Children of Substance-Abusing Parents
Dynamics and Treatment
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Shulamith Lala Ashenberg Straussner, PhD, CAS
Christine Huff Fewell, PhD, LCSW, CASAC
Editors
Dedication

To those who as children suffered from substance abuse in their families and to those who have dedicated themselves to healing them.
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Foreword

Nearly 19 million children (one in four) in the United States live with a parent who abuses or is dependent on alcohol. Additional millions of children and adults have been and continue to be impacted by other parental substance abuse.

These children often grow up in homes characterized by unpredictable and even chaotic behavior. While many are highly resilient, others are often at higher risk for emotional, physical, and mental health problems, such as depression, anxiety, eating disorders, and suicide attempts. They may suffer from low self-esteem and have difficulty in school. They are also much more likely than other children to become addicted to alcohol or other drugs themselves. These issues do not end in childhood. Adult children of alcohol- or other substance-using parents often continue to demonstrate adverse emotional, behavioral, and mental health consequences. They are also at high risk to develop a substance use disorder or marry someone who has one, thereby passing on the problems into the next generation.

Social workers and other health and mental health professionals have a long history of working with young and adult children of alcohol- and other drug-abusing parents, and in the last three decades have helped to develop a significant body of research-based knowledge and clinical wisdom. This knowledge has led to the development of core competencies for mental health professionals that can guide them in providing increasingly effective interventions and support programs for impacted young and adult children and their families.

Children of Substance-Abusing Parents: Dynamics and Treatment is a necessary reference for all mental health professionals and students who need to understand and treat this population. It offers an invaluable look at treatment options and programmatic interventions across the life span and fills an important gap in the current literature. The contributors include a wide range of experts who provide up-to-date, evidence-based clinical and programmatic strategies for working with children of alcohol- and other substance-abusing parents of any age and in almost any practice setting.
This highly recommended book is a valuable resource for all practitioners and students concerned about this very large, but often hidden, group of individuals and families.

Sis Wenger  
President/CEO  
National Association for Children of Alcoholics
Preface

It is estimated that 27 million children in the United States live with a parent who abuses or is dependent on alcohol or other substances. Additional millions of young and adult children have been and continue to be impacted by parental substance abuse. Thus, is it a rare social worker or other health and mental health professional or educator who does not encounter such an individual in their everyday practice and even in their own private life. This book is intended as a clinical reference for all those encountering young and adult children of substance-abusing parents regardless of the setting.

Each of the chapters is written by an expert familiar with both the most recent research studies as well as the application of theory and research to clinical practice. Throughout the book, clinical examples guide the reader in how to best intervene with the particular group of children of substance-abusing parents the authors are addressing.

In addition to providing important evidence-based information and guidance to working professionals, this book can be used by both undergraduate and graduate students in a variety of fields, ranging from social work to psychology, nursing, medicine, and education. This edited book is divided into four parts:

Part I provides an overview of the existing state of knowledge regarding children of substance-abusing parents and examines the developmental effects of alcohol and other drugs on children and implications for practice. Chapter 1 by Straussner provides a general introduction and overview of the issues in this field and is followed by Fewell’s chapter focusing on the latest theoretical conceptualization affecting parent-child interaction, that of mentalization and how it can be applied to clinical practice. The final chapter in this section, by Lam and O’Farrell, identifies the dynamics typically found in substance-abusing families and their implications for family treatment.

The four chapters in Part II explore treatment issues across the life span of children of substance-abusing parents beginning with the prenatal impact and spanning the life cycle. The emphasis is on those individuals who need treatment in a clinical setting. Chapter 4 by Pomeroy and
Parrish provides the latest research data on the prenatal impact of substances on newborns and the implications for effective interventions. It is followed by a chapter focusing on treatment issues and intervention with young children and their substance-abusing parents written by Johnson, Gryczynski, and Moe. Chapter 6 by Fenster identifies the treatment issues and interventions with adolescents from substance-abusing families, while the next chapter written by the expert on psychodrama, Tian Dayton, identifies treatment issues and psychodrama interventions with adults who grew up with substance-abusing parents.

Part III of this book focuses on programmatic interventions for children of substance-abusing parents across the life span. The first chapter in this section, Chapter 8 by Smith, focuses on prevention and early intervention programs for substance-abusing pregnant women, and is followed by Mallow’s chapter on exemplary programs designed for young children with substance-abusing parents. Morehouse’s Chapter 10 describes a variety of school-based and residential programs aimed at adolescent children of substance-abusing parents, youngsters who are often at great risk to become the next generation of substance-abusing parents. Chapter 11 by Venarde and Payton discusses the large, often overlooked, population of college students with substance-abusing parents. These authors provide examples of effective interventions specifically designed for this age group. Begun and Rose conclude this section with an important chapter focusing on the growing number of children with substance-abusing incarcerated parents.

The final section of this book includes four brief, real-life personal accounts of individuals who grew up in substance-abusing families. Their vivid and poignant descriptions of their early traumatic lives reflect both the pain experienced by children of all ages who grew up with a substance-abusing parent as well as the resilience that is found in many such children and which allows them to go on and succeed in life and become caring professionals.

Given the limited literature on this important topic, we strongly believe that this book makes a critical contribution to those working with or concerned about the millions of young and adult children whose parents abuse or have abused alcohol and other substances.
Acknowledgments

Writing and especially editing a book is always a communal endeavor. We would like to thank all the authors who made this book possible and who were willing to keep revising the chapters to make it into a coherent book. We also would like to thank Jennifer Perillo, Senior Acquisitions Editor at Springer Publishing Company, who first approached us about a book on this topic and has been a constant source of support, and Sis Wenger, CEO/President of the National Association for Children of Alcoholics, for all her work on behalf of children of alcohol- and other drug-abusing parents.

Shulamith Lala Ashenberg Straussner
Christine Huff Fewell
I. Conceptual Overview of Theory and Practice

1

Children of Substance-Abusing Parents: An Overview

Shulamith Lala Ashenberg Straussner

Addiction does not begin and end with the abuser; it sends shock waves through an entire family unit. The reach of substance abuse also extends to schools, communities, health and welfare agencies, the justice systems, and to society at large. We all shoulder the costs. Children of substance abusers suffer the most—from direct effects on their physical and mental health to influences on their own use of tobacco, alcohol, or drugs.

(CASA, 2005, p. 1.)

