Risk Factors Among Adult Children of Alcoholics

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Abstract

Family patterns of dysfunction that often reinforce maladaptive behaviors and cognitions of children growing up in an alcoholic home environment are often difficult to overcome. Adjustment issues associated with being an adult child of an alcoholic (ACOA) are presented along with factors that have been identified as being important in developing resilient behaviors. In addition to describing family related issues and resilience, brief overviews of three interventions for ACOAs are presented.
Keywords: Adult Children of Alcoholics (ACOAs), risk factors, family dysfunction, resilience, adjustment, life-stressors

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Introduction

Alcoholism impacts the lives of many individuals and results in substantial societal costs - monetary as well as emotional. The emotional impact of alcoholism can be especially costly for children growing up in an alcoholic home. According to the U.S. Department of Health and Human Services and SAMHSA (Substance Abuse & Mental Health Services Administration), we have an estimated 76 million adult children of alcoholics or ACOAs (2007) in this country. The very nature of many alcoholic homes increases the vulnerability of children to develop problems later as adults (Hall & Webster, 2007; Hall & Webster, 2002; Hall, Webster, & Powell, 2003; Johnson & Tiegel, 1991; Sher, Walitzer, Wood & Brent, 1991). While a substantial number of children of alcoholics (COAs) experience problems in adulthood, there are also other COAs who are successful as adults and show few or no signs of difficulty ((Centofanti, 1999; Goertzel & Goertzel, 1962; Goodwin, 1991; Johnson, Sher, & Rolf, 1991; Menees & Segrin, 2000; Wright & Heppner, 1991). Growing up in an alcoholic home does not necessarily mean an individual will develop problems, but it does serve as a very real and significant risk factor.

This article focuses on the familial factors and potential adjustment difficulties; resiliency factors; the dysfunctional family system and heightened vulnerability; and assessments/interventions for ACOAs. While learning and conditioning elements remain key to understanding how maladaptive behaviors may develop, it is also important to incorporate cognitive components. Maladaptive cognitions and beliefs can result in inappropriate behaviors that are resistant to change and can lead to psychopathology (Brewin & Holmes, 2003; Larimer & Cronce, 2002). Maladaptive cognitions also serve to lower an individual's ability to engage in resilient behavioral strategies when faced with life's challenges. Resiliency factors serve a protective function and help the individual cope with life stressors. Unfortunately many of the familial factors in an alcoholic home place the individual at higher risk for potential problems and reduce the opportunities necessary for the COA (child of an alcoholic) to build resiliency. A greater understanding of how vulnerability and resiliency interact in the adjustment of ACOAs may help to develop more effective interventions if and when problems do develop.

Familial Factors Influencing ACOAs

Early writings on ACOAs proposed very specific stereotypes based on the role the child assumed within the family structure. Examples of these roles include peacemaker, scapegoat, and hero, caregiver, lost child, mascot, arguer, conflict resolver and rescuer (Black, 1982; Wegscheider-Cruse, 1986). While subsequent research in this area did not always lend support these stereotypic roles (Baker & Stephenson, 1995; Lyon & Seefeldt, 1995), it did provide an initial framework toward understanding some of the unique and intricate environmental pressures within the alcoholic home dynamic.

Several studies have identified and clarified some of the basic "rules" operating in an alcoholic home. Ruben (2001) presented some of these rules as follows:

1) *Don't talk about family problems.* Problems the family encounters are to stay within the family. It is unacceptable and forbidden to share problems with outsiders. It is not unusual for alcohol abuse problems to go undetected by extended family members, friends, business associates, and acquaintances. In fact, the children of alcoholics are strongly pressured by the family to present with a fictionalized normalcy both at home and to the larger community.

2) *It is not appropriate to express feelings openly*. Feelings are often not allowed to be expressed or addressed openly in the alcoholic family system.

3) *Limit communications*. The child may often limit communications with others outside the home in order to maintain the family secrets. In the unpredictable environment created within the alcoholic abusing family, it is hard to know when a statement or expression will receive either a positive response or elicit a negative response that may also evoke negative verbal and/or behavioral consequences. Thus, the rule for the child becomes keep communications to a minimum.

