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# An alcoholic family and its harmful effect on children

Rodzina alkoholowa i jej szkodliwy wpływ na dzieci

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## Abstract

A large number of people in our society have been brought up in alcoholic families – this is a difficult and often traumatic experience for a little, delicate human. Children are not capable of self-defence and can't understand why they have been deprived of respect and attention. Their adult emotional life is burdened by numerous unpleasant memories, fear, sadness and anger. Since the majority of Adult Children of Alcoholics are not aware of the relationship between their childhood and adult life failures, only few of them decide to start therapy.

*Keywords:* addiction, co-addiction, Adult Children of Alcoholics (ACOA) Syndrome, traumatic experience, ACOA therapy

## Streszczenie

Wiele osób w naszym społeczeństwie wzrastało w rodzinach alkoholowych – jest to doświadczenie trudne i często traumatyczne dla młodego, wrażliwego człowieka. Dzieci nie potrafią się bronić i nie rozumieją dlaczego są pozbawione szacunku i uwagi. Ich dorosłe życie emocjonalne jest ograniczane przez liczne złe wspomnienia, strach, smutek i złość. Ponieważ większość Dorosłych Dzieci Alkoholików nie zdaje sobie sprawy ze związku ich dzieciństwa i niepowodzeń w życiu dorosłym, tylko część z nich decyduje się na rozpoczęcie terapii.

*Słowa kluczowe:* uzależnienie współuzależnienie, Zespół Dorosłych Dzieci Alkoholików (DDA), doświadczenia traumatyczne, terapia DDA

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Alcohol addiction in a family is usually accompanied by inability to bring up and take proper care of children and their needs. As the number of families (especially those with many children and one parent) which suffer from unemployment is gradually increasing (which leads to poverty and helplessness), we see more and more dysfunctions related to alcoholism, violence, begging, prostitution and crime.

A family should be an environment where a child is prepared to perform social roles in adulthood. Therefore, a child from an alcoholic family, unprovided with such skills, learns how to deny problems instead of facing them and does not try to find solutions. A dysfunctional, alcoholic family presents a child with destructive patterns of social behaviour, aberrant rules and shapeless systems of ethical values which lead to malfunctioning in society and life directed at keeping family affairs secret ('Don't tell anybody!'; 'Don't trust anybody!'; 'Don't feel anything!'). Children from an alcoholic family are not familiar with relationships based on honesty, open-mindedness or trust. They feel lost and unable to find a balance between the world outside and their personal life. Finally, they develop self-defence mechanisms which allow them to survive domestic chaos and violence but which also, at the

same time, make it harder to function in the surrounding world. Stress experienced by these children results in suffering, fear, immunological and somatic disorders, and trauma [1]. Research by Witold Skrzypczyk proved that children who had suffered from traumatic experience in their families felt afraid of their parents, displayed anger or hatred towards them, and felt ashamed, guilty and lonely [2]. Beverly James highlights post-traumatic symptoms resulting from parental alcohol abuse such as intimacy disorders, the sense of loss and abandonment, helplessness, conversion disorder, fragmentation of bodily experience, stigmatization, erotisation and destructive behaviour [3].

All these disorders play an important role because they help a child to cope with trauma. Nevertheless, in future they become the source of numerous problems. Harm suffered by children from alcoholic families is also increased by the environmental neglect of their needs [4].

It has been reported by practitioners that the risk of developmental problems, as well as the ones related to adulthood, is much higher among children of alcoholics. Furthermore, levels of that risk can be increased by parents' psychological and intellectual disorders, aggression, poverty and a repeated alcohol drinking pattern. Long-term post-

traumatic effects on children result in somatic diseases, emotional disorders, lack of life satisfaction, difficulties forming relationships and violence [1,4].

Aleksandra Karasowska's observations also prove that young people from alcoholic families very frequently find it difficult to achieve personal wholeness, form long-lasting relationships and they often display tendencies to repeat destructive family patterns, including violence, which can be also accompanied by depression, anxiety and eating disorders. These problems, as other research projects show, usually continue in adulthood in the form of increased psychopathological symptoms such as fear, depression, hostility, lack of resourcefulness and purpose of life [4]. Apart from emotional or social functioning problems, children from alcoholic families may often suffer from different health problems that cannot be medically explained; they are usually more prone to some diseases (like allergies, asthma, anaemia, eating disorders) than their peers from properly functioning families. All these disorders may become more severe in adulthood and be enhanced by low self-esteem. Other diseases, which are common among children from alcoholic families originate from various heart and vascular disorders characteristic of Type A personality which usually becomes apparent in about 5-year-old children who try to perform so called family hero role. As was discussed in the previous paragraph, this is also the way to cope with a difficult family situation, but it is not without harmful effects for a child who is forced to become an adult too quickly by performing a parent role. In adult life people with Type A personality display impatience, aggression and hostility towards others, low self-esteem, etc. [5].

