Adult Children of Alcoholics: attachment, object relations and dependency patterns and implications for treatment

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Abstract

This research set out to explore attachment, object relations and dependency patterns in Adult Children of Alcoholics (ACA). An outline of what it means to be an ACA is examined, along with research into difficulties experienced by many children of alcoholics from their infancy. Results of numerous research in the field of attachment, object relations and dependency are discussed, showing significant differences between ACA and individuals who grew up in functional families, and similarities with people from other types of dysfunctional families. There are a number of interventions available for ACA treatment, with various clinicians proposing different approaches. Regardless of the style chosen, the aim needs to be helping the ACA understand the increased vulnerability that may be a consequence of growing up in an alcoholic household, and help ACAs see possibilities of change and support their move towards this change. The mixture of individual and group treatment helps to create more robust support and address a wider range of pathologies.

Chapter 1: Introduction

Alcohol harm to others

In the last decade there is a significant increase of research in the area of alcohols' harm to others. The studies are being carried worldwide, with countries of different economical wealth adding to the literature. Overall reports show that a large part of population is impacted by the problematic drinking of others, be it known or strangers, with more severe negative effects to people in drinkers' close circle (Hope *et al.,* 2018). Studies are partially being conducted in order to contribute to the World Health Organizations' (2010) call for policies to protect people who are being impacted by the effects of harmful drinking by others. This involves physical, economical, sociological and psychological harm and affects family, neighbours, co-workers and strangers (Hope *et al.,* 2018).

Irish Perspective

In Ireland, according to HSE report (Hope, 2008) in a ¼ of severe domestic abuse incidents alcohol is involved. The same report estimates, that the number of children under 15 living in the families adversely affected by the alcohol consumption is between 61,000 to 104,000. Ann Hope & North West Alcohol Forum Ltd (2011) elaborates on the effects on children, noting that:

- 1 in 10 of those whose parents **drank** alcohol during their childhood often felt ashamed or embarrassed by their parents' drunken behaviour or witnessed conflict with alcohol involved or felt unsafe as a result of their parents drinking
- The National Drinking Survey found that 56% of adults who engage in regular hazardous drinking have children living in their household. This suggests

194,000 families with children aged under 15. Considering 1.4 (statistical) number of children in the family, 271,000 children are exposed to risk from parental hazardous drinking. The estimated figure of children of all ages is over half a million.

- A comparison shows that adults who have children living in their home are more likely to drink at home (49% v 43%), are more likely to report family problems as a result of someone elses' drinking (18% v 11%), and are more likely to be drinkers (84% v 75%).
- The National Drinking Survey 2010 notes that 1 in 10 adults who are actively parenting reported their children being a victim to at least one form of abuse (verbal, physical, being a witness of and left in an unsafe situation). Parents who are themselves regular hazardous drinkers reported "others heavy drinking" related harm more often.
- Harm reported by lower social class is in the region of 15%, upper social class 10% and middle at 7%.

While there is a need to create policies and support to reduce the impact while it happens, or to eliminate it if possible, there is also a realistic need to establish the support network for those, who have slipped through the help available and managed to grow up in the family with at least one problematic drinker.

Who are Adult Children of Alcoholics?

Adult Children of Alcoholics (ACA) are one of the groups affected by the disease of alcoholism. Due to their experiences at early stages of their life they are at a higher risk of falling into substance abuse, and leading generally dysfunctional lifestyle (Woititz, 1984). The clinical definition of Adult Children of Alcoholics comes from Janet Woititz

1983 book “Adult Children of Alcoholics”. Basing her findings on her psychotherapeutic practice Woititz named 13 features that are in her opinion characteristic to Adult Children of Alcoholics:

1. They guess at what normal behaviour is.
2. They have difficulty following a project through from beginning to end.
3. They lie when it would be just as easy to tell the truth.
4. They judge themselves without mercy.
5. They have difficulty having fun.
6. They take themselves very seriously.
7. They have difficulty with intimate relationships.
8. They overreact to changes over which they have no control.
9. They constantly seek approval and affirmation.
10. They usually feel that they are different from other people.
11. They are super responsible or super irresponsible.
12. They are extremely loyal, even in the face of evidence that the loyalty is undeserved.
13. They are impulsive. They tend to lock themselves into a course of action without giving serious consideration to alternative behaviours or possible consequences. This impulsively leads to confusion, self-loathing, and loss of control over their environment. In addition, they spend an excessive amount of energy cleaning up the mess.

The book, originally refused by publishers, was eventually printed and available only on request, and not ordinarily on the shelves of the book shops. The road it took before it became widely available is somehow resembling the secrecy of living in an alcoholic household.

ACA has a theoretical character, based on the findings of practitioners, and while there is an established body of empirical research, the picture is still not unified nor clear (Margasinski, 2009). It is also subject to critique, which mostly relates to the questionable sample and control groups: many of the researches were based on experiences of people already in therapy or ACA self-help groups or 3rd level students (Margasinski, 2009). Some researchers suggested that children from alcoholic families function normally (according to the norms in a particular society) and that there is no major differences between ACA and control groups (Burk & Sher, 1988; Tweed & Ryff, 1991; Windle, 1990). Some critics suggests that the features outlined as characteristic to ACA can be easily applied to everyone, as they are written the same way as the horoscopes for popular magazines (Logue *et al.*, 1992).

Harrington and Metzler (1997) undertakes a research study aiming at comparing a group of ACA with group of Adult Children from Dysfunctional Families and a group of adult children from functional families. The subject seek to explore their perspective on their current relationship satisfaction. The outcome shows that people who grew up in dysfunctional families, including those in alcoholic families, do struggle with solving problems and experience higher general level of distress and dissatisfaction in intimate relationships. This is also a finding of numerous other researchers (Brown, 1988; Miller & Jang, 1977; Parker & Harford, 1988; Tweed & Ryff, 1991; Vannicelli, 1989; Wegscheider-Cruse, 1989; Woititz, 1984) with often added: lack of trust in others (Black, 1979; Wegscheider-Cruse, 1989), fear of loss of control (Black, 1979; Cermak & Brown,

1982), conflicts over personal responsibility with extreme polarised attitudes (Black, 2001; Cermak & Brown, 1982; Wegscheider-Cruse, 1989; Woititz, 1984).

This present research focuses on exploring the literature available on implications that growing up in an alcoholic household has on attachment, object relations and dependency patterns. In the light of these, the implications for the therapeutic relationship are then discussed.

Chapter 2: Growing up in an alcoholic household

Growing up in a family where there is a problematic drinker is inevitably challenging. Children are subject to experiencing risk factors specific to alcohol use (parental unavailability while under the influence) as well as those non-specific to alcohol use (parents' low levels of parental skills) (Grzegorzewska & Cierpiałkowska, 2012, 2015). Children are often both witness and victims of conflict, parental separation, assaults, and domestic violence. They can suffer from deprivation such as lack of a proper diet, lack of school books, clothes and toys due to the family's' high spend on alcohol (Hope, 2008). Frequent circumstances that occur in alcoholic families include: inconsistent parenting, unpredictable rules and limits, chaotic or tense family environment, poor communication, broken promises, loneliness and isolation linked to attempts to hide the family's' problem, in hope to reduce potential shame and embarrassment (Vannicelli, 1989). Lack of predictability and inconsistency sends mixed messages to the offspring, which affects their internal sense of safety. This creates an environment in which an individual experiences stress for prolonged periods (Dąbrowska & Oleś, 2016), which in turn dysregulates optimal body functioning, leading to overproduction of adrenaline. This is debilitating on behaviour, reactions and self-soothing abilities (Dąbrowska & Oleś, 2016; Gerhardt, 2015; Shore, 2000). Alcoholic illness often takes the attention of the whole family, taking away from its ability to meet physical, emotional and developmental needs of a growing child. This leaves an offspring with the necessity to develop coping strategies to deal with needs and demands (Vannicelli, 1989).