4) *Nothing is ever good enough, but you are still expected to strive for unobtainable perfection*. Children live within a world of extremes and see things in an absolute or polar manner, while believing they have caused the events that have made them either good or bad. When something bad happens, it occurs because of something he/she did or did not do. This belief eventually becomes integrated as part of the child's view of himself/herself. The need to be the perfect child (and eventually, the perfect adult) results. The environment in an alcoholic home often reinforces these beliefs.

5) *You have to work for the benefit of others and you can't be selfish*. The child who grows up in an alcoholic home is often taught that consideration of one's own personal needs and wishes is inappropriate. Thinking of yourself or giving your own needs a high priority is often labeled as selfish and the child is punished for this selfishness.

6) *"Do what I say, not as I do."* Many parents who have problems with alcohol urge their children not to engage in similar behaviors. Unfortunately, the modeling behavior of the parent is a very strong learning tool and many times children do follow the same behavior patterns of their parents.

7) *Play is not something you do*. As teenagers and adults many ACOAs have trouble relaxing and experiencing personal enjoyment in activities. Self-worth is often predicated on the productivity and accomplishments of the ACOA, and the ACOA can never achieve or accomplish enough to feel worthy and acceptable as a person to either themselves or others. Consequently, they constantly must "prove" their own worth to others and to themselves by incessant achievements and deeds. There may also be the feeling that if you let down your guard and begin to enjoy something, bad things will happen.

8) *Whatever else; avoid conflict*. In some alcoholic homes conflict is seen as something to be avoided at all costs. Experience has taught the child that situations involving conflict will likely result in unpredictable parental aggression and parental punishment. The child learns from these experiences to avoid or escape situations that may result in confrontation. With this strong need to avoid or escape confrontations, there are few opportunities for the child to learn the behaviors necessary for effective conflict resolution. In addition, conflict may also be used by the alcoholic parent as a reason to "have a drink" thereby reinforcing the guilt the child feels for "causing" the parent to drink.

Basically, the child is taught repeatedly, overtly and covertly, not to trust anyone, including him or herself. They are taught to not talk and not feel, but at the same time are taught they must be responsible for their alcoholic parent. To complicate the situation even more these rules are not always clear-cut and distinct and are often intertwined and highly changeable. In understanding the ACOA's behavior, it is also important to remember that cues for behavioral responses can be learned from primary or secondary conditioning. In an alcoholic home, secondary cues, or generalized aversive stimuli, are present; and stimuli that would under different circumstances be perceived as neutral, can take on a strong aversive quality when paired with primary aversive stimuli. The restrictive environment for a child growing up in an alcoholic home in turn severely limits opportunities to learn more adaptive behavior patterns.

Familial Factors and Potential Adjustment Difficulties

These rules within the family exist as controlling mechanisms that eliminate, or at least limit, problems from arising that might interfere with the alcoholic parent's control and dominance over the family. Responsibility in the alcoholic household becomes a central issue. Blame for drinking or other family problems is often attributed to either others or outside situations. Children growing up in this environment may take on a sense of hyper-responsibility where they believe they are responsible for anything bad that happens in their family and eventually for situations that occur at work or in personal social relationships. Interestingly, this over-responsibility does not typically extend to positive events. When anything positive occurs, it is a matter of luck or due to something outside the influence of the child (Bepko & Krestan, 1985; Krestan, 2000). The child who becomes overly responsible in the alcoholic family is responding to the adult who fails to assume the appropriate adult caretaker responsible role in the family. The child's perceived worth is often tied to doing and being of value to others. Over time, the child gradually begins to assume increasing levels of responsibility for the other person's well being and happiness. This role is very attractive because it creates the illusion of feeling powerful and being important and needed. The opposite side of the coin, however, is that there is very little or no control over events. The child feels responsible for the behavior of the alcoholic parent but does not have any real influence or power to change the behaviors of the parent or the family dynamics (Ruben, 2001). The caretaking behavior is also negatively reinforced in that at times it seems to serve the purpose of allowing the child to avoiding, delaying or altering (i.e., less intense response on the part of the parent) negative events in the family.