Maternal alcohol abuse during pregnancy threatens an unborn child with Fetal Alcohol Syndrome (FAS). It has been scientifically proved that a child's brain can be damaged even if a pregnant mother consumed high levels of alcohol only once. The main effect of FAS on children is permanent brain damage in the area of the frontal lobe responsible for attention span, self-control, self-awareness, personality characteristics, emotions, cognitive abilities, memory, speech and voluntary movements of specific body parts. FAS children's physical and mental development is slow and often accompanied by different heart, kidney, eye and other diseases. Other disorders caused by maternal alcohol abuse during pregnancy are related to Fetal Alcohol Effects syndrome (FAE). People born with FAE, unlike people with FAS, do not display any specific craniofacial features in their appearance and their IQ score may be as high as their peers' within the health norm. However, in their case brain damage can be also quite severe and in consequence may lead to some mental disorders. Children with FAE are not self-reliant, often

drop out of school, can be easily drawn into criminal circles, become addicted to alcohol and their sexual behaviour may be disordered as well [5].

A child brought up in an alcoholic family very often suffers from the syndrome called Adult Children of Alcoholics (ACOA). Therapists recognise three groups of ACOA:

1. People, who despite their alcoholic family background, are well adapted and their psychosocial functioning is normal, probably resulting from their high development potential as well as from a lesser amount of stressors affecting their childhood;
2. People with typical ACOA Syndrome who face numerous emotional problems, low self-esteem and difficulties forming intimate relationships; and
3. People with maladaptive behaviour, mental and personality disorders, suffering from addictions and neurosis, whose childhood was affected by numerable stressors; the etiology of their disorders is very complex [6].

Another piece of research, conducted by Krzysztof Gąsior, into connections between dysfunctional families and psychosocial problems or mental disorders in Adult Children of Alcoholics leads to the following conclusions:

1. In dysfunctional families, harmful effects on children result from factors such as:
  - a person who dominates and pressurises other family members and who has a destructive influence;
  - a father addicted to alcohol who uses violence;
  - the atmosphere at home is tense (constant conflict between parents), deprived of love, and the family has a negative image in the local environment; and
  - children lack parental care (specifically from the mother) especially in difficult and threatening situations.

According to the author, the two most harmful factors are the first two mentioned above (a father addicted to alcohol who dominates other family members and who uses violence).

2. A high level of family dysfunctionality correlates with problems apparent in adulthood, for example:
  - an increase in neurotic characteristics combined with symptoms of depression;
  - the forming of relationships is fraught with mistrust and inability to accept people as they are; and
  - a weak sense of coherence, resourcefulness and satisfaction in achievement; excessive readiness for making sacrifices and lack of distance towards the past [6].

Małgorzata Dąbkowska [7] proves that traumatic experiences of early childhood have a substantially harmful effect on mental health. The majority of dysfunctional families are alcoholic families where

numerous stressors affect a child's everyday life and may cause mental and somatic disorders. Children from alcoholic families live in constant fear, and feel helpless and tense, resulting in lack of stability, routine and, in consequence, a lack of control over their own lives.

An atmosphere of chronic danger and high levels of stress may lead to serious disorders in adulthood. The term "trauma" describes different types of difficult situations, ranging from minor failures to life tragedies, which negatively affect one's mental condition [8]. Post-traumatic Stress Disorder (PTSD) is a disease which has been introduced by the American Psychiatric Association into the classification system of mental disorders. The disorder may develop just after exposure to an event resulting in psychological trauma or much later. Not all people who suffered from psychological trauma are later affected by PTSD, and its occurrence depends on their personality, biopsychological factors and the intensity of the trauma.

An alcoholic family is a traumatic environment for a child. Children subject to chronic stress are anxious, frightened and always alert. Their vision of the world is based on unfairness, harm and uncertain future. Their families do not give them much opportunity to release tension and emotions [9].

