's development has been one that those who read will also face: How to understand and acknowledge the heavy burden of negative experience that has permeated the lives of many of these children, without losing sight of the strengths resources, and resiliencies that exist, often in great abundance.

## Contributors

The Guide has been developed by the Illinois Prevention Resource Center, with guidance and collaboration by guest editor and contributor Cathleen Brooks. Ms. Brooks is the Founder and President of NEXT STEP, a national training center for education and consulting in the alcohol and other drug field; a founding board member, past President, and current Advisory Board Member of the National Association for Children of Alcoholics (NACoA); and author of *The Secret Everyone Knows*, a book for young and adult children of addicted families. She has designed programs for children of addicted families throughout this country and others. Nine other prominent authors, lecturers, trainers, and program administrators have also been quoted here, to help illuminate this complex subject. They are:

- Claudia Black, PhD: Internationally known lecturer, trainer, and author. Her first book, *It Will Never Happen to Me*, was an early standard in the children of alcoholics field.
- Stephanie Brown, PhD: Nationally recognized consultant, lecturer, author, and Director of the Addictions Institute, Menlo Park, California.
- Ruth Davis, PhD: Director of the CASPAR Alcohol and Drug Education Program, a Somerville, Massachusetts-based training, consultation, and program-development organization.
- James Dempsey, CCDC: Clinical Coordinator of NEXT STEP in Ronan, Montana, with expertise in young children and adolescents, parenting and family problems, and the effects of cultural loss.
- Ron Figueroa, MA, CAC, NCAC: Executive Director of the Rockland Council on Alcoholism in Nyack, New York, with many years' experience in designing programs for children.
- Lottie Jones, EdD: President and CEO, National Council on Alcoholism and Drug Dependence, Greater Detroit Area, Southfield, Michigan.
- Betty LaPorte, CSW: Project Director of Community Partnership, a Rockland County, New York-based prevention program.
- Jerry Moe, MA: National lecturer, consultant, trainer, author, and Children's Program Manager at Sierra Tucson Center for Addictions Recovery in Tucson, Arizona.
- Ellen Morehouse, ACSW: Founder and Director of Student Assistance Services Corporation, Ardsley, New York; co-author of *Children of Alcoholics: Meeting the Needs of the Young COA in the School Setting*.



## Table of Contents

Introduction 1

### Section 1: Living in Addicted Families: The Effects on Children

IA: The Nature of Trauma	9
1B: The Complexity of Alcoholism and Other Drug Addiction	13
IC: The Generational Momentum of Addiction	15
ID: The Family System	17
1E: Core Issues	21
IF: Promoting Our Own Health and Growth	27

### Section 2: Developing Effective Programs

2A: Which Children Need Help?	31
2B: Making Programs Available to All Children	33
<i>Suggestion Box: Making Help Accessible to All Children</i>	35
2C: Screening Words to Avoid Doing Harm	37
<i>Suggestion Box: Seeing Children in the Context of Their Own Realities</i>	40
2D: Listening and Understanding	41
<i>Suggestion Box: Creating Safety</i>	44
2E: Respecting the Realities of Children's Lives	45
<i>Suggestion Box: Helping Children Express Their Realities Through Creativity</i>	46
2F: Making Sure Support Systems are in Place	47
<i>Suggestion Box: Creating a Healing Environment</i>	50
2G: Strengthening Self-Concept	51
<i>Suggestion Box: Maintaining Respect and Concern</i>	53
2H: Focusing on Strengths, Resources, and Resiliencies	55



## Introduction

Programs for children, pre-teens, and teens—in communities, in schools, in churches, in hospitals, in social service provision systems—are excellent places to gain the skills, knowledge, and strength that can lead to healthy, happy, fulfilling lives. We who are in a position to help children are often their best hope in a world that holds so much confusion, fear, pain, and stress. That world also contains many dangerous ways of escaping those feelings—including alcohol and other drugs.

For many children, family life can be their greatest source of confusion, fear, pain, and stress. Many of these—an estimated one out of five in every classroom—are children whose families are affected by one or more members' alcoholism or other addiction.

These children's experiences often render them unable to accept, believe, or trust people, programs, and presentations that reflect only more functional family models. Unless we do our best to understand what children are going through, and how our programs might look and feel to them, we'll miss our opportunity to help many of the children who are at highest risk.

### Trauma and Risk

For children who live in addicted families, the risk of becoming addicted at some point during their lives is two to four times greater than that of other children. The trauma of family life, the survival responses that children learn there, and genetic predisposition all contribute to the generational transmission of the disease<sup>1</sup> of alcoholism and other addiction.

These children's circumstances aren't always more painful than those of children living with other types of family troubles. But, as Cathleen Brooks has observed in many years of working with people who sustained chronic trauma as children, addicted family systems are characterized by at least one factor that doesn't exist as often in other families: Children's pain is generally not validated, comforted, or resolved, either inside or outside the family. It's the fact that the pain isn't addressed or resolved that turns pain into trauma.

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<sup>1</sup>In this manual we refer to alcoholism and other drug addiction as a disease. Here we refer to a primary, chronic, and fatal condition that affects people on physical, mental, emotional, and spiritual levels. Although the disease concept isn't the only recognized method of describing addiction, it is the most widely accepted in the prevention and treatment fields. While the neurological mechanisms and genetic predisposition have not yet been fully explored, disease-based concepts seem to offer the most practical and effective help in understanding the phenomenon of alcohol and other drug dependence, and in treating the individuals, families, and other systems affected by it.

That trauma doesn't disappear as children grow up; it merely is buried under their systems of survival responses. Those responses often include the abuse of alcohol and other drugs, marriage to alcoholics and drug addicts, difficulty in self-care and direct communication, and counterproductive work patterns.

Along with the stresses and trauma imposed by family life, these children carry other burdens as well: the example within the family of an escape-oriented way of dealing with problems and, in many cases, a genetic predisposition toward alcohol and other drug addiction. The coping responses that help them survive within the family turn into problems in the outside world, and in adult life.

### **Breaking the Chain**

For many children of addicted families, breaking the generational chain will require a lifelong healing process similar to recovery<sup>2</sup> from addiction. But even the process that leads to the beginning of recovery can be a long one, a gradual absorption of information and insights. It can start in small and simple ways, like a piece of information picked up in school, or a look of understanding from a friend.

Programs for children offer an excellent opportunity to begin the process of hope and healing. If we are to play our most effective part in this powerful form of prevention, we need to know all we can about addictive family patterns, the momentum of addiction through generations, and how recovery works. Even more important will be our ability to listen to, understand, and respect these children's experience of the world, and to see their behavior in light of that experience. If we want to help children from alcohol and other drug-dependent families, often the most important things we can do are:

- Listen, rather than talk. To these children, the perfectly valid prevention information that we bring will often be meaningless when it's held up against the realities in which they live. What will be meaningful will be our ability to really listen to what they're trying to say. Through our ability to do that, we can give them a chance to break through the isolation and shame<sup>3</sup> that surround them.
- Learn and understand what these children experience in alcoholic/addicted families on a day-to-day basis, and how that experience shapes their survival systems. See these survival systems—things like denial or a lack of trust—as normal and necessary for them.

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<sup>2</sup> In this manual, the term recovery refers to the ongoing, lifelong process of recovery from alcoholism/addiction and its effects on families and friends, rather than to any specific clinical function, like treatment or therapy. On the Continuum of Care (Prevention, Intervention, Treatment, and Aftercare), recovery is considered a subsection of the category Aftercare. That category is used to include both post-treatment clinical services (clinical therapy and relapse-prevention programs) and the mutual-help groups (usually 12-step groups - Alcoholics Anonymous and others which follow its model) that support lifelong recovery.

<sup>3</sup> "Shame" is a term that's commonly used to indicate the feeling of worthlessness that children often develop in addicted families and carry with them into adulthood.

- Understand that these children’s behavior—however confusing or inappropriate it may seem in school or community settings—makes sense in the context of their home experience. Give children from dependent families a consistent message that their behavior is understood and respected. Help them eventually feel safe enough to explore other options.

## **Meeting the Need**

This Guide is designed to help in two general ways: First, to help people understand the effects that addicted families have on children’s lives, emotions, and development; and second, to help people develop prevention programs that are appropriate for these children. It’s structured around two sets of recommendations. The first set of recommendations focuses on the effects that life in addicted families has on children—things that we need to study and understand in order to respond to their needs. The second focuses on things to consider in developing effective programs.

### **Section 1: Living In Addicted Families: The Effects on Children**

In looking at these family systems, and the needs of the children affected by them, our vision must be:

- (1A) flexible enough to consider the combined effects of addictive family circumstances and other trauma-producing influences in children’s lives;
- (1B) sophisticated enough to respect the complexity and variability of the disease of addiction—its ability to hide under surface functionality, the sophistication of its denial process, and the varying degrees to which it affects families;
- (1C) long enough to see the generational momentum of the addictive process through the history of the family, carried not only in genetic factors and learned behavior, but also in attitudes and patterns;
- (1D) broad enough to take in the whole family system—with all its complexities and contradictions, balance and imbalance—not just the identified alcoholic/addicted parent(s);
- (1E) deep enough to focus on the core issues—components of health that have not been allowed to develop naturally in children’s lives and the self-defeating attitudes and patterns that have developed in their absence—and the connection between that pain and the risk or reality of destructive life patterns; and
- (1F) open enough to assess our own attitudes toward addiction and continue to work’ our own growth, health, and wholeness, understanding that our success in promoting health and respect will depend more than anything else on our success in modeling those qualities.