Being a child in an alcoholic family

Studies show that as early as in 18th month infants from alcoholic families, as compared to those from non-alcoholic families, show higher level of aggression. This level fails to decrease with age, while it does in the control group. Self-regulation, as an inhibitory control ability, is non-adequate and adverse effects of that are noticeable as early as in toddlers' relation to their environment. In later childhood it impacts their cognitive abilities (Park & Schepp, 2015). Many children of alcoholics are likely to have lower school achievements, display psychopathological symptoms, have diagnosable mental disorder (Park & Schepp, 2015; Schultz & Videbeck, 2013), experience learning difficulties, eating disorders, as well as engaging in compulsive achieving (Schultz & Videbeck, 2013). On emotional level children often develop a distrusting attitude to others, struggle with excessive need for control and disproportionate sense of responsibility (Schultz & Videbeck, 2013). They often have higher tendencies to externalizing behaviours (conduct disorders, ADHD, impulsive behaviours) and internalizing ones (depression, anxiety) (Grzegorzewska & Cierpiałkowska, 2012, 2015).

Being an adolescent in an alcoholic family

During adolescence an individual is negotiating a number of tasks in life. Some of them are accepting ones appearance, developing and maintaining intimate relationships, increasing autonomy and independence, identifying required life roles and planning for the future (Dąbrowska & Oleś, 2016; Ritter *et al.*, 2002). Undertaking those tasks in the context of having an alcohol abusing parent is often accompanied by disproportionate internalizing or externalizing behaviours. The former leads to exercising excessive control through denial and repression, and manifests in depression, anxiety, substance

abuse, sense of isolation as well as psychosomatic symptoms. The latter presents in the difficulty in experiencing intense emotions, especially those perceived as negative, leading to auto-destructive, direct and indirect, and destructive behaviours (Dąbrowska & Oleś, 2016).

Researchers notice an association between exposure to drinking and violence in the family during childhood with the quality of psychosocial functioning of an individual in adolescence. At that time of intensive changes and peer pressure, teenagers from alcoholic families show low levels of school bonding and family and personal strengths. They more often engage in antisocial behaviours (King *et al.,* 2009) and are prone to running away (Ritter *et al.*, 2002). There is also an evident emotional impact with higher risk of suicidality, eating disorders and teen pregnancy (Mylant *et al.,* 2002). If the alcohol issues in the family are longstanding, both parents are abusing it, or the other parent is co-dependent, parenting is often linked with physical violence used for harsh punishment, deficient monitoring of boundaries along with low social support (Ritter *et al.,* 2002). Alcoholism in a family often occurs with marital aggression. Witnessing family violence is linked with many psychosocial difficulties including young offending, disobedience, anxiety and lower social competency (Dąbrowska & Oleś, 2016; Ritter *et al.,* 2002). For children with exposure to alcohol abuse in the family of origin reports show a significantly higher risk of engaging in substance abuse in the adolescence (Dąbrowska & Oleś, 2016; Grzegorzewska & Cierpiałkowska, 2015; Mylant *et al.,* 2002) affecting both boys and girls. Exposure to alcohol abuse and violence increases the risk of deviant behaviour and conduct disorders in female adolescents (Ritter *et al.,* 2002). Alcohol problems in a family adversely affects adolescents general satisfaction in life (Grzegorzewska & Cierpiałkowska, 2015), and negatively influences self-esteem of adolescents of both sexes (Dąbrowska & Oleś, 2016; Ritter *et al*., 2002), with more drastic effects in females (Ritter *et al.,* 2002).

Role reversal – parentification

Parentification is described as a process in which a child takes up the role of a parent towards siblings, or immature parents, while neglecting their own needs (Grzegorzewska, 2016; Jones & Wells, 1996) or when a child is expected to act maturely and fulfil some failed ambitions of the parent, or a family (Jones & Wells, 1996). It is not classified within DSM or ICD, however some researches indicate, that parentification can be a predictor of narcissistic and masochistic disorders (Jones & Wells, 1996). Parentification happens in many families. On a continuum of this phenomena theorists differentiate between:

1) supported by parents exposure to new tasks,
2) temporarily needed and appreciated help during crisis (sickness, accident)
3) demanded and unrecognized role reversal with significant depreciation of boundaries,
4) and infantilisation – when expectations towards the child are significantly below their developmental capabilities.

Two latter ones have negative impact on childs' development, and tend to repeat in the next generation. The notion of "accounts due" is used to explain parents approach, when they believe that they are due to receive what they have given in the past to their own caregivers (Goglia *et al.*, 1992). Research in ACA confirms, that the destructive form of parentification is often present, due to parental shortcomings associated with the alcohol intake in the family (Grzegorzewska, 2016). Denial of ones own needs inevitably causes denial of ones problems. This leads to shaping of the "false self", which is there in order to maintain the system working, and avoid separation (Jones & Wells, 1996). The child does not know how to attend to oneself, and the presence of others, who need to be cared

for, is required to function. This role reversal is in place to compensate for the shortcomings of a dysfunctional family. It happens when the child is not ready nor has the competency to meet the demands. It is often replayed in their later life within other relationships (Grzegorzewska, 2016). Research in the field of ACA shows that some of them have a deeply rooted belief, that they must look after others at the expense of meeting their own needs (Goglia *et al.*, 1992; Grzegorzewska, 2016).

There are findings suggesting, that those of teenagers, who undertook parental functions in their families, often show resilience, which stops them from engaging in auto-destructive behaviours (Dąbrowska & Oleś, 2016). The question that the research does not address is the underlying reason for this responsible behaviour. Children of alcoholics show an increased capacity to care for others, and extremely strong sense of accountability (Goglia *et al.*, 1992). One could question, if resilient behaviour due to feelings of over-responsibility for others is a healthy pattern.

Resilience and protective factors

Resilience is defined as an individuals' ability to process and positively adapt despite the obstacles, dangers and challenges for optimal development; to seek to reduce risk factors and enhance protective factors in stressful situations (Dąbrowska & Oleś, 2016). There is a growing body of research showing, that many ACA grow up to be well adjusted, despite, or perhaps due to growing up in the alcoholic household (Dąbrowska & Oleś, 2016; Vannicelli, 1989). They can manage very well and adapt positively to changing circumstances, without showing signs of psychopathology. Research suggests, that the protective factors influencing that outcome are: inborn sensitivity levels, temperament, stage of development, attachment style, support from the wider community, family rituals, healthy relationship with older sibling (Dąbrowska & Oleś, 2016) and support

from a non-drinking parent (Dąbrowska & Oleś, 2016; Kornaszewska-Polak, 2019; Kucińska, 2002) as well as the level of violence in drinking, with less violent style possibly affecting the family on a lower level (Lease, 2002). Also higher levels of hope, sense of humour, determination and tolerance of the negative effects are linked to ability to induce positive emotions and negatively correlated with auto-destructive behaviours (Dąbrowska & Oleś, 2016).

There is some research on ACAs suggesting that this is a heterogenic group that includes individuals with adaptive as well as maladaptive behaviours. This leads to shaping a probabilistic, as opposed to deterministic, model of outcomes of living in an alcoholic household, (Grzegorzewska & Cierpiałkowska, 2015). In this more recent theory the outcome depends on dynamics between biological, psychological and social resources of the individual. Literature in psychotherapy, not linked to ACA research, suggest that having even one good modelling figure in childhood can lead to developing hope and faith in the future (Gerhardt, 2015; Miller, 2007). There is, however, no research into the presence of this factor in the life of ACA, who did manage to shape resilient behaviour patterns and those, who struggle with destructive ones. Research also suggests that children from families, where the problematic drinker entered treatment and stayed in it for over 5 years, are managing inter-personal relationships with peers and negotiating the identification of the current and future life roles as well as children of parents who did not drink (Grzegorzewska & Cierpiałkowska, 2012, 2015; Ritter *et al.*, 2002). There is also an emphasis on a positive relationship with a non-drinking parent (Obuchowska as cited in (Dąbrowska & Oleś, 2016; Kornaszewska-Polak, 2019; Margasinski, 2009). However, even after the problematic drinker enters the treatment, their children do struggle with gaining independence and separating from the family of origin (Brown, 1988; Grzegorzewska & Cierpiałkowska, 2012). Some findings suggest that resilience acquired in such adverse circumstances, comes with an enormous effort, significantly

higher than in individuals from functional families (Grzegorzewska & Cierpiałkowska, 2015), and it might be worth exploring if that has an impact on the perceptions of those resilient individuals. The notion of having to struggle throughout life may affect the perceived satisfaction from life.