Adult Children of Alcoholics, as mentioned before, do not feel secure and comfortable in the surrounding world. A constant state of excessive alert and fear often results in depression. A childhood traumatic experience can be relived during a later situation that resembles it, for example, when hearing shouting, and it causes a sudden reaction of fear.

Another symptom of PTSD in ACOA is apathy, which suppresses their emotions. This mechanism, which allows them to stay ostensibly calm, appears in their adult life when they experience sadness, feel helpless or rejected. Dissociation from their own feelings makes them unable to recognise any emotions at all and form intimate relationships, which they avoid for fear of being rejected. Quite often, their relationships are casual, without any strong bonds; this, they wrongly believe, protects them from suffering when a relationship is finished. Their partners are frequently alcoholics or other ACOA – this fact correlates with a mechanism of repetition. Apathy may be displayed by lack of activity or its opposite, which is also an efficient way to distract attention from emotional life.

Another symptom of PTSD is a sense of guilt. Children from alcoholic families are not able to blame their parents because they feel dependant on them and need somebody to rely on, so they start blaming themselves instead. As a consequence, they also experience opposing feelings – on one hand they love their parents, but on the other they feel hatred, anger and bear a grudge for harmful and violent treatment. Such a

bipolar emotional condition may lead to a very strong sense of guilt, which continues in their adult life and may even result in self-destructive behaviour and self-punishment.

ACOA usually find it difficult to ask for help. They postpone or even avoid talking about their childhood trauma. What's more, they can also change facts about their past because they feel ashamed, awkward and unable to trust people; thus, when starting therapy, they feel even more guilty for revealing 'family secrets' [9].

Despite the fact that co-addiction has not been classified as a disease, it is nosologically diagnosed according to the International Classification of Diseases, 10th Revision (ICD-10). Co-addicted people may suffer from functional and psychosocial disorders that can be related to genetic predispositions towards, for example, mental or behavioural disorders and alcohol or other psychoactive substance dependence [10].

Patients with co-addiction can display neurosis symptoms related to stress, for example:

F43 Reaction to severe stress and adjustment disorders [11].

F43.1 Post-traumatic stress disorder

F43.2 Adjustment disorder

and syndromes such as:

F41 Anxiety disorders (generalized, mixed and depressive)

F42 Obsessive-compulsive disorder

F45 Somatoform disorders

F60 Specific personality disorders.

A problem diagnosis is the next stage of the healing process. At the first meeting, the therapist tries to initiate a relationship with the patient and investigates their psychosocial situation, especially the current one, and the way the patient has coped with everyday life and difficulties so far. The therapist also tries to find out about the patient's expectations and motives to start therapy. A therapeutic interview should focus on behavioural changes in the patient's partner, changes in family structure, mental and physical health etc. Also, the patients' lifestyle, their financial and career situation, as well as their interests and ethical values should be examined very carefully and in detail. Another important aspect to diagnose is the patient's psychosocial functioning and self-attitude. If the patient is a co-addicted person, it is important to find out what beliefs are shared within a family or a relationship. A psychological interview should focus on problem areas concerning co-addiction and the whole diagnostic process should lead to a complete analysis of the patient's personality, including their current functioning, life experience and the events that caused these problems and that are responsible for various disorders, and shouldn't be limited only to a symptom description.

Apart from nosological and problem diagnoses, a clinical approach is very helpful because it complements other analyses with historical context that relates to sources of problems and disorders, particularly traumatic experiences in early childhood. Other important aspects to be analysed are relationships with people who played a prominent role in the patient's life, relationships with peers, schooldays, adolescence, sexual development, diseases, accidents, traumas and also adulthood relationships, birth of children, the patient's social roles and decisions [10].

Qualification criteria for psychotherapy:

1. Disorder severity: psychosis, permanent neurotic disorders and severe personality disorders cannot be treated by the type of psychotherapy discussed above. Disorder severity should enable investigation into a disorder mechanism and therapy treatment.
2. A patient's age is irrelevant – the majority of people starting therapy are 25-45 years old patients.
3. Current problems related to addiction, co-addiction or violence should be solved before starting therapy for ACOA. People who want to start this type of therapy must first undergo therapy for their basic problem [12].