## **Section 2: Developing Effective Programs**

In the programs we develop for children, we need to keep these things in mind:

- (2A) the fact that the amount of trouble children are causing for adults is not a reliable indicator of how troubled they or their families really are, or how severe their problems will be in the future;
- (2B) the need to give general audiences of children carefully prepared information about alcoholic/addicted families and their effects on children, knowing that our success in doing so will benefit all children;
- (2C) the vulnerability to a sense of “shame” or worthlessness that children develop in alcoholic/addicted families, and the importance of screening our words and actions to avoid doing harm;
- (2D) the concept that children need empathic adults who can listen to, accept, and validate their emotions and experiences far more than they need any of the information or activities our programs can provide;
- (2E) the need to make all of our prevention programs respect the realities in which children live, including children of alcoholic/addicted families;
- (2F) the need to have ongoing support systems in place before we do anything that might raise children’s awareness of alcohol and other drug dependence in their own families;
- (2G) our opportunity to supplement the growth of health and wholeness by teaching children and adults about core components of healthy self-concept that often get lost or distorted in troubled families; and
- (2H) the strengths, resources, and resiliencies already available in children, families, recovery programs, and cultural heritage, and the importance of emphasizing these positive elements and the hope that they represent.

The second of these sections, “Developing Effective Programs,” also contains outlined pages of practical advice in developing programs that will work for children of addicted families. These are called “Suggestion Boxes.” Their contents were provided by Cathleen Brooks, based on many years’ experience working with these children and developing programs for them.

### **Purpose and Opportunity**

Our goal in developing this Guide is to promote an understanding that reaches beneath and beyond the formulas often used to describe and explain the issues that surround alcoholic/addicted families. The depth of our understanding will tell us what to say and when to be quiet, how to do the most good and the least harm.

Our opportunity for positive impact is very powerful, because of the positive stance we've been cultivating in prevention: our vision of health and wholeness. Children of alcoholic/addicted families already know how to focus on the negative. They've received lifelong training in that. What they need are people who convey sincere empathy for the pain these children might be living, and still affirm their worth and believe in their strength, resiliency, and potential for full health.

We can resemble the traditional "healer" whom Ron Figueroa (Executive Director of the Rockland Council on Alcoholism in Nyack, New York) describes as a model for people who would like to help children of alcoholic/addicted families. "The healer is caring and empathic. The healer has the ability to listen and hear the pain without succumbing to it or losing hope.

"In the most hopeless of situations, the healer exemplifies hope."



**Section 1:**

**Living In Addicted Families: The Effects on Children**

1A: The Nature of Trauma	9
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1C: The Generational Momentum of Addiction	15
ID: The Family System	17
IE: Core Issues	21
I F: Promoting Our Own Health and Growth	27



**The Nature of Trauma**

Many families, in many different circumstances, experience serious trouble and confusion. Many children feel the effects of those conditions, and some seem to suffer no problems as a result. Why focus on children of alcoholic and other addicted families for special study and help?

Aside from the genetic and role-modeling factors that often predispose these children to dependence on alcohol and other drugs, there is a central condition that frequently leads children to long-term trouble: the experience of trauma in their lives. According to Brooks, when children's pain isn't validated, comforted, and resolved, that pain can solidify into something that is beyond the healing power of ordinary human processes.

Of course, addicted families aren't the only places where children experience trauma. Sometimes other types of negative events or conditions within families are neither addressed nor resolved within the family or the community—or these experiences can overwhelm children's stress systems and the helping resources that are available—and children's experience can be traumatic. In these families, children may learn some of the same survival skills that others learn in addicted families.

In working with children, it's important to understand that a wide variety of conditions and events can have strong negative impact on their behavior and development. In some cases, we may have an intuitive sense that something is “wrong” at home, but it might never be clear to us what the problem is. The important thing is that children whose family troubles don't include addiction can benefit greatly from the same skills — listening, understanding, empathy, detachment, encouragement, belief in their potential—we learn to employ with children of addicted families.

**Other Conditions and Events**

Other trauma-inducing factors in children's lives can include natural disasters; serious illness, hospitalization, or surgery; community violence; the experience of poverty, hopelessness, or prejudice; events such as parents' separation or divorce, or a death in the family that children don't fully grieve; or the effects of parents' or other family members' process addictions, religious rigidity, mental illness, chronic illness, chronic pain, or other disabilities.

The tendency of families and communities to ignore and deny family conditions—and therefore fail to recognize and address children's pain—is often stronger and more pervasive when family problems include addiction to alcohol or other drugs. For isolated events or more “acceptable” conditions, families generally feel less shame about broaching the subject with their children, or finding outside sources of support.

When the problem is not alcoholism or other addiction, people in the community often feel more comfortable about offering their support, and children are less reluctant to accept it. Unlike children of addicted families, these children are less likely to “internalize” the family problems and feel responsible for them. They often feel less isolated, less “all alone” with the problem.

The most common exceptions to this might be in cases of sexual or physical abuse, where children tend to take responsibility for the abuse, feel intense shame about it, and try to keep it secret. But in cases where the abuse is discovered, the community tends to intervene more readily. After all, physical and sexual abuse are illegal; addiction and emotional abuse are not. Finally, statistics show a large correlation between physical, sexual, or emotional abuse and addiction in the family.

### **“Double Duty”**

Within alcoholic/addicted families, if other dynamics also exist that can tend to produce pain, shame, or isolation, children’s troubles can be compounded. “Double duty” is the term that Claudia Black, a leader and early pioneer in the children of alcoholics field, has coined to describe some forms of this condition. “Simply put, double duty refers to added complexity, added trauma,” says Black.

“Double duty exists when a child has one major trauma-inducing dynamic in their life, and an additional dynamic comes in and reinforces those consequences.” The examples Black gives of double-duty experiences in alcoholic/addicted homes include being the only child; being gay or lesbian; having physical disabilities; having two addicted parents; and being the victim of physical, sexual, or emotional abuse.

Of children in these and other double-duty situations, Black says, “In order to survive, what we’ve had to do is to toughen up, these kids more so than other kids. As a group, they experience far greater shame, and I believe that they have a need to walk through the grief part of recovery more slowly.” Children with these combinations of traumatic experiences will need more help, and more patience with themselves in the healing process.

### **Negative Effects of Outside Systems**

And finally, if a sense of worthlessness within the family system is reinforced in outside systems, the child’s burden can be greater than the sum of its parts. This can include communities where poverty or oppression have led people to give up hope, neighborhoods where children see and experience violence, or schools where children are not treated with respect or are actually abused, physically, sexually, or emotionally.

The family might be the strongest and most intense influence on children's early development, but it isn't the only one that matters. Other systems that affect children—like schools, churches, and service organizations—can only be as healthy as the adults who run them and work in them. Abuse does occur in some of these situations, and it can have profound effects on children if the abuse isn't addressed and resolved.

Negative environmental conditions within the community can also be powerful destructive forces:

- When children are raised in environments that aren't cared for, they're vulnerable to feeling the same lack of care for themselves.
- When the immediate world looks and feels hopeless and impoverished, children are at greater risk of growing up without a sense of hope—perhaps the greatest risk factor for failure and self destruction.
- When the community is unsafe, and children are routinely exposed to crime and violence, they're exposed to trauma on a regular basis. They risk internalizing that violence and failing to resolve the anger, sadness, and fear that accompany it. When the violent and illegal activities are among the most financially lucrative, as in the case of drug traffic in low-income neighborhoods, children associate crime and violence with survival.

The most common example of systemic reinforcement of negative messages is racial prejudice. Lottie Jones, President and CEO of the National Council on Alcoholism and Drug Dependence in the Greater Detroit Area, describes her family. The family sometimes functioned well and sometimes functioned badly. Because of a preoccupation with an outside force, alcoholism, it failed to validate her thoughts and emotions; left her confused; and taught her not to talk, not to trust, and not to feel.

“I also grew up in another dysfunctional system,” she says. “It was a larger family. It was a larger unit called society. It was functional in some ways, and in other ways it was not. This family is and was unable to function in a healthy way because of a preoccupation with an outside force. That force is racism.

“It was a family where I was confused. My natural reasoning process told me one thing. The people in authority, the larger society, told me something else. And then nobody would validate what I felt. Everybody was caught up in it, and I had no place to turn.

“The people in authority were caught up in it, and my fellow blacks were caught up in it. And we were all confused. So I developed a mechanism to cope with it. The mechanism that I developed was, ‘Don't talk about it. Don't trust any of them because they will get you. And don't feel, because it's too painful.’”



### **The Complexity of Alcoholism and Other Drug Addiction**

No other reality puts twists and turns in our thinking and feeling like the phenomenon of alcohol and other drug dependence and the way it affects the people around it. More than any other factor, it confounds our attempts to draw a straight line between “healthy people” and “unhealthy people.”

Other diseases may lie hidden or dormant for years or generations, but they don’t carry anywhere near the degree of denial, deception, and shame that seem to hold this one together. When most people feel the pain of other diseases, they seek help. Not so with this one.

The individual’s internal sense of shame or worthlessness is mixed in with the denial that pervades individual and family life. When this combination meets the outside senses of moralism, disapproval, and denial that are the legacy of society’s incomplete understanding of this disease, it seems much more dangerous to acknowledge the pain than to retreat back into it.

#### **Factors to Weigh**

When we consider the needs and risks of children of alcoholic/addicted families, we juggle a number of largely invisible factors:

- the absence or presence of genetic predisposition toward addiction, something we still can only guess at in any individual;
- the degree of dysfunction within the individual family system, and the amount of fear or anger children have accumulated;
- the degree to which children have begun to feel that they are essentially worthless—a progressive time-bomb that often doesn’t show from the outside but, although it doesn’t cause addiction, can easily lead to substance abuse and other destructive life patterns;
- the degree to which children have not learned to take care of themselves in important ways, often hidden under an exceptional ability to put on a good front and to take care of others; and
- the strengths and resiliencies already existing in these children, and in their families.