Summary

Emotional, behavioural and social relating patterns in children of alcoholics are very similar at various stages of their development. While the publications reviewed are not follow up studies on the same group of individuals, it is noticeable that similar patterns emerge. Deficits in self-regulatory abilities and externalizing behaviours in infancy, correlate with disinhibitions in adolescents, who can act-out the emotion, or use substances for regulatory purposes. Poorer than control group emotional control in toddlers can be mirrored by psychosomatic symptoms in older children, their eating disorders, and mental health disorders. Distrusting attitudes in children can lead to researched low levels of bonding abilities in adolescents. This suggests that similar patterns can develop no matter at which stage of the child's' development the adult starts drinking. Another suggestion is that alcohol intake of parents, puts in place modes of coping, that stay present later in life of their children. And if there is no intervention put in place, those immature ways of dealing with internal and external stressors, needs and demands, can influence adult decisions of individuals, as well as their satisfaction levels in relationships and life in general.

Some of the coping strategies developed are beneficial in adulthood, others will not work. Those individuals who struggle could benefit from help in undoing some of the learned behaviours and modes of operation (Vannicelli, 1989). The literature review shows that one of the most troublesome developmental tasks for children whose parents drink, or

used to drink, is gaining independence and separating from the family. This is in line with clinical findings, that ACA often stay in an emotionally close relationship with their parents and siblings, even after starting their own family. This is paired with feelings that the family of origin is their real family, and that they are due to be a certain kind of child (Kucińska, 2002).

There is a need to address those, who experience issues following growing up in the alcoholic household. And that can be supported by identifying the developmental disturbances individuals have experienced, with aim to identify treatments that will address that.

Chapter 3: Psychotherapeutic perspective

Attachment, object relations theory and dependency, while linked to different approaches to the explanation of the origin of the development, are all ways of describing the nature and implications of the child's relationship with Others (Salter Ainsworth, 1969). The first other in human life is usually the mother, however soon enough the world perceived widens, and relations start to include more people: a father, grandparents, childminders and soon after neighbours, peers, and teachers. The baby, through experiences, creates internal working models of patterns of how the world reacts to the child, and the child to the world. Those are encoding ways to regulate the emotional arousal and individuals adaptation to relationships (Wallin, 2007). An individual learns when to regulate on its own (intra-regulation), and when, if and how to look for help from others (inter-regulation) (Gerhardt, 2015; Shore, 2000). The quality of care is thus of a great importance at the time of shaping the styles of being, as well as later, when the previously internalized patterns can be challenged, or strengthened. All three developmental theories imply that the quality of our relationships with others in adulthood is rooted in the quality of our relationships in childhood. Children of alcoholics tend to grow up in a chaotic, unstable home environments (Park & Schepp, 2015), have lower self-esteem (Schultz & Videbeck, 2013) and even genetic vulnerability (King *et al.*, 2009; Park & Schepp, 2015). According to research they are three times less likely to develop resilient behaviours during school age, and twice less likely in adolescence (Grzegorzewska & Cierpiałkowska, 2015). At various stages in their life they present with distrusting attitudes, difficulties in bonding, and struggles with intimate relating.

Attachment

Attachment is a term used to describe an affectional relationship and individual forms in relation to another specific individual (Salter Ainsworth, 1969). The first instance of it happens in childhood through relations with care givers. Attachment, once it is formed, tends to last. This means that even if the object of the affection is not present, an individual still remembers that person. It happens through the interlace of presence and absence of the object of the attachment, which allows a child to discover and trust the predictable outcome: that the object returns after separation. This feature, of remembering and expecting reunion, is what distinguishes attachment from dependency (Salter Ainsworth, 1969).

Main attachment behaviours include contact and proximity seeking (Salter Ainsworth, 1969). This can happen through a number of signals that the child is sending out to get the attention: reaching out, calling, screaming, and approaching the person it seeks a comfort from. Closeness seeking behaviour gets activated by a greater than usual distance from the attachment figure, or by an alarm. Illness, pain, hunger, and discomfort are in the array of triggers that activate attachment behaviours. The greater the intensity of activation, the more proximity is required to ease the affective state: at times a sound of voice is enough, at times the visual contact, and at times only physical proximity is seen as an accepted minimum (Salter Ainsworth, 1969). Attachment figures reaction to the proximity seeking behaviour also influences the choice of signals, as well as the decision when they are displayed. That experience shapes the competence and skills an individual achieves in negotiating meeting of its attachment needs and taking into consideration other people needs. This in turn, influences relationships with any new figure that an individual may attach to later in life.

Attachment patterns differentiate between secure and insecure. Securely attached individuals clearly express their needs, display joy upon reunion, have faith that their needs are going to be sooner or later met. Insecure patterns include avoidant, ambivalent, anxious and disorganized. In those, individuals learn that their needs are perhaps not understood and attended to, and chose strategies that allow them to keep the caregiver close. Those strategies stem from denial of any affectionate response to the attachment figure or bodily or emotional needs, through anxious display of tension, manifesting in clinging behaviours that are aiming at making the significant other stay close. The last pattern- disorganized- is characterised by experiencing the need to be close and at the same time the fear to be close to the attachment figure (Wallin, 2007). That style can spring from relating to the parent, who at times is warm and loving, and at times punishing and rejecting. Adult attachment style is linked with the quality of the romantic relationships and parenting in adulthood (Priel & Besser, 2001).

a) Attachment in ACA

Researchers link the unpredictability of the parental care in the alcoholic families with the internal working models of the unpredictability of the world in the ACA (Newcombe *et al.*, 1995). Lease (2002) emphasises the possibility, that behaviour linked with parental substance abuse may also be a significant factor influencing attachment style of ACA, with aggression impacting it possibly in a more negative way, than drunken withdrawal. This model leads to ACA's feelings of being lost, isolated, and struggling with recognizing and regulating ones' own emotional states (Grzegorzewska, 2016). Lack of trust that ACAs learn in the family home, often filled with broken promises and chaos, leads to maintaining the attitude of distrust further in life (Newcombe *et al.*, 1995). The

sense of a loss of control, of not knowing if needs are going to be met, leads to an active, forceful pursue to satisfying them, or indeed denial of having them. It is also possible that through the role reversal individuals are gaining some sense of control (Grzegorzewska, 2016). Parentification, with its role to delay individuation, is used as a coping mechanism against the fear of separation. Attending to the needs of others at the cost of ones' own, from the point of view of the attachment patterns, serves a purpose of ensuring the closeness of the significant other. By being important for a family system and people in it, an individual is ensuring that they will never be abandoned. This sense of omnipotence, which comes with caring for others, serves as a defensive mechanism for an immature psyche (Grzegorzewska, 2016). That style of relating, carried into adulthood, can take a form of compulsive caregiving, seen as a self-defeating style (Jones & Wells, 1996). In adult life an individual compelled to look after another is maintaining the phantasy, that it is compulsory to be needed to keep people close. Any negative or indeed lack of reaction from the environment, if ACA will seek for attention and help, can strengthen the belief, that unless ACA cares for others, they are not loved nor wanted. Jones and Wells (1996) suggested, that there are two main patterns of caregiving – narcissistic and self-defeating, depending on the reason for the original instance of surrounding of ones' own needs. Narcissistic style is more likely to develop when there is an expectation on the child to realize parents unfulfilled dream. It can be that "smart one" in the family, the "good one", "family's' pride". Self-defeating style could develop in children, who had to take on carers role in their families, minding siblings, or parents, "little helpers" in the family. The tendency to overachieve, displayed by many ACAs, links in with behaviours rooted in parentification, and so does the close relationship that ACA maintain with their parents, even after starting their own family or moving out. Kucińska (2002) describes how these contacts are often frequent, yet hostile, and filled with adult children helping,

supporting, and caring for their parents. This style of relating to care givers links in with insecure (anxious) attachment style.