INTRODUCTION

According to the latest U.S. government data, approximately 22.3 million persons 12 years or older, or 9% of the U.S. population, met the diagnostic criteria for alcohol or other substance dependence (AOD) or abuse (Substance Abuse and Mental Health Services Administration [SAMHSA], 2008). Of these, 15.5 million were dependent upon or abused alcohol, 3.7 million were dependent upon or abused illicit drugs, and 3.2 million were dependent upon or abused both alcohol and illicit drugs. However, as indicated in the quote above, addiction, or the abuse and dependence on alcohol and other drugs, “does not begin and end with the abuser.” Millions of family members are impacted by substance abusers, including an estimated 27 million children who live with a parent who
abuses or is dependent upon alcohol or illicit drugs (National Center on Addiction and Substance Abuse at Columbia University [CASA], 2005). More critical is the fact that substance abuse by parents is more likely to involve the most developmentally vulnerable of all children, those who are the youngest: According to SAMHSA (2008), almost 14% of children living with a substance-abusing parent were aged 5 or younger, compared with 9.9% of youths who were aged 12–17.

Children of alcohol and other drug-abusing parents, who will be referred to as children of substance-abusing parents or COSAPs, run a risk of multitude of short- and long-term problems and are likely to become the next generation of individuals who are alcohol and/or drug dependent, thus perpetuating this cycle into the future (Hussong et al., 2008). However, since COSAPs exhibit not only problematic behaviors, but also strengths or resilience, careful individual assessment of each family and each child is required. Help needs to be age and culturally appropriate and systemic, and must take into account the needs of the individual child and his or her family members.

The purpose of this chapter is to provide an overview of the dynamics of families with substance-abusing parents, the impact on their children, and the most effective treatment approaches for children of various ages, ranging from those impacted by prenatal maternal substance use to older children, adolescents, and adults. Such children are found in every socioeconomic and ethnic and racial group in the United States (SAMHSA, 2008; Straussner, 2001) and in every setting ranging from preschools to community agencies, to colleges and universities, to hospitals and mental health facilities, and in the private offices of mental health clinicians.

UNDERSTANDING SUBSTANCE USE DISORDERS

Every day millions of Americans use alcohol and other drugs; however, not everyone experiences a problem due to such use. It is therefore helpful to conceptualize the use of such substances as ranging on a continuum from nonproblematic social use to substance misuse or abuse to dependence or addiction (Straussner, 2004).

Although there is no generally accepted distinction that differentiates between the “use” and “abuse” of a substance, the fourth edition of the American Psychiatric Association’s (APA, 2000) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) classifies all mood-altering substances under the category of substance-related disorders, which is further differentiated into two substance use disorders: substance abuse and
Chapter 1. Children of Substance-Abusing Parents: An Overview

substance dependence. The DSM defines “abuse”1 as the continued use of a substance despite experiencing social, occupational, psychological, or physical problems; recurrent use in situations in which use is physically hazardous, such as driving while intoxicated; and a minimal duration of disturbance of at least 1 month. “Substance dependence,” which is synonymous with the term “addiction,” may vary in severity from mild to severe, and refers to compulsive and continued use despite adverse consequences. Depending on the particular substance, it typically implies the existence of an initial increase of tolerance to the drugs, that is, that more and more of the substance is required to achieve the same effect. Once dependence or addiction develops, the individual cannot wait too long between doses without experiencing craving and symptoms of physical withdrawal (Doweiko, 2009).

IMPACT OF SUBSTANCE ABUSE ON THE FAMILY SYSTEM

The concept of family as a system has long been accepted in substance-abuse literature and clinical practice (Nichols, 2011). The basic definition of a family system dynamic is that a change in the functioning of one family member is automatically followed by a compensatory change in other family members. Consequently, in a family in which one of the members becomes a substance abuser, profound and significant implications for the rest of the family can be anticipated as familial roles are shifted and generational boundaries are crossed. For example, as a substance-abusing parent becomes unable to fulfill his or her role, other family members, including the children, may begin to fill the existing vacuum and assume the missing parental roles and responsibilities, often at the expense of their own development (Straussner, 1994).

Given the generally different roles assumed by fathers and mothers, it is important to closely examine the differential impact on the family when the father or mother, or both, have a substance abuse problem (Edwards, Eiden, & Leonard, 2004).

Paternal substance abuse, particularly alcohol, is often correlated with domestic violence, child emotional and physical abuse, incest, and poverty (Donohue, Romero, & Hill, 2006; Gruber & Taylor, 2006). Although alcohol abuse by husbands/fathers has existed throughout the ages, the impact today is more profound since traditional extended family members

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1It appears that the next edition of the DSM (DSM-5), which will be published in 2013, will no longer use the terms alcohol or drug “abuse” or “dependence.” The diagnostic term is likely to be Substance Use Disorder with qualifiers of “moderate” or “severe” depending on the number of criteria met.
who used to provide emotional and physical support with childcare are likely to live far away, and the mother is more likely to be experiencing the stresses of the labor force or be herself more dysfunctional due to her own use of alcohol or other substances (Grucza, Bucholz, Rice, & Bierut, 2008).

Many women, whether they have a substance abuse problem themselves or not, tend to remain in relationships with substance-dependent men. On the other hand, men, in general, tend to leave women who have a substance abuse problem, leaving the women with limited financial and emotional resources that make it difficult to care for themselves, much less their children (Straussner & Brown, 2002). Moreover, many substance-abusing women come from homes where they were physically and/or sexually abused and where parenting was poor or nonexistent. As a result, their own parenting behavior may be markedly deficient, and they may have difficulty in developing a healthy attachment to their infants and young children (see Fewell, Chapter 2, this volume; Pederson et al., 2008). Many such women are reported to child welfare services and often lose custody of their children. Finally, women are likely to have other family members who are alcohol and drug users; consequently, even if they do seek and obtain help, their recovery is made difficult by the fact that they tend to return to environments that are not supportive of their continued abstinence (Greenfield et al., 2007).

With the growing number of women with substance abuse problems, it is more common to find families in which both parents have alcohol and other drug problems. In such situations, the child is essentially parentless and likely learns to take care of himself or herself. Unfortunately, depending on the child’s age, he or she may become a “parentified child” (Fitzgerald et al., 2008), who becomes a caretaker of his or her own parents and siblings even at the cost of his or her own development. For example, the 15-year-old eldest daughter in a family with an alcoholic father and a pill-addicted mother may take over the responsibilities of making sure that her younger sister gets to school on time and is picked up safely after school, even if it means that she cannot attend the afterschool choir practice that she loves so much, while her 14-year-old brother gets an afterschool job at a neighborhood grocery store in order to bring in money and leftover food for the family.

Although the above descriptions focus on traditional families, similar dynamics may occur in families where the parents are gay or lesbian. Unfortunately, though there is a large body of literature on gay and lesbian substance abusers (see Senreich & Vairo, 2004), the literature on gay/lesbian families with substance-abusing parents and their children is sparse.