## **“Healthy” and “Unhealthy” Families?”**

Our first step in helping children of troubled families might be to discard any notions of “healthy people” and “unhealthy people,” or “healthy families” and “unhealthy families.” If instead we think—and speak—in terms of healthy and unhealthy attitudes and patterns that people and families have, we will be more accurate, avoid negative labeling, and do more to promote both unity and healthy change.

Human dependence exists on a continuum, with the healthy interdependence of all beings at one end, and things like addiction and isolation at the other. We all live on that continuum, and even the people and families in whom health is strongest have stressful situations in which they need to seek help.

“When we look at families, we have a tendency—particularly those of us who are raised in dysfunctional families—to think in 1s and 10s,” says Betty LaPorte, Project Director of Community Partnership. “And so we think there are good families and bad families. But there’s varying degrees of dysfunction in families.”

### **Beware of Formulas**

In the confusion that comes out of family troubles, there’s a temptation to paint things black and white, or to look for some formula that will make it all understandable. Among the first—and sometimes the only—information people receive on the subject are the roles and “characteristics” often taken on by children of alcoholic/addicted families. Stephan Brown, highly respected author, lecturer, and consultant, asks that people be careful not think or speak of these formulas in absolute terms.

“What we want to understand is how these defensive maneuvers might be overused in a negative way,” says Brown, “and not how they differentiate children of alcoholics from other people.” Even the use of the words ‘characteristics’ or ‘traits’ can be dangerous, making them seem like ingrained and indelible qualities—what people are, instead of what they do. “What you may refer to as ‘characteristics’ I see more as defensive maneuvers,” says Brown.

## **The Generational Momentum of Addiction**

While it might be our worst mistake to view children of alcoholic/addicted families coldly and clinically as “carriers of the disease,” no study of this subject will be effective unless we take into account the generational cycle of addiction.

It would be both inaccurate and counterproductive ever to “blame” one generation for alcohol and other drug dependence in the next, or to say that addiction and addictive attitudes can *always* be traced to parents and their parents. But the cycle has generated too much evidence to ignore, and an objective focus on it will bring us closer to a true understanding of the problem at hand.

“In the last year, there’ve been about 20 parents who came to our program, and they’ve said, ‘I can’t stop, but would you help my child?’” says Jerry Moe, Children’s Program Manager at Sierra Tucson. “The reason is invariably the same: ‘When I look at him, and I look at her, I see myself when I was eight years old and 11 years old, and it’s so painful I don’t want them to go through what it is I’m going through.’”

### **Looking Beyond the Present Generation**

To understand the momentum of addiction through family history, it will be necessary to see far behind and beyond the children currently or at one time living with alcoholic/addicted parents. “We are talking about generations,” says Brooks, “generations of children who are still being impacted by the legacies of ‘You don’t matter. You’re not important. Gear up, get with the system. Don’t make too much noise. Don’t laugh.’”

“Large numbers of people have been wounded by these childhood losses. Their wounding does not magically disappear. It simply becomes more intense and less ‘fixable’ as time goes on.

“And one day a mother may be sitting in your office, crying about her son who’s using drugs, and you may be tempted to focus on how to get that son to stop using drugs, and not see the tears of that mother, and not ask yourself, ‘Is she reliving a nightmare that she had when she was a child?’”

And so you have to think quickly about grandchildren and great-grandchildren, and to see this family as a generational legacy, and see yourself in that incredible moment in time—what I call a miracle moment—where you can say, ‘I’m going to do something more than my job here’.”

Brooks describes that moment as the chance to reach beyond the topic at hand, and with care and empathy answer the question behind the mother's tears: "Are you going to be the one who's finally going to feel my pain? Because if you don't, it doesn't matter what you do for my son." The wounding is still there, and it will go on generation after generation, because I'm going to tell you a secret: She may have been sober when he raised her son, but she wasn't well. She wasn't able to give him what he needed, because it wasn't given to her."

### **Looking Beyond the Problem Behaviors**

Brooks challenges us not to think of children's or adults' needs just in terms of the problems they are causing, but to ask ourselves this question: "What can I do to begin with my behavior and my words to give a clear message that a child's pain, in and of itself, is worthy of attention—that we need not wait until that pain becomes so great that the child takes it upon him- or herself to medicate it with chemicals or some other behavior that bothers us?"

"And that child's pain does not end when childhood ends. It is carried on into adulthood, often manifesting itself in adult-onset alcoholism; often manifesting itself in marriages to alcoholics, addicts, gamblers, other dysfunctional situations; manifesting itself sometimes in work situations that are destructive, compulsive, addictive; manifesting itself in a whole range of stress-related disorders.

"And most important, manifesting itself in communities of adults who—having never been children, and having never known what it was to be to be parented lovingly and unconditionally—can not do it for their own children."

**The Family System**

A family is an interconnected, interdependent system. Each person affects everyone else and the system as a whole. For example, if one parent's emotions, words, and actions are distorted by addiction, the entire system is thrown out of balance. Often without realizing it, the other parent begins to adjust his/her own emotions, words, and actions to bring the system back into balance—but in doing so destroys the balance in his/her own life. The children are left to make a complicated set of adjustments to balance out each of the parents, their siblings, and the system as a whole. So if we think of children's experience solely in terms of the alcoholic/addicted adult(s), we risk missing important information. Although the words "addicted family" don't tell us what a given family looks like, acts like, or feels like, they can conjure up an eloquent and profoundly affecting set of images. Whether or not we have lived with alcohol and other drug dependence, we have all heard enough to respect its destructive potential. A few examples provided by the contributors to this Guide:

- the seven-year-old boy who eagerly woke his father up for the promised fishing trip, the first in his life, then was forced to deal alone with his hurt, anger, and confusion when his father—who had made the promise in a blackout<sup>4</sup>—asked him, "What the hell are you talking about?" and his mother, who'd been sober when the promise was made, simply told him to go back to bed;
- the five-year-old girl who consistently expressed shame and self-recrimination that her 17-month-old brother, who spent most of his time in her care, still had diaper rash; and
- the four-year-old boy who stood guard on the porch while his mother shot heroin at her connection's house, then sat on two thick phone books beside her on the ride home, so he could pat her face periodically to make sure she didn't nod out.

Any attempt to portray a "typical" addicted family would be an oversimplification, a disservice to the families living with the disease. Some families function quite well most of the time, and trouble plays only an episodic role; in others, everyone is very well behaved, and all the disease blocks is communication and closeness. Those conditions are enough to interfere with children's healthy development and well-being.

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<sup>4</sup>This refers to the state of inebriation in which people are conscious and capable of walking and talking, etc., but once the effects of the alcohol or other drugs have worn off they'll have no memory of what happened during that time.

At the other end of the scale live the horror stories, and they definitely do exist. There is a high correlation between addiction and physical, sexual, and emotional abuse and neglect. Whether or not parents really do have absolute power over their children, it often feels that way to the children. When that power is abused, or the basic responsibilities of parenthood are neglected, the damage can be significant. But when we think about what happens in families, it's important to remember that addiction is a disease. No one chooses to be afflicted.

### **Conditions and Patterns in Families**

Because there are so many variations in individual personalities, amounts and types of substances used, and reactions to drinking or using, it's impossible to pin down the details of a "typical" alcoholic/addicted family. The best we can do is to describe the conditions and patterns that seem to emerge within these family systems. Here are some examples:

- **Problem Focus**

"Our families, rather than being support or affirmation focused are problem focused," says LaPorte. According to Brown, "The focus is on the alcoholic, and the rest of the family is sacrificed." This problem focus can translate to many areas of children's lives. They can think of themselves as problems, or become so focused on problems that it becomes difficult to find, or believe in, solutions.

- **Codependence**

Codependence is a set of coping responses that family members often take on in their attempts to restore balance to their family systems. Codependence is defined and described in many ways, among them as an obsessive tendency to deny one's own needs and focus on, deny, and/or try to "fix," someone else's problems—to the point of unconsciously seeking out people with those problems over time. It can be a response to the pain caused by someone else's addiction, and/or a pattern learned from a codependent role model. It easily exists along with addiction in the same individual.

- **Denial**

Denial has as many definitions as people defining it. One would be that denial is the ability both to know something and not to know it, to look straight at **it** without seeing it. While denial in addicted families might begin with denial of the alcohol or other drug problem, it's a coping response that can be turned toward any other aspect of life. It can become children's and adults' primary response to all types of realities that they find uncomfortable.

- **Preserving Addiction**

The alcoholic family system is organized to deny the reality of alcoholism, while preserving it at the same time,” says Brown. In order to remain “balanced,” the system must maintain the status quo. “Individual development; healthy perception; healthy logical operations—all the normal developmental paths of childhood—become sacrificed to preserve the drinking.”

- **Rigidity**

Because the family’s balance is often based on distortion of natural functioning, that balance can be a delicate one. People compensate for this precariousness, becoming rigid in their *ways* of thinking, feeling, and acting, and in their expectations of others in the family. The family structure grows rigid, and people are expected to play specific roles. The roles then become so rigid that children often continue to play them outside the family, and into adult life.

- **Isolation**

The shame and embarrassment that are attached to this disease and its symptoms often propel family members into profound forms of isolation—from the outside world, and often from each other. That isolation keeps people from seeking or accepting help, and so prolongs the problems. “It’s emotional isolation as much it is social isolation’ said Claudia Black. Even if they have frequent social contacts, family members might be able to talk about everything except what’s going on in the family.

