

White, W. (2005) Fire in the family: Historical perspectives on the intergenerational effects of addiction. *Counselor*, 6(1), 20-25.

**Fire in the Family:  
Historical Perspectives on the Intergenerational Effects of Addiction**  
William L. White

*Alcoholism is a fire that has raged through my family for generations. We've all been burned. We all carry its scars. –a client*

Interest in the effects of addiction on the family system and the prolonged developmental effects of children exposed to parental addiction has ebbed and flowed for nearly two centuries in America. Periods of illumination and enlightened response to addiction-affected families emerge, only to be re-engulfed by social stigma and public and professional misunderstanding and neglect. A recent essay details the history of family perspectives on addiction, tracing those perspectives from the American temperance movement, to the rise and faltering of the adult children of alcoholics (ACoA) movement and family-centered approaches to addiction treatment, to the role of family members in the New Recovery Advocacy Movement (See <http://www.bhrm.org/advocacy/recovadvocacy.htm>). This much briefer essay will extract from that history a few key lessons about the impact of addiction on families and family members and about lay and professional responses to families affected by addiction.

**Addiction and the Family**

*Family adaptation to addiction distorts family roles, rules and rituals; negatively affects family subsystems (adult intimacy dyad, parent-child relationships, and sibling relationships), alters the family's relationship with the outside environment, and affects the long-term development of children exposed to parental addiction. While modern studies have added scientific credence to these assertions, such studies only confirm the realities that were first conveyed in the literature of the American temperance movement. The temperance novels of T.S. Arthur and temperance plays such as The Drunkard, One Cup More, and The Doom of the Drunkard portrayed the devastating effects of alcoholism on the family as vividly as any subsequent scientific study.*

The modern understanding of the effects of alcoholism and other addictions on the family begins with the publication of Joan Jackson's 1954 article, "The Adjustment of the Family to the Crisis of Alcoholism," and her subsequent articles on the developmental problems experienced by children of alcoholics (Jackson, 1954, 1964). Subsequent family studies evolved through several stages of primary focus: the alcoholic wife, the alcoholic marriage, the nature of the alcoholic family as a dynamic system, the effects of alcoholism on children and adult children of alcoholics, and family therapy approaches to the treatment of a broad spectrum of substance use disorders.

### **Parental Addiction and Child/Adult Development**

*Childhood trauma resulting from parental addiction unfolds developmentally within three domains of adult life: emotional turmoil, disorders of perception and thought, and self-destructive behaviors.* During the 1980s, growing interest in the special needs of children of alcoholics generated the concepts of "co-alcoholism" and "para-alcoholism" (Greenleaf, 1981) that were further amplified by the writings of Claudia Black and Sharon Wegscheider-Cruse. These writings graphically depicted the developmental effects of parental alcoholism on children and catalogued how these experiences continued to affect children of alcoholics in their adult lives (Black, 1982; Wegscheider-Cruse, 1985). Professional interest in and responses to the needs of children and adult children of alcoholics have ebbed and flowed since peaking in the 1980s. Greater continuity of support can be found within the arena of mutual aid groups for families impacted by addiction. Such continuity is reflected in the family support groups within the American Temperance Movement and by the progressive growth of Al-Anon and other family support structures since the mid-twentieth century.

### **Intergenerational Transmission**

*Biological vulnerability, developmental trauma and social learning interact to elevate the risk children of alcoholics face in their own relationships with alcohol and other drugs.* In 1835, Robert MacNish observed that alcoholism could "descend from parents to their children" and went on to suggest that while this might result from "bad example and imitation," it was more likely a problem of "family predisposition" (p. 61). One of the founding principles of the American Association for the Cure of Inebriety (1870) was that the disease of inebriety could be inherited or

acquired. Modern research has shed considerable light on the complex etiological roots of addiction and how multiple factors interact to sustain the intergenerational transmission of alcohol and other drug problems. I envision a future in which interventions into severe alcohol and other drug problems will include a central focus on breaking intergenerational patterns of problem transmission. If achieved, that focus would mark the full integration of treatment and prevention technologies.