Given the differential impact of the various substances on individuals, it is important to examine those differences in more detail.
Chapter 1. Children of Substance-Abusing Parents: An Overview 5

IMPACT OF DIFFERENT SUBSTANCES ON THE FAMILY

The most commonly abused substances impacting on family life are alcohol and other sedative-hypnotics (sleeping pills and tranquilizers); opiates, in particular heroin, and more recently, prescription pain medications such as Oxycodone; stimulants such as cocaine (including crack) and methamphetamine; and cannabis (marijuana and hashish). Due to their different legal and social status, addictive potential, and differential effects on the brain, the impact on the family will vary depending on which substance is being abused (Straussner, 1994). Although there has been an increasing trend toward multiple substance use, most individuals tend to have a definite preference for a given substance.

Since alcohol and other sedative-hypnotics are usually obtained legally, the lifestyles and ethnic backgrounds of families who abuse them vary widely, reflecting the population at large. Although it is possible for adolescents and young adults to have severe alcohol problems, in general dependence on alcohol develops slowly and usually tends to interfere with a person’s functioning after adult independence has been achieved. Thus alcohol abusing individuals are very likely to marry and have children before the insidious impact of their addiction on family life is fully recognized.

Although the effects of alcohol abuse by a spouse or parent vary considerably from family to family, common patterns of familial interaction and behavior have been described in the literature (see Gruber & Taylor, 2006). Families of individuals with alcohol-use disorders are often characterized by communication problems, conflict, chaos and unpredictability, inconsistent messages to children, breakdown in rituals and traditional family rules and boundaries, and emotional, physical, and sexual abuse (see Lam & O’Farrell, Chapter 3, this volume). Moreover, it is not uncommon for family members to engage in behaviors that maintain and perpetuate the substance use by protecting the individual from any negative consequences. For example, the wife of a man suffering from a hangover after a night of drinking may call his employer to say that he is sick with the flu and will not be able to come to work that day. This dynamic has been termed “enabling” (Zelvin, 2004). Another important and somewhat more controversial concept is that of “co-dependency.” It is defined as “an exaggerated dependence upon a loved object or, by extension, external sources of fulfillment... Co-dependent individuals are ‘people pleasers’ who... tend to rescue others at the expense of their own needs” (Zelvin, 2004, pp. 269–270). While codependent individuals can be found in any dysfunctional family, they are more typically found in a substance-abusing one. All these issues will have to be addressed in the treatment process when working with substance-abusing families (O’Farrell & Fals-Stewart, 2006; Steinglass, 2009).
Part I. Conceptual Overview of Theory and Practice

Unlike alcohol, nonprescription opiate use is illegal and many opiate abusers grow up in dysfunctional and often physically abusive families with alcohol and/or opiate abusing parents and even grandparents. Due to the highly addictive nature of opiates, individuals become affected by them at an earlier age than alcohol, frequently before completing their education and functioning as self-supporting adults. Consequently, they are more often connected to their dysfunctional family of origin and less likely to form and/or maintain a stable family of procreation of their own (Straussner, 1994).

In general, opiate abusers are more likely to be members of minority or disenfranchised, low-income groups and/or characterized as having an antisocial personality with poor superego development (Kaufman, 1994). Since the time and effort necessary to obtain drugs and to pay for the addiction are considerable, the lifestyle associated with opiate addiction is highly unstructured and generally characterized by poverty and illegal activities that tend to have a severe negative impact on family life. A series of live-in partners, prostitution, and incarcerations are fairly common.

The impact of AIDS resulting from intravenous heroin use or sexual relations with a HIV-infected individual has had a profound effect on family life of opiate users in the United States (Lester et al., 2009). Of the estimated 1 million people in the United States living with HIV/AIDS, about one-third were infected directly or indirectly due to injected drug use. Intravenous drug abusers (IVDA) or sexual contact with IVDAs accounts for the vast majority of HIV/AIDS cases in women, particularly black women, and their children (National Institute on Drug Abuse, 2006).

In addition to HIV/AIDS, the use of dirty, shared, and reused needles results in various systemic infections. Illnesses such as hepatitis C, anemia, tuberculosis, heart disease, diabetes, and pneumonia are also common among heroin abusers, whereas cocaine use affects the cardiovascular system, resulting in blockages in blood circulation, abnormal heart rhythms, and strokes. Prostitution, a frequent means of support for drug-dependent women, leads to a high incidence of sexually transmitted diseases (Friedman & Wilson, 2004).

The impact of cocaine use on the family system is less known with much of the research limited to studies of perinatal and child-related issues. It is likely that familial impact of cocaine varies depending upon the route of administration, socioeconomic class, and gender of user (Straussner, 1994). Since the cost of loose, snortable cocaine is high, users tend to be trend-setting and high-income individuals. Cocaine’s expense and high potential for addiction may lead to stealing from the family and workplace, business bankruptcies, and legal repercussions. Moreover,
the common psychological side effects of increased paranoia and suicidal ideation wreck havoc on family life (Ockert, Baier, & Coons, 2004).

The use of a low-cost, but even more addictive, smokeable form of cocaine known as crack tends to be more common among low-income families, paralleling the familial dynamics seen with heroin abusers. The use of crack in the United States has had a particularly destructive and tragic impact on African American families and communities, due in part to the high rate of use among black women (SAMHSA, 2008; Straussner, 1994), thereby diminishing their availability to maintain familial and community life.

Little is known about the impact of marijuana on family life. Since the addictability and the cost of marijuana is not as high as for some of the other substances, the impact on the family appears to be more subtle. Clinically, marijuana-abusing individuals appear to be less socially interactive and more inner-focused making them less physically and emotionally available to the family.

THE IMPACT OF SUBSTANCE-ABUSING PARENTS ON CHILDREN

COSAPs can range from those exhibiting severe emotional and behavioral problems to resilient children who do well in life. In a well-known longitudinal study, Werner and Johnson (2004) followed children of alcoholics for over a 30-year period beginning at age 2. These researchers found that it was the availability of support systems within the extended family or in the community that significantly affected the development of the children into adulthood. Strong extended family support and the maintenance of family routines were the important mediating factors on the potential for positive outcomes for the child (Gruber & Taylor, 2006; Lam, Fals-Stewart, & Kelley, 2008).