- **Manipulation**

The denial, rigidity, and isolation that characterize addicted families tend to discourage open, effective communication. If abuse is also a factor, then vulnerable family members will often hide their wants, needs, and opinions in order to avoid further abuse. When one’s needs can’t be met through direct means, a natural tendency is to try indirect ways of getting what one needs and wants: getting one’s way without asking for it or taking responsibility for it. A number of subtle and not-so-subtle manipulative techniques—like hinting around, being a martyr, inflicting guilt, sulking and banging things, or giving the silent treatment—spring up in many addicted families. Children learn these techniques and carry them into other situations, and into adult life.

- **Obscuring Love**

Addictive family conditions don’t negate, but often confuse, the love that exists in families. “In 14 years of working with addicted families, I’ve never met a family where everyone didn’t love everyone else,” says Moe. “But one of the by-products of this disease is that love never gets expressed in a consistent fashion. And virtually every child I’ve worked with somewhere in the back of their mind is gnawed by that question: ‘Do they love me? Why don’t they always show it? What can I be doing differently?’”



Where is the child in all this? What’s missing from the mix of love and instruction that was meant to surround the child as a healthy human being was formed? What essential elements of human development does the child have to give up in order to survive and function?

The survival responses that children develop in addicted homes come at a high price. The term “core issues” is often used to refer to a set of emotional patterns that children often take on out of their need to survive in addicted families, and carry into adolescence and adulthood in spite of the severe problems they can cause. These patterns lie at the center of many counterproductive and self-destructive thoughts, emotions, and behaviors.

### **Shame**

Throughout the literature on children of addicted families runs one central theme: that addictive systems interfere with the development of a healthy sense of self-worth. The hole where that essential quality was supposed to have developed is often called “shame.” One common explanation of the difference between shame and guilt is that “guilt says I’ve made a mistake; shame says I **am** a mistake.”

The sense of self-worth—of wholeness, of completeness, of having a right to exist—is something that families functioning at their ideal capacity naturally instill in children. In these situations adults are free to show consistent love and respect, to be honest and dependable, and to clarify and respect the “boundaries” between their own lives and those of the people around them. A child’s sense of self-worth simply develops.

In the tangle of the addicted family system, important things get distorted or discarded. Love is there—often in great measure—but the pain, rage, and obsessiveness of the addictive process can sometimes drown it out, so that it feels to the child like hatred or indifference. The messages are often mixed, and even if the child receives evidence of love, he/she might also receive equally strong messages that diminish his/her worth as a human being.

Shame is often called one of the primary core issues that children carry into adulthood, because it underlies so many destructive and self-destructive choices people make. “The consequences to shame are many,” says Black, “from blatant, chronic victimization to self- abuse, to the abuse of others.”

Some of the most common consequences of shame include preoccupation with control, taking a victim's stance, engaging in apathetic relationships, addiction to rage, perfectionism, compulsive behaviors, addictive behaviors, and suicide. The "grandiosity" so characteristic of the addictive personality is rooted in shame.

### **Abandonment**

"Almost always, when you pull away the layers of shame, I think you will find abandonment at the foundation," says Black. "And that abandonment can be either physical or emotional, and oftentimes both. This abandonment is typically on a chronic basis, the message being, 'You're not important. You're in the way. You are not of value'."

Physical, sexual, or emotional abuse or neglect all create feelings of abandonment, no matter how often the abuse or neglect occurs. One of children's strongest needs is for consistency in the love and care they receive from significant people in their lives; The absence of that consistent love and care creates deep fears that feel like threats to children's survival. In severe cases, life actually is threatened. The more severe the abuse or neglect, the greater the trauma.

If these issues aren't resolved in childhood, a deep sense of abandonment—a sense of being helpless, hopeless, and lost, like an abandoned infant—can be triggered by any or all of the losses and broken relationships that people experience as an ordinary part of childhood and adult life. This dramatically increases the intensity of people's fear, pain, and anger over real and potential losses, and clouds their judgment and distorts their actions where relationships are concerned.

A popular concept among people who study addictive family issues is that of the "inner child." This term often refers to the facets of normal childhood development that weren't able to take place in dysfunctional family systems. It also refers to that unresolved sense of abandonment that keeps people feeling helpless and dependent, often on levels that they're not aware of, in adult life. Using the inner child imagery helps some people develop a sense of love and care for themselves, as if they were nurturing that "child" and helping it grow into an adult.

### **Boundaries**

How well is the child able to detach from the potentially damaging messages either implied or stated in family members' abuse or neglect? That depends on the child's ability to differentiate his/her life, worth, needs, perceptions, control, and responsibilities from those of the people who are sending the messages. "One needs to have a sense of oneself separate from others, and one needs to have a sense of self-worth, to be able to reject shameful messages," says Black.

Unfortunately, one of the most common effects of alcohol and other drug dependence on family systems is a breakdown, distortion, or rigidity of the “boundaries” that were meant to be clear and flexible—to outline people’s lives and responsibilities, all interdependent but each essentially whole. This can take the form of dissociation or disengagement, where there is little interaction or healthy interdependence. It can also manifest as enmeshment, where people continually ignore one another’s appropriate boundaries.

For example, if an alcoholic/addicted and/or codependent parent is consistently blaming others for his/her problems; if a codependent parent is ignoring his/her own needs and trying to “fix the other parent; or if one or both parents are trying to change, control, or manipulate the child in excessive, inappropriate ways, the child will not develop a clear sense of where she/he ends and other people begin. There’s little or no defense against others’ real or imagined opinions.

Physical and sexual abuse constitute actual invasions of the child’s physical boundaries. Under these assaults, it’s hard for the child to maintain a sense of physical wholeness and integrity, and even more difficult to form a clear sense of delineation from others on mental and emotional levels.

Unresolved boundary distortions are carried on into adolescence and adulthood. This can take many forms, including:

- an imitation of family dissociation/disengagement or enmeshment patterns in work, friendship, sexual, and domestic relationships;
- acting out on others the forms of abuse or neglect that one suffered as a child;
- seeking out relationships where one experiences abuse or neglect that somehow resembles childhood experiences;
- a lack of respect for one’s own physical, mental, and emotional needs and health, with a resulting lack of appropriate self-care. This often is acted out in self-destructive overeating, addictive sexual patterns, and/or the abuse of alcohol or other drugs.

### **Lack of Trust**

For the child living in an addicted home, several important adjustments are necessary for emotional survival. One of these is an ability to be selective about trust, or to live without trusting anyone. In the words of Cathleen Brooks, “A child grows up in a world that tells the child, ‘We put you in this family, and this family is going to take care of you. Now the problem is that if you need anything, they won’t be there; when they need something, you have to be; and if you ever say you’re unhappy with it, you’ll be accused of ruining the family. But these are the people that you’re going to learn to trust around’.”

When trust issues pass into adolescence or adulthood unresolved, they can cause significant problems in relationships with friends, neighbors, co-workers, and family members.

These issues can be complicated by the high levels of loyalty—often inappropriate loyalty—that people learn in many addicted families. Once people have learned the skill of maintaining loyalty even though trust is repeatedly broken, their loyalty to themselves and to their principles can be in jeopardy. They're much more vulnerable to abuse, and to compromises that threaten their sense of integrity.

## **Denial**

For the child in the addicted home, surrounded by contradictions—love and abandonment, the obvious and the denial of it, basic human needs and the neglect of those needs—reality seems to conflict with itself. When the pain of this conflict becomes too great, the child learns to split reality, and to hold conflicting versions of the truths without letting them interfere with one another.

Most often, this learning process is aided by the fact that other family members are also in denial about many aspects of life. As written earlier in this Guide, denial can be thought of as the ability to simultaneously know something and not know it. It differs from simple dishonesty in that it isn't a conscious choice. It involves temporarily blocking important pieces of information from conscious recall, when it's convenient to do so.

This ability isn't limited to the child's perception of the parent's use of substances, a necessary survival skill that affects many areas of the child's life and perceptions, carried into adulthood. It might eventually include denial of one's own needs or a partner's self-defeating or self-destructive patterns.

Even when people are successfully recovering from their own addiction or codependency, denial about many aspects of life can be a persistent problem. They need to work to improve their ability to see circumstances the way they really are, and to understand their full implications.

## **Isolation**

One common result of the shame, abandonment, distorted boundaries, and denial is a deep sense of loneliness and isolation. In some very tangible senses children can be separated from themselves, from their own perceptions, from other members of their families, and from the outside world that must never know what family life is really like. The enmeshment that sometimes happens in families where boundaries are not well defined serves to reinforce the isolation, rather than break it: isolation can seem like the only available defense.

I believe the loneliness and isolation that children of alcoholics experience is invisibly intertwined,” says Black. “I find that loneliness is more internal, a feeling that’s experienced mixed with great sadness. Isolation I believe to be more external, like an invisible but ever-present wall that exists.”

Carried into adolescence and adulthood, a tendency toward isolation can deprive people of important opportunities, and of the healing potential that a sense of community carries. Isolation also can increase the risk that alcohol and other drug abuse will progress into addiction, and keep people from seeking or accepting help.



### **Promoting Our Own Health and Growth**

The ability to talk about health, and the willingness to work hard to promote it, are important qualities for anyone who seeks to help people raised in addicted families. But for children—and adults too, for that matter—no description of health will have anywhere near the impact of seeing it in practice.

What good will it do to talk to a child about self-esteem if we're self-deprecating or—even worse—judgmental and critical in our day-to-day interactions with that child? “The most important thing to model to these children is our health,” says Moe. “And keep in mind that often we're the first healthy people that they've ever had in their lives.”