Some research shows that ACA compared to a control group of non-ACA scored similarly on a secure attachment scale, and significantly higher on insecure attachment scale (Juroszek, 2012). However, this examination of a group of therapeutically involved ACA fails to inform how long each member is in the therapy. Juroszek (2012) also realises, that it would be beneficial to compare those involved in therapy, and those who have not been in treatment. Newcombe *et al*.1(995) takes on that task and findings suggest that there are no significant differences between groups of ACA and non-ACA in treatment as well as in corresponding groups of those not seeking one. With one exception: ACA who do not seek treatment score significantly lower on the self-regard comparing to the non-ACA who do not seek treatment. Negative self-image and view of others is linked with vulnerability to non-clinical depression, which is also very characteristic to ACA (Lease, 2002). Newcombe *et als'* (1995) research does not inform about the length of treatment of those in it, nor does it look into the corrective experience or reasons for resilient behaviours. There are numerous indications that "earned security" can be an outcome of a successful therapy of an individual who starts the therapy with an insecure pattern (Wallin, 2007). Newcombe *et al* (1995) also notice that the possible corrective experience, as well as triggered by parentification need to present as capable, in control and not needing, could have an influence on the ACAs' attachment scores in their study.

b) Romantic relationships

In adulthood secure attachment is linked with a positive view of others and self, and corresponds with more stable and positive romantic relationships (Lease, 2002). Growing

up in an alcoholic family, children may often observe an unhealthy model of relating to the romantic partner (Juroszek, 2012). Marital violence, unavailability due to substance intake, excessive control in relationship, lies, broken promises – while not all of them are always present in every family affected by the problematic substance abuse, they all affect the modelling of how the romantic involvement works. Especially violence, suffered or witnessed, is linked with insecure attachment in ACA women (Lease, 2002). ACA often withdraw into the world of phantasy dreaming about a perfect romantic love, or the one filled in with fascinating physical attraction and emotional stimulation, leading to experiencing something new. Some get involved in a very controlling relationship, filled with jealousy and obsessive thinking about other person, many of them are single (Kornaszewska-Polak, 2019). This shows how in adulthood ACA are hoping for a secure attachment, while in many cases they are re-enacting insecure relations or opt to avoid having a romantic involvement entirely. Research shows that ACA women often have an idealized picture of love, and high expectations towards their partners, with a need to be cared for and appreciated being the most common. High expectations are rarely met. In another study ACA women report thoughts that their family is not functioning well enough, and feelings of a lower satisfaction from their marriage and higher conflicts rate in that relationship (Domenico & Windle, 1993). Kornaszewska-Polak (2019) finds out, that ACA women are mostly attaching in an avoidant or pre-occupied style in their mature life, with only circa 10% attaching securely. These results show that this group is not homogenous – there is a variety of attachment styles present. It also indicates that many children of alcoholics suffer even after growing up. Researchers also notice that a half of examined women report having troubles in forming intimate relationships with others. This research explores the attachment style through the lens of quality of the relationship with non-drinking mothers (Kornaszewska-Polak, 2019). However, it seems unjustified pointing at mother-daughter relationship as a cause of insecure attachment pattern. In

those families there were also fathers, to whom their daughters did not attach securely, and who did not provide the corrective experience. Literature also mentions significant gap in studies with ACA of alcoholic mothers (Lease, 2002).

c) Parenting

Compulsive caring also reflects itself in parental styles of many ACA. They are often overprotective towards their off-springs (Kornaszewska-Polak, 2019), doubting their child rearing skills, and beat themselves up for not being a good enough parent (Domenico & Windle, 1993). Research carried on female ACA participants shows that those styles of parenting are often learned from their mothers. This suggests that there is a generational transfer of patterns of relating to the attachment figures (Kornaszewska-Polak, 2019). Comparative research on female participants (Domenico & Windle, 1993) suggests, that while ACA and non-ACA function in a quite similar way in the new family setting, ACAs have lower self-esteem and feel more depressed. They show higher levels of parental stress and have a tendency to ignore problems in a random fashion. They also feel helpless more often, when dealing with challenging behaviours of their children. ACA harshly judge their parental abilities and skills. At the same time, they do not feel they can look for support in their social network. Both groups have a similar rate of using tobacco, alcohol and marihuana, however ACA women felt they reach out for substances more often to deal with emotional tension. While this study is not taking into consideration attachment styles, experiences described are a manifestation of insecure feelings in relation to significant others – partners and children, as well as suggesting a very harsh view on oneself linked with a sense of isolation – when there is no one available to reach out to with a need for support. Those are the characteristics linked with insecure

attachment patterns, as described above. Another study on female ACAs (Kornaszewska-Polak, 2019) shows that many of them engage with an abusive partner, feel not respected, unhappy, not loved enough and lacking closeness in their relationships. Researchers notice that those ACA women tend to score highly on anxious-avoidant, and pre-occupied styles of attaching in the adult life – suggesting that unpredictable and mis-attuned care in the family home left them feeling inadequate, isolated, helpless and reaching out to unhealthy ways to maintain a sense of safety. Despite having alcohol abusing fathers, those women had a hostile relationship with their mothers, very often remembering them as rejecting and distant. Mothers are often blamed for leaving daughters with overwhelming tasks they were not ready to deal with, and failing to withdraw from unhealthy relationship with abusing father (Kornaszewska-Polak, 2019; Woititz, 1984).

Some research suggests, that there is a difference in attachment style between male and female ACA (El-Guebaly *et al.*, 1993). Study reveals that female attachment behaviour is heavily influenced by separation anxiety, and males are leaning strongly towards excessive self-reliance. Both are extreme ways of managing, suggesting unhealthy patterns. Those findings are from over 2 decades ago. In the last quarter of a century there has been a shift in the gender role assignment, and this could influence the way both genders are attaching in current times. For example, there is a popularly held opinion that experiencing alcohol abuse and violence in the family home leads male children to exhibit deviant behaviour and conduct disorders. However, recent research shows, that more often females are being affected in that way (Ritter *et al.*, 2002). Progressing emancipation of women and emotional equalisation for males is shifting a lot of previously held opinions of public, and it is likely that scientific results would also shift, if re-examined few decades later.

While having different names, insecure attachment is characterised by excessive detachment or enmeshed patterns of relating. Studies show difference between attachment scores for ACA and non-ACA. Lack of trust, vulnerability to emotional suffering, fear of emotional engagement, low self-esteem – all those features are characteristic of both: insecure attachment and experience of relationships of ACA.

Object relations

Object relations theories are attempts at explaining the influence of early experiences on the individuals' internal world. With its origin in Hungary, in the psychoanalytic school led by Ferenczi, the movement includes theories of Melanie Klein, John Bowlby, Margaret Mahler, as well as Winnicott, Fairbairn, Balint (Hinshelwood, 1991; Salter Ainsworth, 1969), Guntrip (Fairbairn et al., 1994; Gomez, 1998; Symington, 1986) and Karl Abraham. The latter one looked at the phenomenon of substance abuse from the point of view of the developmental model (Abraham, 1926). At times their theories contradict each other, but they all have one crucial thing in common: it is a belief that being an individual means being in a relationship. Object Relations theory explains how intrapsychic structures are shaped through interpersonal experiences. Object is the mental representation that an individual holds of the world (Hadley *et al.*, 1993). The feelings, that constitute that relation, are directed towards it. It all starts with infants' experiences of early relationships with caregivers (Holmes, 2001) mainly through internalization and rejection. The former allows to shape internal view of self, and the latter enables attribution of features to the external objects. These two realities, internal and external, are influencing each other. Both conscious and unconscious forces are dynamically operating in them, shaping how an individual experiences the world, and the self (Gomez, 1998). Theories imply that at the beginning baby is able to relate only to partial

experiences, good when needs are met, and bad when needs are frustrated. With time reliable experience of parental care allows baby to understand and contain the ambivalent feelings towards loved and frustrating object (Klein, 1952; Segal, 1988). If there is a mis-fit between babys' needs and the sources in the environment, pre-verbal techniques are used to navigate the survival. Often they are aiming at avoiding emotional contact. Creation of a "false self" (Phillips, 2007; Winnicott, 2001) leads to denial of needs, and protects the immature psyche of a child. However later in life these same techniques may cause a sense of futility, and emptiness (Gomez, 1998). An individual remains forever object seeking (Johnson, 1994) but if lacking sufficient connection in early days, one may encounter inability to maintain nurturing emotional relationships with people later in life.