Nonetheless, though some COSAPs are relatively well adjusted, many become dysfunctional with high risk of developing their own substance abuse and/or establishing their own substance-abusing family systems in adulthood (Anda et al., 2006; CASA, 2005; Peleg-Oren & Taichman, 2006). It is important to keep in mind that the impact of parental substance abuse varies depending, as pointed out previously, upon whether the abuser is the father, the mother, or both parents; the quality of parent-child attachment; the coping abilities of the nonaddicted parent; the age when parental substance abuse is most problematic; the physical and psychological status of parents and other family members; the availability of extended family and other support systems; the existence of sexual and physical abuse; the economic and health care resources of the family; and inborn ego strength or resiliency (Straussner, 1994).
Recent neurological and psychological studies reveal that children who grow up in violent and otherwise traumatizing households suffer not just from the psychological impact, such as emotional dysregulation and difficulties in social relationships (Eiden, Colder, Edwards, & Leonard, 2009; Fewell, Chapter 2, this volume) but may also have permanent neurological changes affecting them for the rest of their lives (Dayton, Chapter 7, this volume; van der Kolk, 2003).

**ISSUES ACROSS THE LIFE SPAN OF CHILDREN OF SUBSTANCE-ABUSING PARENTS**

A critical factor in determining the impact of parental substance abuse and the most helpful intervention is the age of the child. The following sections explore the impact of parental substance abuse on children at different ages and discuss the best interventions for a given age.

**Impact of Prenatal Substance Use**

While there are some indications that *paternal* substance use is detrimental to the fetus and newborn child, such impact has yet to be fully explored (Klonoff-Cohen & Lam-Kruglick, 2001). On the other hand, there is a growing knowledge about the consequences of maternal substance abuse during pregnancy. The impact of fetal exposure to substances is determined by many factors, including the gestation age of the fetus at exposure, the dosage and frequency of substance intake, other substances consumed simultaneously, mother’s nutrition, and environmental factors (Nadel & Straussner, 2006). Substances used by the mother are transmitted to the fetus during pregnancy and may result in the birth of an addicted baby or, depending on the substance used and the timing, in permanent physiological and neurological damage (Azmitia, 2001). It is important to note that though substance use during pregnancy can be very destructive, for many women pregnancy and motherhood can function as a motivating factor in seeking treatment, although fear of losing custody of their children or lack of childcare resources are frequent treatment obstacles (Greenfield et al., 2007).

Alcohol consumed by pregnant women is the most frequently used destructive substance for the developing fetus. Although much of the early research focused on a singular disorder titled fetal alcohol syndrome (FAS), more recent research has revealed a continuum of developmental outcomes known as fetal alcohol spectrum disorder...
(FASD), which is believed to affect approximately 1% of all children born in the United States (Centers for Disease Control and Prevention [CDC], 2009). This continuum, which includes FAS and the milder fetal alcohol effects (FAE), can range from subtle neurobehavioral effects to hyperactivity to central nervous system and information processing problems to facial deformities to profound mental retardation. In fact, FASD is now recognized as one of the leading causes of mental retardation and birth defects (CDC, 2009).

The use of illicit drugs, particularly heroin, is also associated with maternal complications and adverse outcomes for infants and children (see Pomeroy & Parrish, Chapter 4, this volume; Smith, Chapter 8, this volume). After birth, some babies, at least in the short term, appear to suffer no ill effects from prenatal drug exposure, whereas others may be premature or small for gestational age and have resulting complications such as respiratory problems. Some newborns suffer from drug withdrawal and have symptoms such as excessive crying and irritability; hypertonia (stiff muscles); tremors; sleep disturbances; and increased sensitivity to light, sound, and touch. As the child develops, other physiological effects may become evident. These can include developmental delays of various kinds, such as failure to thrive, cognitive deficits, and speech, language, and motor delays. Physical problems, such as asthma, may develop in connection with respiratory deficiencies. During the school years, learning disabilities and behavioral problems such as attention deficit hyperactivity disorder and conduct disorder may become evident (Azmitia, 2001; Floyd et al., 2008; Nadel & Straussner, 2006).

Although there has been some research on the effects of cocaine, marijuana, and tobacco on newborns, it has been difficult to disentangle the unique effects of each substance as polysubstance use, and nutritional deficiencies are prevalent in the populations studied (Floyd et al., 2008). Research has documented that prenatal cocaine and methamphetamine use leads to an increased risk of perinatal death, placenta abruption, low birth weight, prematurity, and small gestational birth weight. Prenatal smoking also increases the chances of sudden infant death syndrome (SIDS) and orofacial clefts (Floyd et al., 2008).

During the 1980s, concern was raised over symptoms displayed by the so-called crack babies. Although many of these concerns were later viewed as a societal overreaction, some of these children have been found to have attention deficit and problems with mental organization as they grew up (Azmitia, 2001). More recently, similar concerns have been voiced about babies exposed in utero to methamphetamines, sometimes referred to as “crank babies.” Although the long-term effects of methamphetamine exposure on these children is yet unknown, such babies should be
evaluated and observed for birth defects and other problems that may be related to this exposure (Jewett, 2005).

**Provision of Services**

There is no cure for fetal alcohol disorders, but there are certain interventions that have proven to be helpful when dealing with both mothers and their young children with FASD or other prenatal effects. Preventing such prenatal effects requires a multipronged approach ranging from patient education focusing on abstinence from drugs and alcohol during pregnancy, to provision of proper nutrition and obstetric care during pregnancy. Substitution therapy under medical supervision such as use of methadone or buprenorphine for heroin or other narcotic users can avoid some of the medical complications related to illicit narcotic use.

Although many substance abuse treatment programs, particularly inpatient ones, are reluctant to admit pregnant women, there has been an increase in specialized treatment programs for this population (Wong, 2006). However, some inpatient programs that do admit pregnant women will not allow them to bring their other children, or will accept only women with preschool-age children, forcing some mothers to put their older children into foster care.

In order to be effective, treatment programs for pregnant substance-abusing women and those with newborns must provide both tools for recovery as well as hope for a better life for themselves and their children. Individual counseling, group treatment and peer support, parenting and communication skills, and assertiveness training are essential components of treatment for pregnant substance-abusing women (Wong, 2006). Many substance-abusing pregnant women and mothers of very young children also need help in other areas of their lives such as housing, income support and financial planning, education and vocational training, and understanding the nature of their often problematic relationships with substance-abusing men. Help also needs to be offered to the men to become better fathers.

Interventions for children impacted by prenatal substance use vary depending upon the severity of their problems and their age. They may include medication to help with medical and behavioral symptoms, educational and behavioral therapy (for both children and their caregivers), and play therapy. The use of pediatric occupational therapy may help with body organization and modulation. Older children may need help with self-image, depression, and suicidality (Bertrand, 2009).
Impact of Parental Substance Abuse on School-Aged Children

As indicated above, school-aged children of alcoholics can range from those exhibiting severe emotional and behavioral problems to resilient children who do very well in school and are rarely recognized as having any problems at home.