### **Addressing Our Own Needs First**

One danger in any human service field is the temptation to focus all of our energies on other people's needs and neglect our own. Healthy living takes time and effort, the kind of effort that's very easy to put off “until things calm down.” Particularly in the fields related to children and families, both the needs and the temptation to ignore them can exist at high levels. And one of the strongest motivations for helping people relieve or avoid pain can be the memory of experiencing pain or caring about someone afflicted with it. That memory can be accompanied by extra burdens.

“We are very aware in the children of alcoholics field that people who go into helping fields of various kinds are frequently given what we might call ‘cradle-to-grave’ training,” says Brooks. “When we do surveys of helping professionals—particularly certain ones: social workers, nurses, teachers, and clergy—we find astonishing percentages of children of alcoholics. In some cases, 60-75 percent of the survey groups are children of alcoholic families.

“Of course, most of the people responding, if they are able to say ‘Yes, one of my parents or my grandparents was alcoholic,’ on the next question—‘Do you believe that this significantly affected you?’—the answer is ‘No.’ And if you do personal interviews, what you usually hear is, ‘but it really screwed up my sister’.”

Simply wanting to help present and future generations is not enough. The dedication and conviction that can come out of a troubled childhood don't negate or cure whatever problems that experience instilled. Unless they are addressed on an ongoing basis, those problems can keep people and organizations from working together in consistently healthy ways, and undermine efforts to model and promote health. “Sometimes people who have had this in their background haven't done enough of their own healing and enough of their own work,” says Moe. “You simply can't give these kids something that you don't have.”

James Dempsey, Clinical Coordinator of NEXT STEP in Ronan, Montana, describes the program planning process undertaken in his Native American tribe. “The idea was, ‘What are we going to do for the children? What are we going to do to break this generational cycle?’ And the word from the people was, ‘We need help for ourselves first.’ And things just happened.

“First it was the healing for ourselves; second it was the health providers. It was then our leaders—our elders, our spiritual leaders. And then it went into families, and then communities. It was like the picture of a hub, working your way out. It’s a beginning for us now. The focus is on the children too, developing healthy models for children to grow to.”

**Section 2:**  
**Developing Effective Programs**

2A: Which Children Need Help?	31
2B: Making Programs Available to All Children	33
<i>Suggestion Box: Making Help Accessible to All Children</i>	35
2C: Screening Words to Avoid Doing Harm	37
<i>Suggestion Box: Seeing Children In the Context of Their Own Realities</i>	40
2D: Listening and Understanding	41
<i>Suggestion Box: Creating Safety</i>	44
2E: Respecting the Realities of Children’s Lives	45
<i>Suggestion Box: Helping Children Express Their Realities Through Creativity</i>	46
2F: Making Sure Support Systems are in Place	47
<i>Suggestion Box: Creating a Healing Environment</i>	50
2G: Strengthening Self-Concept	51
<i>Suggestion Box: Maintaining Respect and Concern</i>	53
2H: Focusing on Strengths, Resources, and Resiliencies	55



**Which Children Need Help?**

In a world of limited time and money, the temptation is just to identify people with special needs and problems and design special programs for them. This option has several flaws where the needs of children of addicted families are concerned.

First, there's the danger of reinforcing children's own sense of shame by "identifying" them. Group and individual counseling programs for children of alcoholic/addicted families can be important and effective if they're done well and carefully. But without safe preparation, only a small percentage of the children who need help will ask for it or make their needs apparent in other ways.

"About 75 percent of children of alcoholics I've worked with fall into the category of either very approval seeking, very achievement oriented, or very quiet and unobtrusive children," says Brooks. "Only 25 percent of the kids I've worked with fall into the category of 'problem' children."

**Who are the "Problem" Children?**

Brooks describes the results of a study of children of alcoholic/addicted families who had been referred to her organization for counseling. Some, about 25 percent, had been identified by the referral sources as having "behavioral problems."

"We put them into one batch, and then we put into another batch all the kids who were there just because somebody in their family or somebody in their system believed they might need some help. But in most of those cases, you should know that their families as a whole, and very often their extended societies, told us that these children had no problems and didn't need help.

"When we did sample psychological testing of that whole group, here's what we found: Overall, the children in the 'problem' category tested out much healthier mentally. They showed higher self-esteem, stronger self-preservation instincts, and a clearer sense of who was responsible for what.

"Interestingly enough, a large portion of that 25 percent were kids who were initially referred for runaway. They scored the highest in terms of self-esteem, self-preservation, and ability to differentiate responsibility.

"This kind of twisted our heads around a little bit. We began to say, 'You know, what happens in our culture is that we don't pay attention to kids' pain until it causes us pain: Children of alcoholics rarely become 'problems' for us until they begin their own chemical problems. And then what do we do? We look at them as chemical dependents.'"



### **Making Programs Available to All Children**

If we are to take a true preventive approach, it will have to recognize that many children of addicted families are being “set up” for serious problems in later life. In many cases those “set-ups”—and often the fact that their families have problems—won’t be apparent even to people who know them well.

If the classroom or community program will be in most cases the first—and in many cases the only—chance to reach children whose needs are acute, then what’s the best way to use this opportunity? This chapter discusses the importance of getting information about alcoholic/addicted families to all children.

“If we were only providing services for children from families with alcoholism to those children whose families were in treatment and were taking their children, then we’d be missing 85 percent of the kids who need our help,” says Ruth Davis, Director of the CASPAR Alcohol and Drug Education Program in Somerville, Massachusetts.

“If you’re talking to a large group of kids in a school system, and giving these messages, you are reaching the one out of five in that classroom living in a family with alcoholism.” Davis talks about some of the messages that the National Association for Children of Alcoholics (NACoA) has printed on posters for schools:

- You’re not alone.
- It’s not your fault.
- Alcoholism is a disease; it’s not your parents’ fault.
- Alcoholics can and do recover.
- As a child you’re a person of worth and deserve to get help.

### **Overcoming Fear and Confusion**

According to Davis, information about the nature of the disease can go a long way toward alleviating the fear and confusion that children feel and “helping them to understand what alcoholism is, because often they don’t have a name for what is going on at home. And what they’re being told it is something very different from what is really going on, because the entire family’s in denial.”

Children need to understand that alcoholic/addicted and codependent parents can love their children very much and still be unable to show it consistently because of their disease. Information can also help children deal with the sense of betrayal they feel when parents contradict or deny things they said or did the night before. “You can do education about blackouts, and explain what blackouts are, and why parents have them,” says Ellen Morehouse, Founder and Director of Student Assistance Services Corporation in Ardsley, New York.

“By your painting that picture, the first thing you’re doing is breaking that student’s isolation. You’re letting that student know that you know what it’s like, obviously because other people have talked about it. And you’re making it a little bit safer for the them talk about.”

Morehouse cautioned that all of this information needs to be placed in words that will be appreciated and understood at the age level they are reaching. “Too often we use techniques that are not age appropriate. We talk in jargon that doesn’t make sense for the adolescent, instead of reframing it in a way that makes sense for kids.”

### **Targeting General Audiences of Children**

Far from being irrelevant to children whose parents are not alcoholic/addicted, “The messages that we’re talking about are important things for all children to hear,” says Davis. “We know at CASPAR, through some of the research we’ve done, that children hear the same information and apply it to their lives differently,”

Brooks talked about her experience in bringing these types of messages to general audiences of children, She found that children who didn’t come from addicted homes really wanted to hear what she had to say, and benefitted from it.

“If you talk about the pain and sadness and embarrassment of living in a home with chemical dependence, the kids who don’t live in those homes also appreciate it,” she says. “They feel connected too, because they inevitably have friends who live in those situations. They want to know, ‘How do kids deal with that? I have a friend who lives in a home like that. What can I do to help him?’

“And what more powerful way is there to let a child know about the dangers of alcohol and other drug dependence than to talk about the hurt they cause in the lives of other children?”

***Suggestion Box:***

**Making Help Accessible to All Children**

It's important to make the subject of addiction and families "talkable" and accessible to all children in school, rather than trying to identify specific children—and risking that they might feel "identified." We never know which children are living in that pain but hiding it from us. For that reason, information and education programs that reach the entire youth population will succeed in encouraging some children to reach out for help. In other cases, it will at least let them know they're not alone.

- Display posters, such as the posters from NACoA, in places where all children can see them.
- Show age-appropriate films on the subject from a variety of sources to general audiences of children.
- Keep books for children of addicted families accessible to all children. Some examples: *The Secret Everyone Knows*, *Pablito's Secret/El Secreto de Pablito*, and *My Dad Loves Me, My Dad Has a Disease*. Use these for reading assignments, or a read-aloud activity with class discussion.
- Bring in speakers from outside the school or program, people who will talk about their childhood in addicted families. Teens or young adults can be excellent in this role. They need to be willing to talk about what happened to them, and about recovery options. This works best in a small-group setting such as a classroom, because children have a chance to ask questions, but it can be done in a school assembly as well. It takes a different approach to the alcohol and other drug experience: It reaches children where they live.



## Screening Words to Avoid Doing Harm

Knowledge, insight, and compassion have been cited as essential qualities in one who seeks to address the problem of family addiction for audiences of children. Just as critical is the ability to screen words, to make sure nothing is said that will reinforce or aggravate the shame that is already a large part of many children's lives. As Brooks put it, "Watch how you refer to people and situations."

### **Avoiding Negative Labeling**

In addressing children, "The first step is for us to say, 'Look, there are a lot of kids in this school and the country who have moms and dads who drink too much, or use too much medication, or use too many drugs,'" says Morehouse. "Let me share with you some of the concerns, and some of the things that go on in some of these families.'

"Don't label them 'problems.' They're 'concerns.' They're 'issues.' And then you generalize, and you go through the common concerns and issues of kids who live in this kind of family.