### **Addiction other than Alcoholism**

*The experiences of family members confronting alcoholism periodically break into public and professional consciousness (even in the autobiographies of our Presidents), but the experiences of family members facing other patterns of addiction have been long-cloaked in silence.* The professional literature on the latter is very meager (focusing mostly on adolescents) and is eclipsed by depictions of such experience in the non-scientific literature, e.g., Eugene O’Neil’s autobiographical depiction of his mother’s opiate addiction in Long Day’s Journey into Night. It is important for the addiction professional to recognize that most of what we know about addiction and the family is based on studies of alcoholism and may or may not be applicable to other patterns of addiction and recovery.

### **Family Support Groups**

*Family support groups have provided a sanctuary of healing for family members wounded by addiction for more than 160 years.* Women and children wounded by alcoholism sought shelter in a rising Temperance Movement of the 1830s. Many women within the American Temperance Movement had experienced the tragedy of alcoholism in their families. Involvement in local temperance societies served therapeutic functions for the daughters, sisters, wives and mothers of alcoholics (Bordin, 1990). America’s early recovery mutual aid societies often created auxiliary societies for wives (e.g., the Martha Washington Society founded in 1842) and created junior auxiliaries for children. These auxiliary societies flourished in the nineteenth century, dissipated in the early twentieth century and were revived via the rise of the “Alcoholics Anonymous Associates” and “Non-A.A. Groups” organized in 1951 into Al-Anon Family Groups which later (1957) spawned Alateen. Al-Anon, which currently has more than 390,000 members in 30,000 registered groups, has been widely used as

a model of family support by other recovery mutual aid societies (Humphreys, 2004).

## **The ACoA/Codependency Movement**

*The ACoA/Codependency Movements illustrate how recovery mutual aid movements can be wounded by “fuzzy thinking” (over-extension of the concept of codependency) and colonized and corrupted for personal and institutional gain.* The writings of Claudia Black, Sharen Wegscheider-Cruse, Janet Woititz, in the 1980s marked a significant shift, in which the alcoholic’s family members were viewed, not simply as sources of support for the alcoholic’s recovery, but as patients in their own right, who suffered from a condition that required treatment and support services. This transition gave rise to a new clinical specialty within the psychotherapy and addictions fields—counseling children and adult children of alcoholics—and gave rise to a broader social-support movement. Adult Children of Alcoholics (ACoA) groups were formed within Al-Anon—some 1,100 by 1986—and the National Association for Children of Alcoholics (NACoA) organized more than 1,500 local groups between its founding in 1983 and 1990 (Brown, 1995). (See sidebar for a chronology of the ACoA Movement)

In the late 1980s, the writings of Melody Beattie, John Bradshaw and others extended the concept of co-alcoholism to the concept of codependence. Codependency was defined via an ever-expanding, all-encompassing symptom checklist. Interest in co-dependence, fueled by Beattie’s writings and Bradshaw’s lectures on PBS, spawned Co-Dependents Anonymous, which by 1990 had more that 1,600 registered groups (Makela, et al, 1996). Responding to this wave of interest, addiction treatment programs began offering treatment tracks for persons suffering from the “disease of co-dependency” and began extending residential stays for alcoholics and addicts to address “codependency issues.” This produced both an ideological backlash (biting critiques of the concept of co-dependency) (Katz & Liu, 1991; Kaminer, 1992; Travis, 1992) and a financial backlash (erosion of treatment benefits) sparked by perceptions of profiteering within the addiction treatment industry. Insurance companies, observing the ever-widening conceptual net of codependency, reasonably concluded that they could not provide coverage for a disease that apparently almost everyone had. These companies backed away from coverage of codependency treatment during the same period in which they began to impose severe restrictions on coverage for the treatment of alcoholism and other addictions. Whatever original value existed within the concept of

codependency was rapidly swept away amid these backlashes and will await retrieval (and probable re-christening) in the future.

## **Family Members as Advocates**

*Family members affected by addiction have historically been a potent force as they banded together to pursue broader policy issues related to the sources and solutions of alcohol and other drug problems. Such advocacy efforts span:*

- the “Women’s Crusade” and “Children’s Crusade” of the 19<sup>th</sup> century temperance movement,
- advocacy for mandatory temperance education, drinking age laws, and state and national prohibition of alcohol,
- the local alcoholism councils of the mid-twentieth century that laid the educational and legislative foundation for modern addiction treatment,
- issues specific advocacy campaigns, e.g., MADD), and
- participation and leadership roles within the New Recovery Advocacy Movement that is spreading across the U.S..