Nonetheless, growing up with a substance-abusing parent is often a painful experience, with many children being at increased risk for negative outcomes with a variety of emotional, behavioral, physical, cognitive, academic, and social problems (Anda et al., 2006; Peleg-Oren & Teichman, 2006). In her classic 1969 study of 115 Canadian boys and girls between the ages of 10 and 16, Margaret Cork described the life histories, feelings, and problems of children of alcoholics who poignantly talked about their lives as being lonely, scary, and without structure. Another early study of children of alcoholics was conducted by Claudia Black (1981) who was among the first to identify the various roles that children of alcoholic parents take on as a way of coping. These included: the Responsible One—who tries to bring order to the chaos at home; the Adjuster—who adjusts to any situation by detaching emotionally; the Placater—who tries to make others feel better; and the Acting Out Child—who by his or her “bad” behavior may distract attention from the dysfunctional parent. Black (1981) was also the first writer to identify the “Don’t Talk, Don’t Trust and Don’t Feel” as reflecting the core dynamics of young and adult children of alcoholic parents.

More recent studies have focused mainly on the Acting Out Child—often referred to as children with “externalizing behavior problems” (Hill et al., 2008; Schuckit, Smith, Pierson, Trim, & Danko, 2007). Such children, particularly boys, not only exhibit attention deficits, hyperactivity, conduct disorders, and academic problems but also cause difficulties for teachers and other students, at times leading them to becomescapegoated by their peers. Consequently, not only do these children lack the basic supports at home but they also may not obtain the support from peers and school personnel that could ameliorate some of the pain experienced by growing up with a dysfunctional alcoholic parent(s). Other children, most commonly girls, are more likely to exhibit what is currently termed “internalizing” behaviors and feelings, such as social withdrawal, low self-esteem, and feelings of loneliness. These behaviors and feelings can predispose the child of a substance-abusing parent toward depression, suicidality, and addictions, which become more noticeable during adolescence.
Provision of Services

For the school-aged child, peer groups are critically important and can serve as the bases for both diagnostic comparison as well as treatment. It is important to assess the child’s relationship with peers and look for such dynamics as bullying and other antisocial behaviors, as well as changes and/or difficulties in mood and school performance (Johnson, Gryczynski, & Moe, Chapter 5, this volume).

For elementary school-aged children group intervention can be an important tool in helping them deal with the impact of parental substance abuse. The group can provide a critical source of support and an arena for the development of appropriate social skills (Peleg-Oren & Taichman, 2006). Psychoeducation for both the non–substance-abusing parent and one who is in the process of recovery needs to focus on the basics of child development aimed at helping parents understand what to expect from their child at different ages, and on parenting skills aimed at helping parents understand how to appropriately set limits, and how to reward and discipline their children (Johnson et al., Chapter 5, this volume).

Moreover, as will be discussed later, adolescent children of alcohol-abusing parents are particularly susceptible to developing their own alcohol and other drug abuse problems; therefore, preadolescence is a prime period in which to target family-systems interventions, since this is when they are more open to parenting influences (Lam, Cance, Eke, Fishbein, Hawkins, & Williams, 2007). A number of evidence-based programs, such as the Strengthening Families Program (SFP; www.strengtheningfamiliesprogram.org) and Celebrating Families (www.celebratingfamilies.net/gettingstarted.htm), use a holistic model to treat the whole family. These programs will be discussed in more detail in the next section.

Services such as Student Assistance Programs focus on identifying troubled students based on cues like deteriorating academic performance, behavioral changes, excessive lateness or absences, sleepiness in class, or neglected appearance. After meeting individually with the child to further assess his/her situation, the practitioner may then refer the student to appropriate school- or community-based services (Morehouse, Chapter 10, this volume).

Since many COSAPs end up in foster care and group homes or are seen in community-based family and mental health clinics for a variety of psychological or behavioral problems, it is critical that all children be assessed regarding parental substance abuse and provided with specialized services that have been developed for this population. Screening instruments such as the Children of Alcoholics Screening Test (CAST) have been found to be useful in identifying such children.
(Pilat & Jones, 1985). Books, pamphlets, and videotapes issued by the National Association for Children of Alcoholics, Al-Anon, and individual authors offer useful information for children of substance abusers at various age levels and can be easily provided by schools, foster care agencies, and treatment facilities.

Impact of Parental Substance Use on Adolescents

An estimated 10% of adolescent children live with a substance-abusing parent (SAMHSA, 2008). Although less susceptible than younger children to being physically harmed by their parents, adolescents with substance-abusing parents are at high risk for suffering other negative consequences affecting their physical, emotional, and behavioral health. In fact, it has been argued that, compared with younger children, teenage COSAPs are at greater risk, since, on average, they have had more prolonged exposure to their parents’ substance use and its consequences (Fenster, Chapter 6, this volume; Peleg-Oren & Taichman, 2006).

It is important to keep in mind the great variability between early (ages 12–14), mid (ages 15–16), and late adolescence (ages 17–18), as well as the differences among adolescents. For example, an early adolescent boy can be as physically developed as an 18 year old but have the cognitive and emotional development of a much younger child. Generally, younger adolescents are more dependent upon peers for a sense of identity, more loyal to their family, and are much more concrete in their thinking (Freshman, 2004; Morehouse, Chapter 10, this volume).

At times, the physical and psychological changes faced by adolescents may play a more critical role in their lives than being a COSAP. Therefore, understanding the developmental issues of adolescents is crucial to effective interventions. Specifically, it is important to remember that the prefrontal cortex of the adolescent brain is not fully developed, so they do not yet have a well-developed capacity to control emotions and make good judgments. Yet the hormonal changes during adolescence impact the amygdala, which controls the emotions, causing emotions to be intensified. It is common for adolescents to experience everything as a crisis, have mood swings, be impulsive, self-absorbed and overly sensitive, and not be able to plan or understand cause and effect (Cozzolino, 2006).

On top of their emotional instability, adolescent COSAPs are likely to confront a constellation of stress factors within and outside their families. Preexisting internalizing and externalizing problems become more evident during adolescence, placing these children at an increased risk for emotional, familial, social, academic, and legal problems. Of particular
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Concern is the increased risk of substance use problems (Saraceno, Munaf, Heron, Craddock, & van den Bree, 2009). According to studies, over half of children who were exposed to parental substance use disorders during adolescence developed their own substance use disorders, compared with 15% of those who were not so exposed (Biederman, Faraone, Monuteaux, & Feighner, 2000; Rothman, Edwards, Heeren, & Hingson, 2008). Moreover, as was found among younger children, adolescents often experience feelings of guilt and shame about their parents’ substance use and may be reluctant to discuss it with peers, authority figures, or even helping professionals.