"Notice the wording I use. I didn't say, 'Let me tell you about the problems and issues of children of alcoholics.' Because what we get from adolescents is, 'Wait a minute. I said my mom drinks too much. Don't you go calling her an alcoholic.' So use the words that a parent 'drinks too much, uses too much medication, or uses too many drugs.'

The last thing you want to do is put a label on the parent, so the child can go home and say, 'Well, mom, I was talking to Mrs. Morehouse today, and she said you were an alcoholic'."

### **Avoiding Moralistic Approaches**

Another danger exists in prevention programs that take a moralistic approach toward substance abuse in general, says Brooks. "There is a great deal of moral judgment that's coming back into the addictions field, and it's not coming into the treatment field, but into the prevention field," she says.

“Children—particularly post-latency-aged children—are very concerned about things legal or illegal, very concerned about good and bad, right and wrong. When you tell a child who comes from a substance-abusing family that driving drunk is morally wrong, and their daddy was drunk when he drove them to school, this sets up a tremendous conflict for the child. What the child concludes is that there’s something not good about him, and about his family.

Discussion of illegal drugs also requires care, says Brooks. “We find that most of the children we’ve been working with have dual-addicted parents. They are not just children of alcoholics my more. They are children of alcoholics and addicts. And children know about their parents’ drug use. A criminalizing approach is shame-based. It may work with the general population, but it doesn’t work with the high-risk kids.”

### **Respecting Children’s Survival Systems**

Denial that has outlived its usefulness can be a formidable obstacle to adults, blocking out the benefits of recovery. But for children living in alcoholic/addicted households, it can be their only defense—against truths too large to suppress but too dangerous to speak, against and levels of pain and danger that they are not yet equipped to process in healthy ways.

“With youngsters, denial takes on a whole different depth and dimension and quality,” says Moe. “Denial allows some kids to stay alive. Never take away a child’s denial and defenses. Because they go right back into that environment, an environment that you have virtually no control of. And kids break through their denial when they’re able, willing, and ready.”

Ellen Morehouse echoed that advice. “Remember,” she says, “the defense mechanism offers psychic protection. And if you remove an adolescent’s denial before they’re ready to give it up, they’ll regress into a more primitive defense.”

Children of addicted families are also often said to have difficulty trusting. According to Brooks, that difficulty is another important survival system. “The key, I’ve learned, is to see his lack of trust—not as proof of his pathology, not as something for you to change, not as something to talk him out of—but as something that makes complete sense within the context of his humanity, within the context of where his humanity was born, and most importantly, within the context of the magnificence of his survival.”

### **Respecting Children’s Cultures of Origin**

Before we attempt to help children whose cultures of origin are different from our own, we need to learn as much as possible about the values, norms, and customs of those cultures as they relate to families, family roles, relationships, and alcohol and other drug abuse and addiction. It’s even more important to understand the extent to which we don’t know what the legacies of those cultures are.

We can never assume that children or adults from different backgrounds have the same values and priorities that we do, or that they'll interpret words, gestures, and facial expressions in the same ways. It would be counterproductive to our purposes to go in assuming—or acting as if we assume—that our ways of thinking feeling, speaking, and acting are the right ways.

For example, in communities of color, we need to take strong family loyalties into account when we talk about parents who have alcohol and other drug problems. “There’s a greater conflict with loyalty,” says Black. “These are people whose population and identity has historically been very subject to attack. Talking about parents in a manner that does not hold them reverent or sacred is often perceived as betrayal.”

We need to start with an awareness that each family is a culture in and of itself. When we talk to children about families—even about families in general—we need to convey sincere respect for family cultures. When we are also crossing larger cultural boundaries, the burden of respect is even greater and more important.

***Suggestion Box:***

**Seeing Children in the Context of Their Own Realities**

One of the most important skills an adult helper can have is the ability to see children within the context of their own realities—to accept them exactly where they are in their development. It’s essential to respect their survival systems and honor them for who they are and what they’ve experienced. Our goal in helping children is never to ask them to betray their own sense of values, but rather to offer them additional, healthier ways of coping.

- Always remember to acknowledge and honor the fact that these children have survived very traumatic events and circumstances by developing certain defenses and behaviors. Do not attempt to “break” these defenses.
- In an environment of trust and respect, children are allowed to learn new behaviors gradually. Modeling these new, healthier behaviors with our own actions will do more to foster them than anything else we could do.
- Learn about any cultural issues that might affect how children act toward us, or perceive and interpret what we say and do. For example, in some cultures, children are taught to avoid eye contact with adults as a sign of respect; in these cultures, looking away is not a sign of dishonesty or avoidance. And in communities of color, criticism of one’s family is often seen as the ultimate form of betrayal. It’s important not to jump to conclusions.

## **2D:** **Listening and Understanding**

One of our greatest challenges in helping children of addicted families is the re-learning process we need to undergo in order to do the things they most need us to do: to listen to them, to respect their experience, and to understand their behavior in the context of that experience. According to Brooks, these three skills can do more to help than any amount of technical knowledge of the subject.

Often when we've read and studied and accumulated many years' experience, we're acutely aware of how much we know that children need to know, and how much pain we can save them by imparting that knowledge. But often a number of factors can combine to keep children of addicted families from being able to listen to what they most need to hear, or to respond to our best efforts to help them.

First and foremost is denial. As described in the previous chapter, denial is an important survival response; It's important for us not to try to break through that defense. These children's natural tendency not to trust people—particularly adults in authority—is another obstacle to our “getting through” to them with information that can help them. Shame plays a big part, too: the sense that we'll know how “worthless” they are if they open up to us.

And many children have the belief that no one could possibly understand what their lives are like. On deeper levels, of course, that can be true: no one who hasn't gone through what they're going through can really know what it's like for them. But most often we can help even if we lack a significant portion of their experience, if we're willing to be open and empathic.

Children hold back from talking about the experiences and emotions that they so desperately need to express, because they feel that their troubles are unique and shameful. With our responses to their words and actions, we can let them know that they're worthwhile, they're not to blame, and they're not alone.

### **Opening the Door**

The first step in trying to get children to be open to us, and to the things we say, is to cultivate and communicate a sincere openness to them and to whatever they might choose to say.

If we have fears about our own internal or external reactions, then we need to start by assessing and working through those fears. Many resources exist that can help with that process, including books, support groups, counselors, and other adults who have worked successfully with children of addicted families.

If our conflicts on this subject seem too deep to be resolved before our work is to begin, then our most effective contribution will be to step back and let someone else work with these children while we address our own issues.

Openness also requires that we relinquish a certain amount of control. We're much more vulnerable when we're listening than when we're talking, because we no longer control the flow of information and emotion. One answer to this is to become certain of our own resilience, and to decide to accept people exactly as they are.

Empathy and detachment are also essential ingredients of openness. "Empathy" is used here to mean the ability to put oneself in another's place and see things from his/her frame of reference, even though one might not share the specific views or experiences being discussed. "Detachment" refers to an ability to see people and issues in perspective, and to suspend any need to control or change people and events.

### **Learning About Their Experience**

Another essential ingredient of openness is a respect for how much we don't know about other people's lives and circumstances. It's essential to study what we can, through this and other sources, about the circumstances and effects of life in addicted families. But no matter what we've read, no matter what we've experienced in our own lives, our knowledge and understanding of anyone else's life will always be incomplete.

When it comes to other people's lives and experiences—even young children's lives and experiences—we're the students and they're the teachers. If we expect them to open up to us, we need to convey respect for their authority on these subjects.

The best we can do is to be as open as we can, learn as much as possible from as many source as possible, and listen clearly without prejudging what we hear. Only then will we begin to earn the trust that we need in order to be able to help.

### **Seeing Behavior in Context**

Often when we're entrusted with the task of helping children grow and develop, our natural instinct is to notice behaviors that will cause trouble for them or others, and to do what we can to help them correct those behaviors. With children of addicted families, this issue is complicated by the fact that many of their "problem" behaviors are actually their best attempts to cope and survive under difficult circumstances.

If we focus first on changing the behaviors that we perceive as inappropriate or confusing, our efforts are likely to fail, or to backfire. These behaviors—which sometimes include the use of alcohol or other drugs—constitute their survival systems. If we begin by asking them to give up the only means of emotional survival they know, we won't get very far.

If instead we learn to understand and respect those survival systems, and convey that understanding and respect in our words and actions, we will have made a start. After we've shown consistent respect over time, their trust will increase, and they'll begin to feel emotionally safe in our presence and in our programs. As that sense of safety increases, we can help them explore other options—healthier coping strategies.

For both children and adults, only when they've learned and practiced alternative ways of coping and feeling safe will they be willing to let go of the old ways. The process often takes a long time; rushing it can jeopardize its success. Often all we can do is plant seeds, be patient, and trust that process.

***Suggestion Box:***

**Creating Safety**

The most essential element of any effort to help children of addicted families is the creation of safety for them. Confronting, challenging, or contradicting their beliefs or behaviors doesn't make them feel safe; it only increases their defensiveness. It's most important that they feel understood. The following are some excellent responses that can be used by any adult who seeks to create a "safe, sharing environment."

- "That makes sense to me."
- "I believe you."
- "I'm glad you told me that."
- "Thank you for sharing your feelings with me."

**Never** ask a child, "Why do you think that?" or say, "You don't need to feel that way."

Most important, the adult helper must learn to be comfortable with expressions of deep sadness and anger from children. **Never** try to discourage or suppress those feelings.

### Respecting the Realities of Children's Lives

Presenting good information about family alcohol and other drug dependence is an important start. The next challenge will be to make sure all of our programs and materials—and the words in which they're presented—work for all of the children who need them.

For children who live in alcoholic/addicted families, traditional prevention programs often fall short, says Brooks. “They don't take into enough account who the high-risk children really are.” Along with the danger that moralistic approaches present, some prevention programs describe reality in ways that children of addicted families know are not true in their lives.