Implicit to this increasing sense of over-responsibility, is the notion that he/she is to blame when things go badly. In the alcoholic family environment, the child learns very early not to make demands or requests about his/her own emotional needs or wants. One's personal needs are not as important as those of others. The child's purpose is to keep the family functioning, to be responsible for adult care taking duties and responsibilities, and to never let down or relinquish this façade (Bepko & Krestan, 1985). As an adult these personal dynamics and belief systems extend to life in general, regardless of the situation, dynamics or actors involved in the situation. The sense of self is bound up in taking care of others, and the child believes that this is the only characteristic that makes him/her valuable and worthwhile.

At times children may become so overwhelmed by the dynamics in the alcoholic family that they relinquish all responsibility. These children rely on others to help them meet their basic needs. These behaviors often evolve because the child does not learn how to identify, label, communicate, or meet their own emotional needs in an appropriate manner (Rubin, 2001). It is not unusual for these children to eventually conclude that their lack of psychological skills and feelings is a personal deficiency that they cannot overcome and that they must rely on others to do these things for them. This over reliance is accompanied by a fear of abandonment by people on whom they rely. The failure to develop personal autonomy, social skills to deal with interpersonal challenges, and psychological self-reliance can eventually generate a great deal of anger. This anger may be experienced in many different ways by these children, but they also learn that

they cannot express the anger directly and overtly for fear of being abandoned (Bepko & Krestan, 1985).

Hypervigilance in regard to social interactions and communications can become a way of life for an ACOA long after leaving the alcoholic home (Ruben, 2001). They are often highly sensitive to comments from others and guarded in their own personal communications. An ACOA may misinterpret verbal and nonverbal communications from others by perceiving negative connotations in words or actions when that was not the intent of the sender. Prior learning experiences that have instilled a fear of negative responses such as criticism, conflict, or rejection make the ACOA hesitant to try to clarify his/her personal inferences (Ruben & Ruben, 1984). This failure to try to clarify unclear behavior from others makes it unlikely that the ACOA will learn more adaptive behavior and those inaccurate perceptions will continue in future interpersonal relationships.

High achievement may be used as a coping mechanism by ACOAs. These high achieving children gain praise and attention from outside the alcoholic home in what would be considered socially acceptable ways (Reuben, 2001). Achievement often becomes an escape for the child from the many stressors and unpredictability that exist in the home environment to a more "normal" functioning world that is more predictable and better able to be controlled. The child may actually learn to separate these two environments and use the environment outside the home as a reprieve from the stressors at home and a source of personal validation and worth as a human being.

Also tied to achievement is a desire for perfectionism. Many ACOAs develop unrealistic and unattainable expectancies. As noted earlier, alcoholics will look for reasons to drink. They then attribute the need to become intoxicated to others who are readily available and most vulnerable to accepting the blame. A child meets these two criteria very well because he/she is highly sensitive to parental approval and disapproval and especially vulnerable to accepting blame for causing the parent(s) to be emotionally distressed and relying on alcohol as a medicine to soothe this distress. As an adult, the ACOA may intellectually understand the illogic of being responsible for the parent's actions, but the emotional conditioning that occurs during developmental stages of vulnerability are not easily undone and clearly are not logical. This blame becomes an automatic reaction to stress as an adult. Research has found blame to be especially relevant for female ACOAs and their subsequent sense of well being (Kingree & Thompson, 2000). The rules and codes of conduct for many social situations are often ambiguous and inconsistent in an alcoholic home environment, and this creates a heightened level of anxiety for the child (Rapee, 1997).

Because an ACOA is often taught not to be selfish, he/she often subordinate his/her own emotional needs and put others' needs as priorities. The individual's own personal needs and feelings are minimized and sometimes even invalidated. Serving others may become the mantra for an ACOA. This is closely tied to what Ruben (2001) identifies as "It is not OK to play." Success becomes the individual's goal, but no success is ever quite good enough. The ACOA may also feel that if he/she does not work

diligently, there will be negative consequences, although these consequences are typically vague and reflect catastrophic thinking without substance or focus.