Provision of Services

Assessment of the adolescent with an alcoholic parent needs to be comprehensive and should focus on the previously identified psychological, behavioral, cognitive, social and physical aspects, as well as family dynamics. The clinician also needs to carefully attend to the adolescent’s strengths, attitudes, aspirations, and resources.

Two screening tools that have been shown to be appropriate for use with adolescent children of alcoholics are the CAST and the Family Drinking Survey. The CAST (www.coaf.org/professionals/screenCAST.htm) is a 30-item self-report measure that gauges the experiences and feelings of adolescents regarding their parents’ drinking behaviors. The Family Drinking Survey (Whitfield, 1991), which assesses the effect of a parent’s drinking on an adolescent’s physical, emotional, and social health, can help clarify the impact of the parents’ substance use. In addition, standardized instruments designed specifically for adolescents can also help determine the existence, extent, and impact of the adolescent’s own substance misuse. One such instrument, the CRAFFT, consists of six age-appropriate questions related to alcohol and drug use and has been found to have good reliability and validity (Knight et al., 1999).

School- and community-based individual, group, and family counseling approaches as well as self-help groups are all helpful for this population. One of the most widely available and free community-based programs for teenage children of alcoholic parents are the Alateen self-help groups provided under the auspices of Al-Anon Family Groups. Utilizing the principles of Alcoholics Anonymous and of Al-Anon, Alateen teaches children about the progressive nature of alcoholism and the importance of detaching from the alcoholic parent’s pathological behavior and focusing on their own functioning. Another free resource is a Web-based discussion board run by the National Association for Children of Alcoholics (www.nacoa.org), where teens can go online to discuss their experiences of living with substance-abusing parents. In addition, a variety of books, booklets,
and movies about COSAPs are readily available and should be used in conjunction with other interventions.

Individual insight-oriented treatment as well as cognitive-behavioral therapies are frequently used approaches for this age group (Eyberg, Nelson & Boggs, 2008; Silverman, Pina, & Viswesvaran, 2008). Regardless of the approach utilized, the overarching goal of treatment is to enhance adolescents’ abilities to care for themselves emotionally, physically, and socially. Adolescents also need to be helped to develop coping strategies to deal with negative affects and develop awareness of their own thinking processes and build skills in problem solving, interpersonal communication, conflict resolution, and negotiation. Relaxation techniques, physical exercises, and other strategies for self-soothing can diminish anxiety or other negative mood states. Helping teens set and follow through with educational and vocational goals is also important, since adolescents with clear goals are less likely to use drugs and to become parents during their teenage years (Harden, Brunton, Fletcher, & Oakley, 2009).

As with school-age children, group treatment is a commonly utilized format for intervention with adolescent children of substance abusers (Fenster, Chapter 6, this volume). Treatment is typically short term, although some groups are long lasting. Groups are particularly helpful in teaching adolescents that they are not alone in dealing with the consequences of having a substance-abusing parent, thereby reducing feelings of guilt, and providing opportunities to interact with peers who are engaged in pro-social behaviors (Fenster, Chapter 6, this volume).

The parents of an adolescent need to be helped to establish appropriate and effective discipline and expectations. Of particular value is help in reinstitution of family routines and rituals such as family meals and holiday and religious celebrations, as these help strengthen bonds and restore a sense of normalcy to the family (CASA, 2007; Steinglass, 2009). If needed, a referral for substance abuse treatment for the parent should be made. As mentioned in the previous section, a number of evidence-based family programs are increasingly being used in different settings. One such program is SFP (Kumpfer, Williams, & Baxley, 1997). The SFP is a family skills training program designed to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems in high-risk families with both younger children (ages 3–5) and teens (ages 12–16). It is designed specifically for parents who have a history of substance abuse but are now in the early stages of recovery. This highly structured intervention teaches parents and teenagers skills in problem solving, interpersonal communication, and conflict resolution. Each week begins with a family group dinner, followed by separate group meetings for parents and youth, and ends with a family session. Both parents and
children receive age-appropriate education and experiential learning in 14 weekly, 2-hour sessions with a focus on multiple themes, such as goal setting, health, and communication. This program has shown a great deal of success with multiple ethnic groups and in both rural and urban settings (Kumpfer, Pinyuchon, Teixeira de Melo, & Whiteside, 2008).

Another program evidencing success in treating addicted parents and their adolescent children is *Celebrating Families!*, which was originally developed for parents involved in drug court proceedings, and later adapted for use with alcohol-involved families in which there is a high risk for domestic violence, child abuse, or neglect. The *Celebrating Families!* curriculum, currently distributed by the National Association of Children of Alcoholics (NACoA), is an evidence-based cognitive behavioral support group model that works with every member of the family, from age 3 through adulthood (for more details, see www.celebratingfamilies.net/gettingstarted.htm).

Finally, it is critically important to help young people in a dysfunctional family with a substance-abusing parent to develop a relationship with a caring adult who can model healthy behaviors. In addition to a caring clinician, community supports, including teachers, sports coaches, and religious leaders, can provide positive role models and growth experiences. Moreover, making teens aware of their increased risk to inherit a substance use problem, and helping them come to terms with that risk, is an essential part of clinical work with COSAPs.

**Impact of Parental Substance Use on Young Adult College Students**

The age span for young adults, generally between the ages of 20 and 30, encompasses many developmental tasks and preparations for undertaking the responsibilities of adulthood, including the formation of families, obtaining and maintaining jobs, and/or establishing career choices. For many young COSAPs, these tasks are complicated by concerns regarding their parents and their own emotional and social difficulties resulting from growing up in dysfunctional families. Some, particularly those from disenfranchised backgrounds, may wind up in jails and prisons (Begun & Rose, Chapter 12, this volume; Lemieux, 2009), whereas many others who are in their late teens and early 20s, can be found on college campuses across the United States. The focus of this section is on these relatively resilient children, who often wind up being seen in college counseling centers not understanding what brought them there (Wright, Crawford, & Del Castillo, 2009).
During the years 2009–2010, there were an estimated 19 million students enrolled in colleges and universities in the United States (U.S. Census Bureau, 2009), with an approximate 3 million of them impacted by a substance-abusing parent (Venarde & Payton, Chapter 11, this volume). College students in general face a myriad of developmental, academic, social, and health challenges. Those who continue to live at home while attending college must balance family relationships with their new social and academic requirements, whereas those who reside on campus need to adapt to an independent lifestyle and a new pattern of communication with peers and family members. For children of parents with substance-use disorders, these adjustments can be even more complex.