These are programs that paint substance abuse as something that exists “out there” among dangerous peers and lurking strangers. Parents are portrayed only as sources of strength and help, with no mention of the possibility that some parents are caught up in the problem, too. “The child or adolescent hearing these kinds of presentations often feels turned off to adults even more than they were before,” says Brooks.

“They feel that adults truly don't understand what's going on in their lives. This type of program is not only ineffective in working with high-risk children—it's often countereffective.

“This child's understanding of alcohol is so much deeper than what is being presented. ‘Yeah, they're talking about alcohol, but they're not talking about it in a way that means anything to me.’ I've heard this so often as a reaction from kids I've worked with. They sneer at it.”

#### **Danger is Not Just “Out There”**

She gives the example of a widely accepted prevention curriculum. In its lesson on “staying safe,” it talks about what children should do if they're riding in a car and the driver is drunk. “It says, ‘Get out of the car and call your parents.’ Can't you just feel how these kids are turned off when they hear that? Instead, we need to talk about, ‘What do you do when the person who is in complete control over you is drunk?’”

Another concern centers on the need that some programs have for parents who understand and support their children's participation. “We have to start by admitting that the kids we really need to reach have parents who won't come to our programs,” says Brooks. “We have to start thinking, ‘How can we create a program during school hours so their parents don't have to bring them in for it—so their parents don't even have to know there's a program’.”

***Suggestion Box:***

**Helping Children Express Their Realities Through Creativity**

Sometimes children have a very difficult time talking about the painful realities in their lives. But we can help them express those realities through creativity and play, in ways that aren't threatening to them.

- Create opportunities for skits and little plays, by providing props and simple costumes that would allow children to act out the everyday dramas they experience. For example, you could have a skit about a mom and dad fighting; a child being "bad" and being punished too harshly; a parent passing out from drinking; a mom not having enough money for food because someone took her money for drugs. The adult helper can outline the drama; the children can volunteer to take part if they wish to do so; and their creativity and personal experiences can take over from there.

Discuss the story of your "drama" afterwards in a non-threatening and non-personal way. If a child chooses to identify personally with some aspect of the play, thank him/her for sharing, but be careful not to violate the child's safety boundaries by probing too deeply within the group context.

- Puppets allow children to speak about things that are too painful to say for themselves. Puppets can be created as part of an art project; they can be made out of brown paper lunch bags with crayons; or they can be purchased.
- Providing an appealing array of art and craft materials will encourage children to express themselves in non-verbal ways. Modeling clay, collage materials, and glitter and glue spark particular interest.
- Simply providing a fresh box of crayons, some textured paper, and special markers (such as the ones that smell like different fruits) can make the "sharing" time more fun and less threatening. Allowing younger children to distract themselves from uncomfortable discussions by coloring creates a safe feeling for them.
- Collecting the children's artwork at the end of your time together and displaying that art in a special place, or asking the child to let you keep the artwork for the him/her, allows the child to be recognized for his/her creation. It also prevents their taking the artwork home with them, and the possibility of exposing them to parents' negative reactions to it. However, it's important to put up on the wall only the artwork that it would be okay for parents to see.

### **Making Sure Support Systems are in Place**

When information about the family disease is presented to general audiences, most children with strong denial systems will filter the words and keep them separate from the realities they're not ready to examine. But what about the children whose denial breaks down under the information? What safety and support systems must be in place before that has a chance to happen?

Suggestions from the children of alcoholics field include safety messages built into all presentations that deal with these issues; training for teachers and counselors before the presentations begin, so that they're ready to provide immediate support for children who need it; and ongoing counseling and mutual-support groups for children of alcoholic/addicted families, engineered so that their participation won't be known to their classmates.

#### **Safety Messages**

Safety messages can be fairly simple. "We're teaching kids about a concept called 'safe people,'" says Jerry Moe. "Because children of alcoholics—not only little ones, adolescents and adults—are notorious for always picking the wrong people to share things with."

A safe person, says Moe, is one who "doesn't laugh, doesn't blab, and isn't always drinking or using. The most empowering thing I could ever do for a child is help them hook up with these people in their lives, whether it's a recovering parent, a relative, a coach, a minister, or a teacher."

#### **Safe Atmospheres**

One can also work to make the atmosphere feel safe to children before beginning any presentation that might raise negative feelings, says LaPorte:

- One way of doing this would be to let children sit wherever in the room they feel most safe, like near an aisle or facing the door.
- Another would be to give children permission to leave the room if things get too uncomfortable; an adult with the appropriate training and skills could be available to help.

- A third idea LaPorte mentioned would be, before the presentation begins, to ask children to write down the names of some safe people—both in the present situation and when they return to their lives that evening—in case they find a need to talk to anyone about emotions that come up after the presentation is over.

### **Help in Understanding Denial**

Another good safety measure might be an explanation of denial. Children could learn why many parents who drink too much, use too many drugs, or take too much medication will deny the obvious—and in many cases, get very angry—if they’re confronted about it.

This could help children make wise choices about what not to say and what not to bring home. Moe cautioned never to let children take anything home—artwork, for example—that might alert alcoholic/addicted parents to the children’s growing awareness. “Then a safe space isn’t safe anymore.”

### **Preparing Teachers**

Brooks discussed the need to prepare teachers before information is presented, so that they will need to be able to respond appropriately to any reactions children might have. “What you really need do is to have an in-service for teachers before anything is done in school,” says Brooks.

In some schools she has found that many teachers are hesitant to be approached by children about problems at home. “A lot of times adults feel that, if child tells them about a problem, that’s a mandate for the adults to do something,” she says. “But in a lot of cases, nothing can be done, or should be done. So sometimes we work with a few teachers who are willing to talk to kids.

“Then in our presentations we say, ‘If anything comes up for you, you’ve got four people in this school you can talk to. They don’t have the answers, and they can’t change anything, but they won’t talk to your parents.’ A lot of times all a child needs is to see that they’re safe to say what they’re feeling. They don’t need counseling. They don’t need guidance. All they need is a safe place to talk.”

### **Having Support Systems in Place**

For the children who are ready to begin working on the issues generated in their families, it’s important that good programs be available, says Ruth Davis. “I feel very strongly that groups are the ideal way of working with kids,” she says.

“It’s very hard to communicate to a very concrete young child that they are not alone when they are sitting individually talking to an adult. In that situation, they are indeed alone. And there’s tremendous power in children sharing the experience, in helping them learn how to communicate with other children, in helping them learn how to support one another. That will translate to some of their other experiences, and I’ve found that they’re less likely to isolate when they’re outside school.”

The group for children of alcoholic/addicted families should be one of many groups run by the school, says Morehouse. For example, her Student Assistance Services runs groups for seniors, newcomers, children of alcoholics, and substance abusers, and a group called “parents, peers, and partying. “

“Nobody knows the names of the groups. We don’t say, ‘The group for COAs will now meet in room 101.’ Everyone just knows they’re coming to one of Mrs. Morehouse’s groups. The key to doing the groups for COAs is to make it anonymous, to make it really safe for them so they won’t be labeled and they won’t be stigmatized.”

The groups’ benefits are many, says Morehouse. “Who’s the best person to tell a COA what’s the best way to cope with the pressures they feel as a COA and as an adolescent? Other adolescents who have dealt with it. Kids can share solutions and ideas. The group also provides positive peer support for breaking the ‘no-talk rule’.”

### **Preparing Children For Outside Support**

According to Morehouse, another advantage of the groups is that they increase children’s readiness for Alateen and other 12-step programs—important resources that they may need to tap. “For too long school people have been saying, ‘Go to Alateen meetings’,” she says.

“And think about it: What happens if you’re Catholic or Jewish, and the Alateen meeting is at the Presbyterian church at 8:00 at night, and it’s 10 miles from where you live, and you’re only 5? The reality is that most of the kids who are in Alateen have parents who are already in recovery or in one of the other 12-step programs or treatment. But by being in a group in a school, the kids feel more ready and able to take a risk to get to an Alateen meeting.”

### **Supporting a Drug-Free Lifestyle**

One of the many benefits of these groups in children’s lives is the support they’ll find for making healthy life choices. These children have as one of their common bonds an understanding of what alcohol and other drugs can do to people. Their mutual understanding can help them support choices not to drink or use.

***Suggestion Box:***

**Creating a Healing Environment**

In order to provide a truly healing and safe environment for these children, helpers will need to create a sense of consistency and ongoing support.

- Make sure to, have some support for yourself before you attempt to give support to the children. This means developing at least one ally or partner with whom you can share the stress and exhilaration of helping these children. In working with children, consistent observance of all safety guidelines (for both emotional and physical safety) is essential.
- Seek professional training from people who have been doing this work for a long time. Several agencies offer this service. Attempt to educate and receive support from the administration of your school or program, so that your efforts are seen as part of comprehensive programming for the children.
- In developing plans for a support group, make every effort to have the group co-facilitated, so that the group can continue in the absence of one of the leaders. Try to plan your groups for a regular time and place.
- Develop a system whereby children can attend the groups without their attendance being an obvious clue to their home situations. Call your groups by a name that is positive and non-identifying, such as “winners circle,” “team,” or an animal name. Another possibility in the school setting is to identify each group as a class or a lunch-hour or after-school activity.
- Allow the children to participate with you in the development of mutually agreed-upon “safety rules” for the group, such as “no hitting,” “no name calling,” “no destruction of each other’s or the program’s property,” and any other rules that you believe are important to be consistent with school or program policies.
- Attempt to keep the environment as free, flexible, and nurturing as possible, limiting rule-making to the bare minimum necessary, and enforcing rules only because of the importance of creating “a safe place.”
- Confidentiality—the ability to speak freely within a trusting environment—is an important rule of any group. At the time each new child enters the group, be sure to explain confidentiality and trust to him/her in the group setting, and explain your requirement to seek outside help for any child who is in physical danger. Have each new child pledge his/her confidentiality about what is said in group, perhaps having the child look each of the other group members in his/her eyes as a way of making the pledge.