Object relations theories focus on the pre-Oedipal anxieties, and how they might have been created in very early stages of life (Symington, 1986). Split in the mind, which Fairbairn (Fairbairn *et al.* 1994) paired into relationship with exciting rejecting object and unachievable accepting object, tears ego apart in continuous struggle of a need of being loved and having our love accepted by the other, with the contempt for the neediness of our being. If the disruption comes later in infancy, fear of losing the object, of being dropped, will also play an important role. As Fairbairn put it, the greatest trauma that the child can encounter is to have their love rejected. Fear of that gets in the way of having an emotional contact established and maintained. Quoting Winnicott: "what happened in the past can only be known about, by being projected into the future as a fear" (Phillips, 2007). Similarly, we can fearfully expect something that we have already been through, while hoping for it to never repeat itself.

a) Sense of Self

There is a gap in research addressing the object relations difficulties and pathology among ACA. Some research in Adult Children from Dysfunctional Families includes or refers to ACA. Hibbard (1989) examined ACA directly to discover, that they score significantly higher on object relational pathology. They show a greater level of self-preoccupation which, he concludes, depreciates their ability to maintain invested, appreciate the autonomy of others, and of becoming engaged in meaningful and realistic interpersonal relations. This in turn affects ACA occupational and romantic abilities, which clinicians notice as a characteristic of ACA (Hibbard, 1989; Kucińska, 2002; Woititz, 1984). Disruption in the ability to distinguish between self and others also leads to developing co-dependent character structures. In adulthood, it can show in the form of delaying separation from the family of origin, in order to establish independence (Grzegorzewska & Cierpiałkowska, 2012). Some research comparing females, of ACA and non-ACA backgrounds, showed that the former are significantly more dependent and self-critical (Hadley *et al.*, 1993). Both groups display very different views on their parents, with mothers generally remembered as warmer, fathers generally more positively idealized, and both parents less ambivalent according to non-ACA women. Ambivalence of parental object in childhood deprives an individual of stable relational experience. Mentioned earlier chaos, as well as parental shortcomings in an alcoholic family, are confusing the child, and lead to creation of an imbalance in relational capabilities. Stable relational experience allows to develop comprehension of a full object, which in turns enables the separation and individuation. Those lie at the heart of a healthy relation to self and the others. Parentification is a process that disturbs identity and autonomy formation, and this in turn leads to creation of a "false self" (Grzegorzewska, 2016). Disturbed relation to ones' own feelings and needs, reported in children from dysfunctional families, including

ACA (Hadley *et al.*, 1993) seriously impacts relations to others. It often shows in impaired problem-solving communication and general feelings of distress (Harrington & Metzler, 1997). An individual not tuned in to ones needs disregards them and engages in over-achieving or compulsory care-giving, characteristics of individuals, who were subject to parentification (Jones & Wells, 1996). This affects the romantic and professional relationships, and also parental abilities in adulthood. Many ACA are worried about their parental skills (Domenico & Windle, 1993; Kucińska, 2002), and even decide not to have children (Kucińska, 2002). Some, due to confusing models from childhood, pass on the parentification role-reversal to their offspring, or engage in role confusion by treating them as an equal partner (child-as-mate) (Goglia *et al.*, 1992; Grzegorzewska, 2016).

The notion of "false self" can also be linked with the clinical theory of roles taken in the alcoholic family. Wegscheider-Cruse (1989) suggested an idea of psychological roles that are adapted in alcoholic families. She based the theory on the family therapy concepts, which highlight the importance of family homeostasis. The presence of problematic alcohol use is disrupting it and roles are there to help to bring it back – an impossible task. Thus the children will never feel happy enough with themselves. Children may move from one role to the other, and will tend to have one they are in most of the time. Sometimes, if one of the siblings moves out others are taking up the missing role – according to family needs. The roles are: The Hero, The Scapegoat, The Lost Child and The Mascot (Vannicelli, 1989; Wegscheider-Cruse, 1989). Similarly Claudia Black (2001) supported the theory of role taking, and proposed a variation of those already known. Roles help children to cope while growing up. They are in place to keep the family secret hidden from all around. Alcohol use and abuse is not named and is perceived as normal. Shame and embarrassment around the alcohol induced behaviours are not welcome and have to remain silent. Confrontation is not welcome and causes a negative reaction. ACA tend to revert to their roles in times of heightened stress or anxiety. They

less often use the mature defences (humour, sublimation) and tend to choose the less mature ones (projections, acting-out, isolation, phantasies) (Wegscheider-Cruse, 1989). Such lists with definition can be helpful in organizing the theoretical stance. However, practitioners as well as lay people, need to be aware that there is always a phenomenological diverse experience of each individual, and need to make sure to do not enter the field of stereotypical outlook on the issue (Vannicelli, 1989).

Individuation allows for discovering the "true self", and attending to it provides a sense of being authentic. Parentification is a factor which undermines the development of the individuals "true self" (Jones & Wells, 1996). Unhealthy pre-occupation with others, their needs and opinions impacts self-esteem. This leads to feelings of being unauthentic, feelings of betrayal and shame, with associated guilt and anger – all presented by many ACA (Grzegorzewska, 2016). Shame reported in many studies and clinical analysis of ACA (Black, 2001; Grzegorzewska, 2016; Hibbard, 1987; Vannicelli, 1989; Wegscheider-Cruse, 1989; Woititz, 1984) is in object relations theory linked with rejection from parental figure, leading to feeling "broken", "faulty" at a deep level (Balint, 1979). It corresponds with the inauthenticity of developed "false self" (Winnicott, 2001), and is the most traumatic experience in the development of a child (Fairbairn, 1994). To navigate that in terms of survival, an individual internalizes the bad image of self that rejection evokes, and learns that only pleasing others can in some way bring about a sense of safety. Alternatively, one believes that it is the world that is bad, and avoids emotional relation with others out of fear of being subject to another painful rejection.

b) Re-victimization

Growing up in an alcoholic family is very often subject to traumatic experiences such as physical and sexual abuse (Dąbrowska & Oleś, 2016; Hope *et al*., 2018; Newcombe *et al.*, 1995). Being abused in early childhood can be linked with shaping a negative view of oneself, or as object relations theorists would call it – internalization of a bad object. It happens through a defensive splitting of the experience (Klein, 1952). The good is being assigned to the abusive, or neglecting, yet necessary for survival parent, the bad is being put into the view of the self to justify the abuse of "good" parents (Carey, 1997). It allows for protecting the image of parents, whom the child loves, and needs. This pattern, if not challenged, informs beliefs and choices of an individual. In the light of Object Relations theory clients internalized bad objects can only be released, if another person becomes good enough object (Guntrip, 1969). Symington (1986) calls it after Balint a new beginning. Object relations theory adds to understanding of struggles with reaching that point in life, when the change can be made. If the pattern is not challenged, abuse and neglect survivors maintain the view of self as bad, and unconsciously pursue the evidence to support the idea. This results in longstanding object relations disturbances with accompanying maladaptive behaviours, which include self-blame, lower capacity for moral behaviours, boundary disturbances, affective disturbances such as depression and impaired emotional contact (Carey, 1997). Re-confirmation happens also through re-enactment of the original traumatic relation. In case of abuse and neglect it means re-victimization. Carey (1997) suggested, that self-verification process is supporting dynamics of object relations theory. Self-verification theory suggests that people seeking feedback about what they see as negative in themselves are prone to accept only unfavourable input. It makes them unhappy, but satisfies the desire for self-verification, at the cost of blocking positive evaluation. This affects self-esteem, which has been

proved to be low in many ACA. Self-verification theory can help to understand the need to engage in unfavourable experiences and environments, which is also noticed in research of ACA.