Conflicts can be overwhelming in an alcoholic home, so many children develop a variety of conflict avoidance techniques (withdraw to their bedroom or a friend's house; sit in a corner of the living room or behind a piece of furniture if the parent does not allow them to exit the house; dissociate while remaining in the presence of the raging adult) to minimize them becoming involved when family dynamics are intense and potentially physically and/or emotionally devastating. The goal of these strategies is to keep things running smoothly and at least have the pretense of calm. In general, such strategies are often very effective in warding off anxiety or reducing the child's active involvement in the family conflict. These coping strategies may be relied upon and generalized to both personal and professional social relationships in adulthood, especially when there is the potential of conflict. As noted by Ruben (2001), escape or avoidance of conflict often becomes routine. If a behavior has been negatively reinforced (the behavior allows the person to avoid or escape an aversive stimuli) for many years and shown to be effective in reducing anxiety and threat to the child, it is especially difficult to change this coping strategy (Hassija & Gray, 2007). The individual sees these techniques as effective in avoiding conflict, an option he/she prefers rather than take a chance in confronting a conflicted issue (Ruben, 2001). By adopting this approach the ACOA never learns the appropriate ways to negotiate successful conflict resolution at home or at work.

However, conflict does not generally just disappear. Not every situation is best dealt with by avoidance or escape. If an adult does not have the necessary skills to deal with and resolve conflicts, it can make it very difficult to negotiate positive solutions that bring conflicted issues to resolution and closure. Unfortunately by trying to alleviate conflict through escape or avoidance, ACOAs may inadvertently create more aversive and distressing conditions for themselves.

A child growing up in this environment may not be able to deal effectively with his/her own feelings of anger or hostility. Being exposed to instances where the alcoholic adult's anger is raging with uncontrolled intensity is highly frightening. Anger soon becomes the monster that you have to keep under control. The ACOA has a limited set of psychological and emotional tools that are necessary and available to recognize and deal with his/her own negative emotions. By avoiding the emotions he/she has been conditioned to fear in himself/herself and in others, there are no opportunities to learn appropriate strategies to deal with anger. They also often fail to learn to deal effectively with the negative emotions of others.

Ruben (2001) proposes that in order for treatment to be effective with behaviors that have a strong avoidance and/or escape component and have become habitual (i.e., caretaking or conflict), it is important for ACOAs to place themselves in the actual situations they find so aversive. ACOAs are taught to use various behavior methods including self-monitoring, relaxation techniques, and systematic desensitization. When ACOAs place themselves in these emotionally charged situations and maintain their

presence even when anxiety levels peak, there is a self-inoculation that takes place. New learning is possible when the highly charged emotional situations are actually experienced. This experience allows for the interruption of the pattern, and the opportunity for ACOAs to desensitize the fears that have been so strongly conditioned.

While avoiding conflict is common, there is also the possibility that an ACOA may use conflict in interpersonal relationships for personal secondary gains especially in emotionally intimate relationships (Hamberger, 1997). The probability of this occurring is greater if the ACOA has seen conflict modeled in this way by a parent. The unwitting partner may be drawn into conflict because the ACOA sees this conflict as being "normal" and something they can deal with very well. Relationships that are going well and are without conflict may actually create feelings of uneasiness for the ACOA. While the ACOA may not necessarily prefer conflict, it does represent familiar territory that offers some degree of predictability. This behavior is reinforced in that the ACOA is in control of when the outburst will occur, and there is a secondary gain of reducing the feeling of uneasiness over having things going too smoothly. The ACOA has the pre-existing coping strategies for dealing with the conflict based on prior experiences, but he/she has not learned the strategies for healthy interpersonal relationships.

There are many expectations that may be seen in an alcoholic home. In the home environment the child may be subjected to arbitrary punishment making it very difficult to comprehend the rules. Learning does not follow a logical pattern of reinforcement or punishment. What is acceptable in one situation, on one day, and at one time, may be totally unacceptable later when the circumstances are almost identical. There is no predictability and as a result there is limited safety (Ross & Hill, 2001). Those skills that may be protective in one situation are totally useless in another. The child learns very quickly that there is no way to judge certain events with any degree of accuracy or confidence.