## Strengthening Self-Concept

It one of the most damaging—and most dangerous—legacies of growing up in a troubled family is an essential, underlying sense of shame, what can programs do to address that problem? How can we reconstruct and supplement the components of healthy self-worth, and teach them in terms that children and adults will accept and understand?

In Illinois, most prevention programs already place high emphasis on building self-esteem and assertiveness skills, in the context of peer leadership, peer resistance, and alternative activity programs. This is an important facet of prevention. But the suggestion here is a type of program that centers on self-worth—on the core elements that are necessary for its development, and the core attitudes that accompany it and allow it to remain strong.

This type of approach would require a synthesis of the types of concepts touched on in Chapter 1E, *Core Issues*. Concepts like healthy boundaries, age-appropriate expectations, acceptance detachment, direct communication, living in the present, and taking care of oneself (physically mentally, emotionally, etc.) could be described and modeled for age-graded general audience of children and adults.

The relationship between these types of concepts and healthy self-worth could be woven into the presentations, along with an affirmation that these are skills that can be developed at any age.

### **Example: Healthy Boundaries**

For example, a discussion of healthy boundaries might begin with a description of what boundaries are and examples of how healthy boundaries help in day-to-day functioning. The relationship between healthy boundaries and trust, self-esteem, and taking care of oneself could be explored.

Next it could describe the types of problems (reactivity, enmeshment, overcontrol, caretaking isolation, etc.) that people experience when they haven't learned to clarify and respect their own boundaries.

These discussions could be tailored to the appropriate age levels and illustrated with the types of concrete examples that would make them understandable to young children. For older children, teens, and adults, discussion could also cover the ways in which children form healthy boundaries when families function in healthy ways, and how that formation can be inhibited when parents' troubles are severe, or when parents were not raised with sufficient clarity around their own boundaries. Finally, the relationship among boundary problems and physical, sexual, and substance abuse could be explored.

## **Why Focus on Core Concepts?**

Although problems with these types of core elements do not cause alcohol and other drug dependence, they certainly can make self-destructive and self-defeating choices seem more compelling. They can also make recovery—from childhood trauma and/or later alcohol and other drug dependence—more difficult to grasp, or even to seek.

Many people never even encounter some of these concepts—“boundaries” is a good example—until they reach counseling, treatment, or recovery programs. Then the burden is much greater and the work much harder. Why not find ways to present these concepts before problems get to that point? It would by no means replace the recovery process for people whose childhood issues or adult patterns make that process important. But it might increase healthy functioning and make recovery easier if and when that path is chosen.

## **Non-Threatening Approach**

Translated into age-appropriate and culturally appropriate terms, this type of information could reach general audiences of parents, children, teens, teachers, and community members. The information could—and no doubt should—be presented separate from information about alcohol and other drug dependence in the family. That way, it wouldn't be quite as likely to get mixed in with the emotions connected with that issue, and children and adults still in denial wouldn't shut the information out.

These issues are not limited to addicted families. It would be fair to say that many of the pressures facing families can make it difficult—or impossible—to provide all of the types of consistent, healthy guidance that children need. This lifts the blame from the individual families, or even the disease of alcohol and other drug dependence, and places it squarely on history.

In working with parents, the best approach would be to ask them to think about the information in terms of their own lives—their own childhood experiences and their own development—rather than apply it immediately to the way they raise their children. This approach is less threatening, and unless the healing of their own childhood scars is underway, it will be much more difficult to address the present.

***Suggestion Box:***

**Maintaining Respect and Concern**

Above all, we need to maintain our respect and concern for the individual child. We need to build self-respect by showing respect.

- Remember that the child is your primary concern. Interactions with his/her parents may be futile, but what you are able to give to the child may give him/her the strength needed to cope with the difficult and perhaps unchanging situation at home.
- Respect the child's emotional and physical boundaries. Always ask for permission before hugging a child. Touch can be healing, but it must be safe and respectful. If you wish to show affection or concern for a child, a light touch to his/her hand, or to the back of his/her shoulder, is probably the safest expression.
- Many of these children never have a place to call their own. Attempt to create a special place that belongs to the children in your program. This can be created by having big pillows, bean bags, their art on the walls, and even a mural that they create on an available wall. This special place should be safe from the intrusion of adults who may be threatening to them.
- Many of these children also hunger for a sense of belonging to something "good." T-shirts and other personalized items that connect them with their support group—but do not identify them in any way with a problem—can create a positive sense of identification.
- In many addicted families, the loss of positive family rituals is a key factor in the children's dysfunction. Attempt to create as many positive rituals as possible between you and the children, and among their support groups. For example, young children can play a favorite game children at the end of each group session. The group can celebrate the birthdays of all participants. Holiday celebrations, with gifts of words of caring and support, are very effective. It's a good idea to open and close groups with introductions of each child, or a repeat of the pledge of confidentiality, or by making circles in which the children hold each other's hands and say an affirmation (such as "Hang in there!" or "Keep coming back!").
- Adult helpers and peers can encourage children to begin to think and speak more positively about themselves by teaching affirmations, such as "I am strong," "I can make the right choice," "I'm not alone," "I have people who care about me," "I'm very special," "Life is good," or "I can get beyond the pain."



### **Focusing on Strengths, Resources, and Resiliencies**

Simply put, children of alcoholic/addicted families are victims of negative messages. These can be small messages—a few harsh words now and then, a look of disapproval, a vote of confidence withheld—or large, loud, deafening messages.

Applied over time, these messages become a main staple of children's self-concept. Logic can't drown them out. Neither can success. Sometimes substances can for a while, but then they get much worse. And against all intentions they get passed on to the next generation of children, until someone has the courage to work on getting well.

#### **Positive Messages**

One of our most important opportunities is to begin as early as possible to apply positive messages. Backed up with respect and a willingness to believe in children's potential for health, these messages will have their effect.

It's a matter of pointing out strengths; they're already experts on their "weaknesses." "We spend way too much time looking at what's wrong with these kids, and we're not spending enough time looking at the incredible resiliency they possess to make it through," says Moe.

#### **Acknowledging Strengths**

In many cases the family itself is another important source of strength. Minimizing family problems would be a severe mistake, but it would also be a mistake to discount the love and other resources that exist there despite the troubles. We can take this into account when we talk about alcoholic/addicted family issues.

And some of the burdens that many children of addicted families develop and carry into adulthood—perfectionism, excessive responsibility, caretaking tendencies, to name a few—are actually strengths taken to excess. The challenge is not to reverse their direction, but to encourage balance.

## **Learning About Recovery Resources**

For many children of alcoholic/addicted families, an important step will be learning about 12-step recovery programs. Although the media are beginning to present more current and accurate information about these programs, many children and adults still attach negative preconceptions to them, unaware of the benefits the programs offer, even to people who are not yet alcoholic/addicted and not currently living with the disease. Many children of alcoholic/addicted families put off exploring those options until problems have progressed to high levels of pain.

The more we're able to understand and accurately describe what goes on in recovery programs, the more we can help remove the mystique and stigma from them in the minds of the children and adults who might need them.

## **Taking Strength from Cultures of Origin**

Additional resources of strength, dignity, creativity, and self-esteem lie in another legacy that these children have, that all of us have: the wisdom, values, and traditions of our cultures of origin. "We're all products of people before us, whatever culture we are," says Dempsey. "I think today, somehow, in all our cultures we're sort of developing this alcohol culture—this drug culture—because of things that have been lost. For all of us, the importance of where we come from is significant."

"I need to know that I am of African descent," says Jones. "I need to know that I come from a proud and ancient people. **We** need to know that. Whites need to know that. Latinos need to know that. Native Americans need to know that. Little kids need to know that."

We can encourage the full use of cultural resources, by studying and owning the positive values of our own cultures of origin, understanding and respecting the values of other cultures, and celebrating the diversity in which we live.

## **A Focus on Hope**

In prevention, this positive focus—on children, adults, families, programs, communities, cultures, and ourselves—may be our best resource in emulating Figueroa's traditional healer, the one who "exemplifies hope." We can keep that focus, through our study of the complexity of family dynamics, and through the words and programs we offer.

When hope is grounded, not in denial, but in an honest acknowledgment of both problems and resources, it can be strong enough to counter even the generational momentum of this disease. We can show with our words and our actions that, not only is a child's pain important, but so is that child's hope.

Figuroa's description of the healer sounds a little like the way we describe our vision of prevention: "The healer is action-oriented. S/he is knowledgeable, decisive, and actively involved. The healer brings enlightenment. S/he encourages understanding of one's humanity, while instilling hope. S/he models and inspires connectedness to everything. Every one of your actions is somehow affecting someone else.

"A healer brings empowerment. Telling the person who they are. A healer has the ability to help the person recognize their own strengths."

As troubles in life are laid down one by one, they can often be lifted one by one—a few kind words, a look of understanding, a vote of confidence. Figuroa told the old African story of the medicine man called in to heal a sick child. "The medicine man whispered a couple of words in the child's ear, put him down, and said, 'The child will be fine now.'

"An observer said, 'What is this nonsense? A couple of words, and this child is fine?' The healer turned around and said to the man, 'You're a fool! You don't know anything!' The man blushed, and he hunched his shoulders, embarrassed.

"And the healer said to him, 'If a few words could cause such suffering, could not a few words heal the pain?'"



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