Research confirms that victims of abuse tend to use denial, escapism and self-blame as their coping strategies. From the object relations theory perspective those are used to avoid confrontation of the self-other patterns. To delay facing internal relations withdrawal and disassociations are most common (Carey, 1997). All those defensive behaviours are confirmed to be recognizable in ACA. Impoverished sense of self is also associated with boundary disturbances. When an individual internalizes the bad object, it affects the ability to see oneself containing more than that. The notion of being bad rationalizes the others abusive behaviours towards self, debilitating the ability to set a clear boundary in relationships. Sacrificing ones' own needs in order to look after others is a trauma suffered by many of those who grow up in an alcoholic household. Many of ACA carry on this pattern, subjecting themselves to repeated re-enactment of the childhood trauma. Internalized sense of being bad may also lay at the core of low skills in communication during conflict, as well as venturing into self-destructive behaviours. Both tendencies are present in children of alcoholics from the earliest days of their life.

Dependence

Dependence is an antonym of "independence", and as such implies immaturity, and connotes the sense of helplessness (Salter Ainsworth, 1969). It is an important factor of a psychic life, which determines behaviours, affects and moods (Parens & Saul, 2014). It is a normal state that all humans are subject to in their early days in the world, and ideally it gives way to a growing independence. During the initial phases of development, the childs' efforts are orientated on actively looking for help, as children are heavily

dependent on the object for satisfaction of their needs. Reaching out takes different forms, depending on the stage of development. At first the baby signals the need through crying, toddler demands satisfaction of the need by physically engaging the object through pulling and pushing, and with time an individual learns to ask questions (Parens & Saul, 2014). At first the object is necessary to satisfy the need, with time child learns to bring about gratification of the needs by ones' own actions. The child does that by internalizing the care givers investment in looking after the child and learning from them how to treat oneself. For optimal development the optimal environment needs to be provided. It is what Winnicott calls "holding environment" and maternal love is required as a way of nurturing (Balint, 1979; Parens & Saul, 2014; Winnicott, 2001). Care givers attention and gratification of needs is allowing a child to believe that it is worth of loving and caring for.

When the child learns to be more independent, the object and its role are replaced by the "transitional object" – an inanimate object that can take all emotions and affects directed at it and what it represents, and survive (Winnicott, 1953). It is a way of moving from being dependent on others, to taking responsibility for satisfying ones' own needs. The object can withstand overwhelming love, great sadness and anger for not satisfying childs' needs. Later in life the degree of which the individual is incapable of satisfying its needs determines the degree in which it is dependent on the object (Parens & Saul, 2014). There are needs which will always require presence of another object, those are non-autoerotic and are independent of ego development. The pathology of dependence on other objects can develop in both ways – by being insufficient, or excessive (Parens & Saul, 2014). Some dependence will always be present in a healthy human. Throughout the life an individual comes across situations, that intensify the need for dependency, like experiencing an overwhelming anxiety, trauma, and arousal (Parens & Saul, 2014; Salter Ainsworth, 1969). Ambivalence in the relationship, if not resolved in a healthy way, tends

to heighten the dependency behaviours, aimed at proximity seeking. However, if anxiety and ambivalence are not tolerated, defences against them will dampen down the dependency awareness and behaviours (Salter Ainsworth, 1969).

Reactions to dependency can be of an acceptance of a need for object, or a thrust to self-reliance (Parens & Saul, 2014), and both are signs of maturity. Pathology shows in the reactions against the dependency. Individuals, who experience repeated object loss, may react adversely to experiencing a need, or being offered help. Among the most common unhealthy stances are rejection and denial. At the moment of having the need met, rather than experiencing pleasure, they feel shame. Another reaction against the dependency may be hostility. In that case individuals experience strong negative feelings towards their own need for others and even while observing someone else openly showing their need for others. Intensification of dependence due to loss of the object is also linked with depression. Many individuals who experienced inconsistency in object relating in childhood resist forming a relationship, out of fear of losing the object again (Parens & Saul, 2014).

a) Group experience

Reports from clinicians working in a group setting with ACA often reflect upon the dependency difficulties that members experience. Brown (1988) explains, how dichotomous thinking (all-or-nothing) shaped up at home is playing out in the group therapy. This style of thinking originates in one of the most primitive psychic defences – denial. In an alcoholic family, where the substance abuser is not treating the condition, there is an amount of denial that is necessary for the family homeostasis to be maintained (Dąbrowska & Oleś, 2016; Wegscheider-Cruse, 1989; Woititz, 1984). Denial becomes a

defence for many ACA, whose emotional, physical, psychological and developmental needs are not being met. In effect it leads to shaping of the dichotomous thinking, a belief that there is a right and wrong. This is also linked to intolerance of ambivalence, which affects cognitive structures responsible for differentiation between self and others, and ability to contain more than one affective response to an individual (Brown, 1988). This in turn leads to lack of tolerance for people who display the needs an individual is denying oneself of experiencing. Having needs is perceived as unacceptable by ACA, who experienced neglect (Goglia *et al.*, 1992; Grzegorzewska, 2016). Alternatively, those from overprotective environment can lack the ability to deal with their own needs (Parens & Saul, 2014). All-or-nothing perception compromises the capacity for insight, and undermines ability to expand level of integrations. Awareness of the possibilities outside of the core beliefs throws a light on the denied reality (Parens & Saul, 2014). Thus in a group, the issue of belonging, wanting to belong, having needs, closeness and distance, control and autonomy, surfaces. Core issues of deep needs and dependence show up in the group transference. The need for a stable, reliable figure to attach to, with whom individuals can bond and experience gratifying merger. A relationship, that will allow to undo the consequences of the parentification, or neglect, that they experienced in the family of origin (Brown, 1988). Such an individual will struggle with developing an autonomous sense of self in the group, and may experience an urgent need to control not only their own needs, but also the needs of others. The attitude to needing and accepting help, and defences used against dependency, are going to get in the way of forming healthy professional and personal relationships.

Chapter 4: Treatment for ACA

ACA are not a homogenous group, and not all individuals in it develop emotional and adjustment issues. However, there is an evidence of a heightened vulnerability (Hall & Webster, 2007). Also, issues that become paramount in working with ACAs are in fact coming up in a treatment of other people, who did not have an alcoholic family member. For example, in the ACA group therapy setting similar dynamics develop, as in any other psychodynamic therapeutic group (Vannicelli, 1989). However, there are benefits in consciously emphasising the theme of being an ACA. Addressing the fact of being from an alcoholic family breaks down the denial of parental alcoholism (Cermak & Brown, 1982) and helps to alleviate the guilt, and responsibility ACAs often feel towards the family of origin (Hibbard, 1987). ACA do have a tendency to blame and shame themselves for parental alcoholism, as well as other shortcomings, and this internalized view of self is often carried into other spheres of their life. Rising the awareness that individuals presenting problems are not entirely their own fault is usually beneficial. ACA cannot change nor erase the past; however, the reparative experience allows for the development of a more adaptive and appropriate ways of relating to a community. Through the therapy they can restructure cognitively their meaning making (Vannicelli, 1989). Meaning making is a key process in the formation of redemptive stories. Those are the stories in a personal narrative, that start negatively and end positively, and are filled with optimism, hope and promise. The redemptive stories are socially desirable, and this may lead to some individuals identifying their narrative identities with them despite living a different reality (Dunlop & Tracy, 2013). Research suggests that ACA tendencies to construct redemptive personal stories are linked with less adaptive psychological functioning (McCoy & Dunlop, 2017). This may be due to the fact, that they feel compelled to create a positive personal narrative, even though their life is not

reflecting one. Thus it is important to address the meaning making through the engagement in the therapeutic setting.