In general, college COSAPs are a heterogeneous group representing a range of socioeconomic and ethnic/racial backgrounds. Although some have been characterized as overachievers, others may begin to manifest a range of negative emotions and behaviors (Venarde & Payton, Chapter 11, this volume). Some of the variability in college students’ adjustment may be explained not only by parental substance abuse, but by the quality of parent–child attachment style (Fewell, 2006).

Of special concern for college students who are COSAPs is the wide availability of substances in the college environment. Alcohol remains the substance of choice on college campuses in the United States. However, the use of some illicit drugs and the misuse of prescription medications have risen on college campuses in the past decade (Johnston, O’Malley, Bachman, & Schulenberg, 2006). Thus, adolescents, who, as discussed above, are at greater risk for developing substance use disorders, are pursuing their educations in contexts where alcohol and other substances may be readily available and frequently used by their peers (CASA, 2007).

**Provision of Services**

Although some college students come to counseling services with parental substance use as their identified concern, most present for other emotional reasons, such as academic problems, stress, relationship problems, eating disorders or depression, and may not even mention parental substance use as an issue. Moreover, some may not consider their home experience as particularly unusual or out of the norm. Thus, it is critically important to obtain a thorough history of substance use by all family members, especially parents. And though some students may not be ready to discuss this topic in treatment, others may be relieved at finally being able to talk about this “family secret” (Venarde & Payton, Chapter 11, this volume).

A variety of programs and treatment approaches are available on many college campuses. These include preventive programs and outreach
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approaches utilizing a public health education model. These “wellness” or “health promotion” programs can be offered throughout the campus, including classrooms, student centers, and dormitories. Psychoeducational programming can help students to identify the effects of growing up with a substance-abusing parent on their own sense of self, moods, interpersonal relationships, and personal substance use (Venarde & Payton, Chapter 11, this volume).

Many college programs include referrals to individual or group treatment on campus or to community facilities or private practitioners familiar with this population. According to Venarde and Payton (Chapter 11, this volume), individual counseling may be most appropriate for those students who have recently become aware of parental substance abuse, or who are being acutely impacted by a parent’s chronic substance use. In addition, it may be indicated for students who react with shame or who fear the judgment of their peers. Group treatment, on the other hand, may be more appropriate for those students who wish to better understand their experiences as COSAPs and those wishing to connect with supportive peers. Such support groups may be the only place where students can feel comfortable voicing their concerns regarding alcohol and other substance use on campus without fear of being judged or rejected. These groups can also provide the opportunity for students to explore their “struggles with the extremes”—of having either a strong aversion to and even repulsion to alcohol or drug use, or their own destructive use of substances, and find a healthy middle ground.

An especially useful tool for college students is the use of Internet resources, including virtual communities and social networks. As an anonymous means of obtaining information and interacting with other COSAPs, the Internet allows young people to absorb and share information and feelings at their own time and place.

Impact of Parental Alcohol Use on Adult Children of Substance Abusers

Much has been written about the impact of parental alcohol abuse on what has been termed “adult children of alcoholics” or ACOAs. As mentioned earlier, the work of Claudia Black (1981) and others, such as Janet Woititz (1983), has led to the formation of the well-known ACOA movement and the identification of a set of symptoms or characteristics of such individuals. Despite the popular and clinical literature regarding personality types or codependency among ACOAs, empirical support for these descriptions is lacking (Doweiko, 2009). Nonetheless, some individuals do
find the descriptions of family roles and styles of relating to others helpful in understanding what they are feeling now and what has happened to them in their childhood.

Studies show that multiple adverse childhood experiences such as neglect, abuse, exposure to domestic violence, and parental alcohol or drug use are associated with depression, poor health outcomes, and early mortality in adults (Anda et al., 2006). Over the past decade, a new perspective has developed on the shared dynamics exhibited by ACOAs and other drug abusers: “. . . The Adult Children of Alcoholics (ACOA) syndrome is, in fact, a posttraumatic stress reaction in which unresolved childhood wounds that lay dormant for decades resurface in adulthood as a delayed reaction to childhood trauma” (Dayton, Chapter 7, this volume). Those childhood wounds are often the result of inadequate caretaking by parents who themselves were the victims of dysfunctional attachment patterns. Such intergenerational transmission of dysfunctional attachment behaviors has been demonstrated in a number of longitudinal studies (Cassidy & Shaver, 2008; Fewell, Chapter 2, this volume).

While not all COSAPs develop dysfunctional symptoms or dynamics, and, as indicated previously, many are highly resilient and emotionally strong, some adults who grew up in traumatized and traumatizing families with an alcohol or other drug-abusing parent may present some of the following characteristics (see Dayton, Chapter 7, this volume):

1. Rigid psychological defenses aimed at protecting oneself from emotional pain, including dissociation, denial, and splitting.
2. Development of a “false self” by creating a persona that “looks good” both within the family and outside, at the expense of one’s authentic self.
3. Problems with emotional dysregulation, which can be manifested by the lack of ability to regulate feeling states, appetite, sleep, or sex drive, as well as swings between states of emotional intensity and numbing.
4. Hyper-vigilance about potential danger, which can lead to perceptions of problems that do not exist, or to an exaggeration of problems that might have been easily managed.
5. A lack of awareness of one’s feelings or discomfort in sharing of feelings.
6. Unresolved grief resulting from actual or psychological losses related to use of substances.
7. Learned helplessness resulting from living in a situation where one feels a lack of control over one’s environment, which may lead to adopting a permanent position of being a victim.
8. Somatization of feelings resulting from an inability to experience or act on powerful emotions, which are then converted into bodily symptoms and experienced as back pains, headaches, stomach, or other physical ailments.

9. Shame that has been internalized as a sense of “I am bad” as opposed to “I did something bad.” It is then manifested as a lack of energy, a hesitancy to become more self-affirming, or a sense that one does not deserve love and caring from others.

10. Survivor’s guilt experience when one has managed to escape an unhealthy family system while a sibling or an abused parent still remains there. This can lead to self-sabotage or becoming overly preoccupied with fixing one’s family and others. It is not unusual for such individuals to become “professional helpers,” such as nurses or social workers.

11. Traumatic bonding resulting from early traumatic relationships that can impel people not only to withdraw from close connections but also to seek them desperately. Traumatized adult COSAPs may repeat this type of unhealthy bonding style in relationships throughout their lives, often without their conscious awareness.

12. Tendency to isolate and inability to trust and accept caring from others as a way of avoiding further feelings of being hurt.