Historically, when systems of care for addiction weaken or collapse, recovering people and their family members reorganize to address those inadequacies.

## **Professional Disdain for Families**

*Family members of those suffering from alcohol and other drug problems have historically been viewed as a cause of such problems or an obstacle to their solution. There are only brief and isolated periods in which professional treatment has been a place of welcome and refuge for addiction-affected families. From the earliest days of addiction treatment, wives of alcoholics were viewed by the staff of those institutions as hostile interlopers (An Inmate, 1869). This perception continued well into the twentieth century, where mid-century goals were not to treat the alcoholic family or involve family members in the treatment of the alcoholic, but to isolate the alcoholic and coax the family into a position of non-interference (Cutten, 1907; Strecker and Chambers, 1938).*

Family members, particularly mothers and wives, were also blamed for the alcoholism of their sons and husbands. Peabody (1936) viewed

maternal domination as a primary cause of alcoholism, and Whalen (1944) and Futterman (1953) created crude clinical classifications of wives of alcoholics (e.g., Suffering Susan, Controlling Catherine, Wavering Winnifred, and Punishing Polly) and depicted these women as neurotic, sexually repressed, dependent, man-hating, and domineering (See Day, 1961 for a review). The typical therapist's view of the wife of the alcoholic in the mid-twentieth century was, "I'd drink, too, if I was married to her" (Reddy, 1971, p.1). These views were challenged only when scientific studies (Corder, Hendricks, & Corder, 1964) of spouses of alcoholics (mostly Al-Anon members) failed to support these characterizations.

### **The Short Era of "Family Programs" (1950s-1970s)**

*The "family programs" linked to inpatient treatment programs (1965-1985) constitute a Camelot period in the treatment industry's response to families—an era of rapid knowledge development that was aborted via the closing or dramatic restructuring of most inpatient treatment programs in the late 1980s and 1990s.* There were several pioneers in the development of family-oriented alcoholism treatment models during the 1960s: Johns Hopkins Hospital, Sandstone Hospital and Hazelden and Lutheran General Hospital, the latter two having experimented with residential "family week" and "family weekend" programs (White, 1998). Family programs spread rapidly as an innovation within the "28-day rehab centers" during the 1970s and 1980s, but fell rapidly in popularity as lengths of stays were progressively shortened and third party payors stopped paying for what they deemed "ancillary" services. Since the late 1980s, the addiction treatment field has been in a period of disengagement from families within the mainstream treatment system. (The only exception to this is the increase in family therapies for adolescent substance use disorders. See Liddle & Dakof, 1995). Programs that have continued strong family programs (e.g., Betty Ford Center) are the exception today. What these cycles of family engagement and disengagement suggest is that family-oriented services have existed only as a weakly attached appendage to the American system of addiction treatment. The 1970s and 1980s represent a brief window of clinical progress in which the complex wounds of family members affected by addiction were recognized and treated in their own right.

### **The "Trauma of Recovery"**

*Recovery from addiction is a process that so dramatically alters family structure and process that family researchers have coined the demands of such adaptation the “trauma of recovery” (Brown, 1994).* The research of Drs. Stephanie Brown and Virginia Lewis challenge the expectation that families can rapidly regain health following the initiation of addiction recovery. The chaotic family environment during addiction often continues well into the early years of recovery; recovery can destabilize family relationships; and without support, families that survived all manner of insults from addiction may disintegrate from the demands of recovery. Family research confirms the need for family-oriented models of treatment and family-focused, post-treatment monitoring and support services.

### **Family Disease: Rhetoric versus Clinical Practice**

Professional responses to those affected by addiction evolved through several overlapping stages in the modern era: referral of wives to Al-Anon, facilitating support groups for wives of alcoholics, conjoint marital therapy, the development of intervention to engage the addicted family member in treatment, family education programs and primary treatment for family members focused on their individual recoveries. Alcoholism/addiction has been characterized as a “family disease” since the mid-twentieth century. That rhetoric continues today, but there is little evidence that such beliefs permeate clinical practice. If we really believed that addiction was a family disease, we would not assess, treat and provide continued support services to individuals in isolation from their families. We would instead deliver family-oriented models of engagement, assessment, treatment and continuing care. The movement to develop such models in the 1970s and 1980s needs to be revitalized and sustained in the twenty-first century. Two groups must join to lead this revitalization movement: family members affected by addiction and front-line addiction professionals.

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