Vannicelli (1989) notices, that the construct of ACA is in fact deeply grounded in psychodynamic theory, through acknowledging the impact that early life experiences have on the later modes of relating and adapting. Attachment, object relations and dependency difficulties, displayed by many ACAs, impact their intimate as well as professional relationships. Insecure patterns are characterised with extreme reactions to separation from the attachment figures, ranging from hyper-vigilantism to dismissive stance (Lease, 2002), both used as defensive mechanisms and impacting personal relations. Also, general stressors are being dealt with better by people with secure attachment patterns, while in those with an insecure style it is linked with depression as a response to the overwhelm of the adult psychological distress (Lease, 2002). Often it is the repetition, or fear of the repetition, of the reality they suffered in as children, that is the trigger that brings about the process of breaking the denial and seeking help (Brown, 1988). Self-help groups can provide a place, where the experiences can be freely talked about, and the difficult emotions shared. They may, however, not be the best place to have difficult dynamics recognized, nor have enough professionalism to work through them, allowing for the emergence of the "true self", and successive separation and individuation (Vannicelli, 1989, Brown, 1988). Self-help groups are generally not commitment based, and they are also not design for therapeutic treatment. This means that they do not provide the consistency which group therapy does, and which allows for the positive transference to occur. Intimacy issues, occupational dissatisfaction, as well as psychological symptoms such as reactive and endogenous depression, anxiety, psychotic episodes, eating disorders and substance abuse can be a reason for ACA to look for treatment (Hibbard, 1987). Therapeutic assessment of the ACA usually uncovers deficits in the ego and superego structuralisation, distorted view of the self, and pathology

in the object relational representations (Hibbard, 1987) as well as insecure attachment styles. There are a number of interventions available for ACA and other individuals from dysfunctional families in general, with various clinicians proposing different approaches. Regardless of the style chosen, the aim needs to be helping the ACA understand the increased vulnerability that may be a consequence of growing up in an alcoholic household, and help ACAs see possibilities of change and support their move towards this change (Hall & Webster, 2007).

Individual therapy

Research in attachment of ACA shows that internal working models shaped in an alcoholic family is linked with unsatisfying intimate relationships with others in adulthood. Overwhelming emotional needs are often directing choices and behaviours. Kornaszewska-Polak (2019) suggests that this can be addressed and processed through emotionally focused therapy, which allows the client to address and heal the early learned internal working models. Attachment, object relations and dependency disturbances are emerging from early childhood experiences, when the relationship is dyadic in nature. An intimate relationship that can be facilitated by the individual therapy provides an environment, where deficits can be addressed and worked through. Studies show that therapy based on object relations and attachment may be particularly useful in work with individuals from dysfunctional families (Hadley *et al.*, 1993; Kornaszewska-Polak, 2019) to which ACA often belong. Behavioural assessment and approach can facilitate pinpointing the areas of concern, and provide ACA with support in re-learning more effective ways of tackling stressors and building and strengthening their resiliency (Hall & Webster, 2007; Ruben, 2001). Research shows that survivors of abuse need to create a safe therapeutic attachment in order to be able to learn about their re-enactment and re-

victimization patterns. Treatment with a high level of empathy, respect and collaboration is most effective in enabling a change for the client. Further research indicates that abuse survivors with severe pathology regress rather than improve, if the counsellor is using approaches aimed at breaking down the defences (Carey, 1997).

Developmental deficits in form of a poor self-image, or inadequate view of the external world, affect all human interactions, and as such need to be addressed and worked through. Awareness, that many ACA display symptoms of being from dysfunctional families, where there was not enough emphasis put on supporting their development, have implications for treatment. Researchers suggest that for individuals with compulsive care-giving styles evolved from role reversal, individual therapy is required in order to undo and counteract the impact on their development (Jones & Wells, 1996).

Reliability of the therapist provides a stable and reliable object the client can relate to. It can be very beneficial for a person in treatment, to allow to let go of the previously internalized bad object, or to challenge the externalized bad object. Healing disturbed object relations is a challenging task, which requires specific approach that allows for creating safe attachment to another person (Carey, 1997). It is likely to occur in a dyadic therapeutic relationship, where the client has an undivided attention of a reliable therapists. Clients abused in childhood do not feel loved nor lovable, and for the working alliance to be possible, they need to feel loved by their therapist (Levin, 1993). New attachment is very important for ACA, as breaking the denial signifies a loss of a parental bond, exposing an individual to intense dependency needs. At times a single therapist may struggle to be as responsive and as available as the client requires. For some individuals it is beneficial to join the group psychotherapy (Brown, 1988).

Group treatment

Vannicelli (1989) suggests, that group psychodynamic experience can be a valuable and enriching experience for clients, as well as therapist, who work with ACA individually. Group setting serves the role of a mirror of other important groups that people belong to. It allows the client to observe the patterns, engage with them, challenge and try new ways of being. Including a group therapy in the treatment plan seems to be plausible also due to the fact, that many of the attitudes involved in individuals' relation to a community are learned and established in a dysfunctional family. Members of the therapeutic group, sooner or later, behave there in the same way, as they did in the family of origin. The "family transference" allows for supported direct observation and exploration (Brown, 1988; Vannicelli, 1989) in a setting of trust and mutual interest. This style of the therapy work suits the need to address parentification, which required from an individual sacrificing their own needs to attend to that of others. Jones and Wells (1996) suggest family therapy as best option in order to break the impact of parentification in childhood. However, for those, who do not have their own family, or whose family is not open to treatment, or who do not want to get their family into treatment, attending the group setting can prove beneficial. Another advantage is that a group treatment is facilitated by an experienced therapist. Their experience and awareness provides an opportunity for a greater depth of insight, and increased possibility to objectively observe the dynamic, and offer if for exploration (Vannicelli, 1989).

In the therapeutic space the re-victimizations patterns can be considered, observed and most importantly addressed. In self-help groups those dynamics may not be fully addressed. Self-help groups are made of ACA, who are not subject to supervision following those meetings, thus there is also a risk of unconscious colluding between the members. Leader in a group therapy, by being able to separate from the emotional and

unconscious dynamics, provides an “observing ego” (Vannicelli, 1989). Attitude to the dependence in oneself and in others can be worked through in a group setting, where members are free to speak how they feel. Generally, the individual therapy is not involving the therapist needs, and is not involving disclosures, and allows only for a reflective work on personal and professional relations. Group setting allows for working on the situation as it happens. Through that, group therapy can facilitate the interpersonal awareness. It is one of the tasks of the therapy for abuse survivors, who display the tendency to re-victimization (Carey, 1997). Through more awareness a new identity can be constructed, and changes to cognition and behaviour introduced, facilitating separation (Brown, 1988).

The “positive transference”, in form of an idealized view of the group as a perfect family that can replace the old, dysfunctional one, is often present in initial phases of treatment. It allows for early bonding (Brown, 1988) and installation of hope (Yalom, 1980). Reinforcing that hope is also one of the tasks of the group leader. Through interpretations, that suggest attitudes and behaviours in group may evolve with trust being built, the leader is setting up sign posts, against which growth and development may be measured by members (Vannicelli, 1989).

Vannicelli (1989) speaks about the special appeal: in a group, individuals can deal with their problems, as well as observe others doing their work, and at times participate actively in helping others. Especially the latter can prove eye opening for some disowned similar issues, which usually become known sometime after. ACA theme groups can initially help to externalize the problem, and name it as a parental substance abuse. This in turn allows for externalizing the internal conflict, and makes it manageable to look at. It can also provide a relief for those, who were blaming themselves for a long time.

Gradually, the individual will be able to work their way through to their internal conflicts, and have courage and capabilities, to deal with them.

The issue of a fear of a loss of control is also more accessible to explore in a group setting, where each member may have a different view of what the group needs to be (Brown, 1988). It is often linked to the fear of being in a learner position, and a pressure to show oneself as capable and impressing others. The dependency issue shows up in an inability to ask questions, to ask for help, as well as fear of being seen without having control of what is visible to others. Having a leader, who is not bound by limitations of all-or-nothing thinking, allows for naming the perceptions that are at play, and looking at them and their effects on the group, and individual experience (Brown, 1988).