The model of ACOA therapy is based on alcoholic family experiences, which develop improper attitudes and beliefs and lack of self-esteem. The main aim of psychotherapy is to help ACOA escape from an emotional trap. According to Zofia Sobolewska and Krzysztof Gąsior [12], expected changes should include:

1. An escape from the emotional trap of childhood, and recovery from a sense of harm and inadequate patterns of emotional reactions;
2. An improvement of self-esteem, and enhancement in sense of identity;
3. A change of psychosocial patterns, forming intimate and independent relationships; and
4. Introducing changes into life.

All these changes concern three spheres: emotional, intellectual and Self-sphere. The work on the emotional sphere concentrates mainly on high levels of fear and aggression; inability to experience pleasure; self-defence mechanisms, especially those concerning feelings (suppression and denial); and, finally, new interpersonal experiences which can be not only the source of harm but also pleasure and happiness.

The work on the intellectual sphere aims to create a new vision of reality (friendlier and less threatening); to change false beliefs about the surrounding world, people and self (to prevent tunnel vision which only suits the patient's beliefs); to abandon excessive faith in intellectual power to solve all, including emotional, problems (a calculating way of thinking, excessive control); and to learn to name feelings.

The work on the Self-sphere concerns self-esteem, independent of other people's opinions and assessments; on setting boundaries, which, in case of ACOA, are either very rigid or fluid; and on self-destructive tendencies [13].

The methods used in ACOA therapy are similar to those used in other forms of psychotherapy. Their choice depends on a patient's characteristics and problems. ACOA therapy may use Personal Therapeutic Programmes which are worked out by both therapist and patient in order to help introduce and enhance life changes through special tasks the patient should carry out between therapeutic sessions.

The whole therapeutic process consists of three phases:

1. A phase of exploring and expanding awareness – patients learn basic facts about how an alcoholic family functions, especially how children's upbringing appears to others and how it affects their life; patients use the knowledge to analyse the influence of their childhood trauma on adulthood; and they investigate family communication and patterns of thinking;
2. A phase of revealing and releasing emotions – at this stage therapeutic work concerns mainly revealing and releasing traumatic emotions, which is very important to transform old and harmful patterns of experience. This is a very difficult stage of therapy when transference between patients and therapists may become apparent; however, the therapeutic relationship can be deepened; and
3. A phase of reorientation and reorganisation – a stage at which patients start to make their life orderly and introduce changes, and thus the following results can be expected: patients get to know their limits and abilities; they can feel free from a sense of harm; and they change their behaviour due to a change in patterns of thinking [12].

Many authors highlight the fact that the most basic factor in psychotherapy, especially in ACOA therapy, is a psychotherapeutic relationship between a therapist and a patient (or a psychotherapeutic group) [12,14,15].

Adult Children of Alcoholics experienced trauma associated with people who were meant to play a prominent role in their childhood; hence, in their adult life, they still have the belief that other people do not accept them and want to use or harm them. Therapy offers them the opportunity to experience a completely new situation, which is a relationship with a therapist. According to Irvin Yalom [16], therapeutic help should provide a patient with an experience of a close relationship with a therapist. Many patients are afraid of intimacy because of their low self-esteem, which makes them think they are not worth forming a relationship with. 'For them, a close and caring therapeutic

relationship, which doesn't lead to the usually expected catastrophe, becomes a corrective emotional experience'.

Carl Rogers characterises efficient therapeutic relationships by three features: acceptance, respect and attention. Other authors give similar descriptions of factors, which form a basis for efficient therapy:

- 'being in' – a therapeutic relationship is based on empathy with a patient and complete acceptance – without judging, analysing and assessing;
- 'being for' – a therapist becomes a kind of guide and ally for a patient, supports, motivates and protects them; and
- 'being with' – includes the two above-mentioned factors, however both sides – therapist and patient – remain independent, listen to each other with attention, and share emotions and thoughts [17].

Czesław Czabała [14] says that 'psychotherapy gives the opportunity to experience a positive relationship when a therapist is sensitive to a patient's problems, expresses emotions, doesn't dominate but allows a patient freedom and autonomy and shows an attitude of warmth and commitment'.

A therapeutic relationship which provides patients with new experiences helps them understand that difficult and traumatic events from their past do not have to be hidden and their emotions do not need to be suppressed. Shared attempts to find new behavioural patterns may result in a patient's improved creativity. The experience of a therapeutic relationship can also enable a patient to fulfil important needs of attachment and supportive bonds. If all these conditions can be provided, any therapeutic method can be efficient.

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