13. Loss of faith and hope in life’s ability to repair and renew itself.

14. High-risk and compulsive behaviors, which are an attempt to overcome a numbed inner world by overstimulating the nervous system. These may include substance abuse, excessive speeding when driving, sexual acting out, overspending, fighting, or dangerous work.

15. Co-occurring mental health disorders on top of substance use disorders, such as anxiety disorders (including PTSD), depression, and various personality disorders.

16. Desire to self-medicate as an attempt to restore calm and inner “balance,” which may lead to substance use disorders.

**Provision of Services**

Given the potential for growing up in a traumatizing household, it is important that every adult child of a substance-abusing parent be assessed for a history of trauma. However, as pointed out previously, children of traumatizing substance-abusing parents have learned to distrust adults, and fears of disloyalty to the family or being ostracized for “telling the truth” can keep adult COSAPs not only telling lies to the outside world but living lies within themselves, thereby complicating the treatment process. It is the clinicians’ task to ensure the establishment of a trustworthy,
healthy therapeutic relationship to make their patients curious about what they are feeling, and consequently feel willing to open up and explore their emotions. Clients also need to be helped to mourn the various losses they experienced, as well as things they never had an opportunity to experience (Dayton, Chapter 7, this volume). They also need to learn to trust again, to overcome their feelings of guilt and shame, and to connect to others while still hanging onto their own, autonomous sense of self. Sometimes this may be better accomplished through the use of nonverbal, expressive therapies, including art, music, gestalt, or psychodrama therapy.

Twelve-step programs, such as ACOA, Al-Anon, Co-Anon (for families of cocaine addicts) and Nar-Anon (for families of narcotic addicts), can be wonderful adjuncts or even offer an initial initiation to therapy since they provide a safe and constantly available “holding environment” in which individuals can slowly identify with the stories of others and feel supported and less alone in their pain (Spiegel & Fewell, 2004; Straussner & Spiegel, 1996). There are also a variety of other 12-step programs that address common issues faced by some adult COSAPs, including eating problems (Overeaters Anonymous), spending (Debtors Anonymous), or sexual problems (Sex and Love Addicts Anonymous) (Dayton, Chapter 7, this volume).

**CONCLUSION**

According to numerous studies, for healthy development a child needs a safe and stable environment and a caring family that provides acceptance, trust, sense of autonomy, and security. Children of parents with alcohol- and drug-use disorders are often unable to experience such an environment and are at an increased risk for lifelong problems, including a relatively high level of depressive symptoms and anxiety, low self-esteem, guilt feelings, difficulties with interpersonal relationships, and their own abuse of substances (Anda et al., 2006).

In assessing and intervening with COSAPs, it is important to note that each child is unique and each has strengths that need to be acknowledged and reinforced. A child’s age plays a critical factor in the kind of intervention that needs to be offered. What is appropriate for a preschool child is not the same as that for an adolescent or a young adult. Even seemingly well-functioning adult COSAPs may need help at different times in their lives so that the destructive family scenarios do not continue into the next generations. It is the responsibility of all clinicians to understand the dynamics of young and adult COSAPs and how to best help them lead more productive and happier lives.
REFERENCES


Black, C. (1981). It will never happen to me. Denver, CO: MAC


Chapter 1. Children of Substance-Abusing Parents: An Overview


**RESOURCES**

**National Association for Children of Alcoholics (NACoA)**
11426 Rockville Pike, Suite 100
Rockville, MD 20852
(888) 554-COAS
Web site: www.nacoa.net

**National Association for Native American Children of Alcoholics (NANACoA)**
6145 Lehman Drive Suite 200
Colorado Springs, CO 80918
(719) 548-1000
Web site: www.whitebison.org/nanacoa

**National Black Alcoholism and Addictions Council (NBAC)**
5104 N. Orange Blossom Trail, Suite 207
Orlando, FL 32810
(877) 622-2674
Web site: www.nbacinc.org

**National Clearinghouse for Alcohol and Drug Information (NCADI)**
11420 Rockville Pike
Rockville, MD 20852
(800) 729-6686
Web site: ncadi.samhsa.gov

**National Council on Alcoholism and Drug Dependence (NCADD)**
20 Exchange Place, Suite 2902
New York, NY 10005
(800) NCA-CALL
Web site: www.ncadd.org

**Children’s Program at the Betty Ford Center**
39000 Bob Hope Drive
Rancho Mirage, CA 92270
Phone: 760/773-4291; 800/854-9211 x4191
Web site: www.bettyfordcenter.org

**Hazelden Center for Youth and Families**
11505 36th Avenue North
Plymouth, MN 55441
Phone: 800/257-7810
Fax: 763/559-0149
Web site: www.hazelden.org

**National Student Assistance Association**
4200 Wisconsin Avenue, NW
Suite 106-118
Washington, DC 20016
Web site: www.nasap.org

**Strengthening Families Program**
Department of Health Promotion and Education
University of Utah
1901 E. South Campus Drive, Room 2142
Phone: 801/581-8498
Fax: 801/581-5872
Web site: www.strengtheningfamiliesprogram.org
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SAMHSA’s Children’s Program Kit
Available free through the National Clearinghouse for Alcohol and Drug Information
Phone: 800/729-6686
Web site: http://ncadi.samhsa.gov/promos/coa/

College-Specific Sites
Binghamton University, State University of New York
Web site: www2.binghamton.edu/smart-choices/but-is-it-a-problem/when-i-was-kid.html

Georgetown University
Web site: www3.georgetown.edu/be/article.cfm?ObjectID=906

University of California, Los Angeles
Web site: http://www.counseling.ucla.edu/

University of Illinois at Urbana-Champaign
Web site: www.counselingcenter.illinois.edu/?page_id=144

Vanderbilt University
Web site: www.vanderbilt.edu/alcohol/students_acoas.html

Self-Help Groups for COSAPs
Al-Anon Family Group Headquarters, Inc.,
1600 Corporate Landing Parkway
Virginia Beach, VA 23454-5617
(888) 425-2666
Web site: www.al-anon.org

Adult Children of Alcoholics (ACA/ACoA)
P.O. Box 3216
Torrance, CA 90510
(310) 534-1815
Web site: www.adultchildren.org

Co-Anon Family Groups World Services
P.O. Box 12722
Tucson, AZ 85732-2722
800-898-9985
Web site: www.co-anon.org

Families Anonymous
P.O. Box 3475
Culver City, CA 90231-3475
(800) 736-9805
Web site: www.familiesanonymous.org

Nar-Anon Family Group Headquarters, Inc.
22527 Crenshaw Blvd. Suite 200B
Torrance, CA 90505
(800) 477-6291
Web site: www.nar-anon.org/Nar-Anon/Nar-Anon_Home.html