Resilience

The cognitive belief that odds can be surmounted (Werner, 1995), a learned optimism (Seligman, 1990), and a realistic sense of hope and personal control (Walsh, 1996) have been identified as components of resilience. Bonanno (2004) identified the "hardy personality" as having the following characteristics: 1) finding meaningful purpose; 2) believing that one can control or influence life events; and, 3) belief that growth and learning occurs from both positive and negative events. These characteristics often evolve from a person having a strong underlying sense of confidence in his/her ability to meet challenges and control or limit its negative effects. Garmezy (1985) also stressed the importance of an adaptable personality, the presence of supportive adults, and a well-defined social support network.

The potential to develop these kinds of protective factors for a child growing up in an alcoholic home become problematic, however. As noted in the discussion of family factors above, an alcoholic home is often filled with inconsistencies. What one learns in one situation is likely not be effective in the next, similar situation. The protective

factors of social support (Garmezy, 1985) are also often difficult to achieve. If the rules within the family require the child not to share feelings with others, to limit communications outside the home, and to not trust in others, it may be highly difficult to gain supportive relationships. The adults in the alcoholic home may not be able to provide this supportive factor due to their own ways of trying to cope with alcoholism. The rules of interaction within the alcoholic family may also clearly restrict the outside emotional and social resources available to the child (Krestan & Bepko, 1993). Research has shown that the ability to discuss feelings and memories within a support network helps limit stress (Kendall-Tackett, Williams, & Finkelher, 1993; Sutker, David, Uddo, & Ditta, 1995), but ACOAs may be highly restricted in this option.

The deviant child who chooses achievement and productivity may be the one who can actually build a pseudo-support system (Ruben, 2001). The child who excels academically or athletically may gain status, receive positive and validating feedback that provides him/her with some temporary sense of personal worth, and acquired social support from peers, teachers, and coaches. The child learns to discriminate very different environments, and the adaptable child learns how to function reasonably successfully in both. The problem becomes living two very different lives with the support system available in only the secondary life and the primary life remaining one of emotional and social isolation. While this can be good in the short-term, the child who uses this for extended periods and is unable to gauge the benefits and costs of this approach in a variety of situations may inadvertently create additional stressors for themselves as they mature. Feelings of not fitting in or being an imposter sometimes emerge, especially when they continue to be successful and experience the financial and social rewards that often accrue from this success.

Antonovsky's (1987) study of protective factors focused on an individual's sense of coherence that is comprised of comprehensibility, manageability, and meaningfulness. Comprehensibility can be defined as being able to make sense cognitively of events in one's life. The child growing up in an alcoholic home faces unpredictability that makes it difficult to make sense of events. Often wide mood swings are exhibited by the adults in the household. There may be a family dinner on Monday that rivals the scenes in Norman Rockwell paintings only to be followed on Tuesday by no dinner and dire consequences if the child even asks about eating. Making sense of what is happening on a day-to-day basis may be virtually impossible. In addition, mixed messages are often sent to the child where a behavior is not only acceptable but highly rewarded one day and then punished the next. There can be open hostility toward the child for violations, or perceived violations, of the "rules". All of this can lead to an unstable and unpredictable environment as well as a great deal of emotional confusion and distress for the child. When the child does develop rules to make the environment more consistent, these rules often become inappropriate and defective quickly (Jahn, 1995).

The second factor proposed by Antonvsky (1987) is manageability. This can be defined as having adequate resources to deal with stressors. The child from an alcoholic home often has limited resources available and accessible from a supportive adult or supportive social network. As noted earlier, the family is not likely to be able to fulfill either of these roles and the rules of interaction are prohibitive for the child to establish

these supportive networks outside the family system. Autonomy is one important resource used to deal with stress, and the child from an alcoholic home may have received mixed messages about establishing his/her own autonomy. The parents may have been overprotective of the child and tried to protect him/her from errors (Ruben, 2001). These children may learn very early to avoid independent action because this is likely to result in punishment for leaving the parent. The fear of punishment is compounded with serious doubts and concerns of not being capable of independence (Ruben, 2001). The child has not received the reinforcement necessary to learn the behaviors that would, under normal development, provide the resources to deal with stressors. As a consequence, the child believes he/she is inadequate and incapable of handing problems and becoming independent.