Importance of the countertransference

ACA grow up suffering narcissistic injury, and associated shame and rage (Levin, 1993). Some of them may not be aware of difficulties, some may suffer a range of recognized problems. Those suffering may seek treatment earlier, those not aware of problems may not seek help until they will actually experience problems (Brown, 1988). To treat the narcissistic wound, shift in identity is required. This carries the fear of a loss of an object, of attachment, and client needs to use the therapist as a "transitional object" (Brown, 1988; Levin, 1993). In this concept in Winnicotts' theory of the development – a child, while growing and becoming more independent, attaches to an inanimate transitional object. It is serving a role of a defence against anxiety, becomes more important than a parent, and almost inseparable from the child. It is also a recipient of all intense emotions (Winnicott, 1953). Therapist, when one becomes the transitional object for the client, needs to be able to survive any re-enactment in clients emotional states and views of the world, without raising psychological defences (Kahn, 2001). Those emotions may include

rage, anger, hurt, as well as love and dependence. The therapist, working with ACA, as well as other clients, needs to be aware of their reaction to all of those states. Group in a therapeutic treatment may also become such facilitator for the transition (Brown, 1988). After denial is broken, and the parental bond is perceived as lost, an individual may attach to the therapeutic group, and use it to create more adaptive ways of being, and make peace with loving parents and feeling disappointed at the same time (Brown, 1988).

Countertransference is generally a name for all feelings aroused in the therapist in relation to work with a particular client, or a group of clients (Vannicelli, 1989). It can be of a great value, if understood and decoded by therapist, allowing for an insightful view into clients' inner life, or the therapists' own issues, which may need to be worked through. If the reactions are not understood, they can get in the way of the therapeutic process. Countertransference can be signalled by shifts in attitude towards client, pre-occupation with a particular client, changes in the therapeutic contract (Vannicelli, 1989). Those changes can be clues to the nature and intensity of particular clients' emotional states. It is thus very important to have the contract and ground rules made explicit, in order to notice shifts, and use them to explore therapeutically, and add to understanding of the presenting issue. Consistency, and observation of any deviation from it, is particularly important when working with ACA, who often grew up in an unpredictable, chaotic environment (Vannicelli, 1989). Any consideration of introducing the change would be best addressed with a supervisor, or an experienced colleague, preferably one, that will challenge the reasons, and induce exploration of what is behind the feeling, that rule needs to be changed. Another reason for paying a particular attention to countertransference, is that many therapist working with ACA are ACA themselves, or in fact all are adult children in a way, that they do have a need to address something from their dysfunctional past (Vannicelli, 1989).

Awareness of the countertransference allows for insightful interpretation, rather than re-enactment or acting out of the emotions. Strong feelings of caring, so familiar to therapist working with ACA (Brown, 1988; Ruben, 2001; Vannicelli, 1989), if not interpreted as an insight into clients' needs, can take a form of an agenda the clinician may have for the direction of growth. If therapist wants the change for the client, then the client may split off that part of themselves and project it to the practitioner, leaving the resistant part as the one they identify with. The internal conflict gets externalized and client may oppose to the change wanted by the therapist (Evans & Gilbert, 2005).

Importance of speaking about ACA

The fact of growing up in an alcoholic family does not mean, that difficulties in adult life are going to be definitely present. Rather, the dysfunction of an alcoholic family, not addressed nor worked through by the members, is what can be a source of difficulties later. There is a number of reports showing that the differences between the ACA and adults originating in other dysfunctional families are scarce. Thus clinicians are called to use caution when using ACA label (Harrington & Metzler, 1997). In fact Vannicelli (1989) points out, that creating ACA focused programmes for the therapeutic work, can support creating a myth, that adult child issues can be addressed only there. Her expertise shows, that any psychodynamic related group therapy can be beneficial for addressing issues developed by growing up in a dysfunctional family. She, however, emphasises the benefits of having ACA together in the group, to allow for shared experience to emerge, increasing the possibility of initial bonding, and for creating support that people of similar background can provide in overcoming the sense of isolation. This sense of loneliness is particularly applicable to ACA, due to stigma of alcoholism and secrecy around it, while facing outsiders, as well as internally, within the family. Also working with the intense,

unconscious and conscious, dependency needs can make it difficult for the single therapist to stay tuned in, as powerful transference is very hard to bear psychologically (Symington, 1986). Group therapy in the theme of ACA can facilitate sharing of the intense emotions (Brown, 1988).

Shame, guilt, sense of betraying the parents and the family by up-taking treatment and the possible subsequent abandonment by them, can be powerful motives to delay breaking the denial and seeking help (Brown, 1988). Speaking of experiences of ACA, normalizing in the public awareness of their impact, can encourage at least part of those who could use some support, to look for it. Vannicelli (1989) notices that focus, which the world literature and treatment provided to ACA, might have opened up an entry to treatment for people, who would otherwise not look for help. The idea, that the difficulties can be back traced and possibly worked on provides a hope for adult children of alcoholics. The ability to observe and relate to group members is also an opportunity for learning, and installing further hope- component strongly linked to resilience.

Summary

Being an Adult Child of an Alcoholic has two meanings: it is being an adult experiencing fears and reactions of a child, and a child forced to grow up pre-maturely, losing a chance to go through natural stages, that result in a healthy adult (Ruben, 2001). In a way, not being an adult is serving a role of protection against acting out the pathological identification, becoming “like a parent” (Brown, 1988). Some of those individuals continue into adulthood with childish or adolescent identification and behaviours locked in place. Those who seek treatment have an intuitive knowledge, that what they learned at home is not normal.

Deficits in attachment, pathology in object relations and defences against dependency are getting in the way of creating meaningful lives. Due to the fact of growing up in a dysfunctional family unit, their view of themselves can best be exposed to change through re-learning how to relate to groups. Psychodynamic group therapy offers such possibility, providing space to observe, explore and work through the old ways of being. Intimacy relations can be best tackled in an individual therapy. Combination of both provides an individual with a chance to address difficulties in community through having to share the members and space with others, as well as discover importance and benefits of having their own space, where they can get the attention that was not sufficient for their development. Creation of a new, "earned secure attachment", process of letting go of bad objects, discovering the "true self" are all components of therapy, and interlace in the treatment. Breaking of the denial brings to awareness losses in various spheres of life: relational, educational, social. Grieving over them is an integral part of therapy for ACA.

It is important to remember to assess each individual separately for their readiness to take part either in individual or group therapy. There is no rule as to with which an individual can start deconstructing their disturbed view of reality. It is dependent on each person individually.

Chapter 5: Recommendations

Increasing awareness about the harm use of alcohol causes to others puts the light upon a need to address it. It is even more important, when the affected are children, as they are less capable to seek help in a wider community. There is also a need to create support for those, who after growing up, are still experiencing struggles. Research into protective factors is growing (Dąbrowska & Oleś, 2016; Grzegorzewska & Cierpiałkowska, 2015; Mylant *et al.*, 2002; Park & Schepp, 2015), and hopefully will lead to designing the intervention plans and policies that support the development and strengthening of resilient behaviours. There is, however, a gap in an insight into reasons behind resilient behaviours in individuals from alcoholic households. Addressing this in research could add to understanding and possibly creating a more facilitating environment for those affected. Resilience often emerges in individuals, as a result of being subject to parentification in childhood. However, they may feel compelled to care for others, and not necessarily for themselves. It would be worth researching in a long term study, if the resilience in those individuals is still present, once they are responsible for themselves only. And to establish if they have a tendency to take up caring roles later in life. There is a need for understanding, that ACA are not a homogenous group, and each person affected presents with various outcomes. Some are managing better than others. And some are experiencing issues along with the inability to ask for help, or to use help provided. Research shows, that even if they do not look for treatment, they still score lower on satisfaction from life and self-regard.

The subject of ACA is particularly important in the Irish setting. The estimated number of children growing up in a household with drinking adults is over a half a million. With the growing research on alcohol harm to others, specifically in the Irish setting, the need

to help those affected is undeniable. It is in society's best interest to support ACA in overcoming their difficulties, so they will not be transferred into another generation.

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