Antonovsky's (1987) third factor is meaningfulness, and this can be defined as life making sense emotionally. There may be little that makes sense emotionally in an alcoholic home. Given the lack of predictability, undermining of autonomy, reluctance or fear to express affection, avoidance of situations that may cause conflict, and restriction of communication patterns, there may be little opportunity to learn to make sense of emotions. To have emotional awareness, an individual needs to be fully cognizant of his/her own emotional states and to be able to channel these emotions appropriately (Salvoey & Grewel, 2005). Salvoey and Grewel identify four components to emotional awareness: perceiving, using, understanding, and managing. Perceiving emotions involves accurate perception of nonverbal communication in others (i.e., facial expression, paralanguage or tone or voice), but it also involves the ability to identify one's own emotions. A child growing up in an alcoholic home learns not to trust his/her own feelings and emotions. Others may prescribe emotions to the child that may or may not be accurate. In addition, a child sometimes learns not to express feelings for fear of retaliation if these feelings are not deemed acceptable by the parent(s). The child may learn to be hyper-sensitive to the emotions of others, but he/she may be unaware or confused by personal emotional states and feelings. The environment in an alcoholic home undermines the child's ability to accurately process and act on his/her own feelings and emotions.

A more complicated aspect of this is that while the child may become hyper-sensitive to the emotional states of others, his/her interpretation of these emotional states may not always be accurate. The child may have learned to be overly responsible for negative events in the family system when he/she truly had no responsibility or power to influence the situation. As the child moves to adulthood, he/she may find it easy to assume personal responsibility for "causing" a friend or colleague's negative emotional state. The ACOA may cognitively replay over and over past conversations and interactions in an effort to identify what was wrong or inappropriate.

Ruben (2001) discusses the role of inconsistent and confusing schedules of reinforcement in relation to patterns of behavior and the child growing up in an alcoholic home. Children typically learn through consistency on the part of their parents' behaviors when interacting with and/or disciplining them. Over time the child develops the capacity to anticipate events based on past behaviors exhibited within the family unit. This is not what happens in some alcoholic homes, however. Not only is there

inconsistency, there are often major difficulties in understanding when and why certain rules apply. The child may feel (and accurately) that he/she is in a "no-win" situation. In these situations both positive and negative reinforcers and punishers communicate highly complicated and often convoluted messages that make it extremely difficult for a child to find meaning in these contexts. For example in the case of conflict between the two parents, the child may be punished for "taking sides" with one parent if he/she tries to talk to one parent, for relinquishing care-taking responsibilities for parent(s) if the child ignores the conflict, or punishment when the child moves to become the focus of attention by creating problems to divert the parents' conflicts with one another (Ruben, 2001).

While most researchers focus on protective factors rather than stress and risk, adversity is a necessary factor in the examination of resilience (Luthar, Cicchetti, & Becker, 2000; Rutter, 1987). Risk factors can contribute to high levels of stress that in turn lead to negative outcomes in non-resilient individuals. Stress can be caused by either specific, acute factors or chronic, ongoing life processes and circumstances (Honig, 1986). One child may deal with chronic drinking patterns of a parent in which the alcoholism occurs on a day-to-day basis and the stress is ongoing and continuous. Another child may deal with acute drinking patterns where a parent may not drink excessively or at all during the week and binge drink only on the weekends. Some adults go for long periods of time without drinking and then become intoxicated for an extended period of time during certain personally significant periods of the year such as holidays or at the end of the tax season. Each of these drinking patterns generates stress for the child that can interfere with his/her functioning. However, the nature of the stress may manifest itself differently. The types of stressors, the frequency of occurrence, and the length of time they are in place are important considerations when looking at coping mechanisms (Cardozo, Vergara, Agani, & Gotway, 2000).

Rutter (1979) states that "most can cope with two risk factors simultaneously, but three or more almost always result in emotional or behavioral problems" (p. 288). It becomes important to know how events interact with other life circumstances. A child dealing with chronic alcoholism in addition to other traumatic events in the family faces an increased risk to develop social or emotional adjustment problems at some time in his/her life (Hall & Webster, 2007; Harter & Taylor, 2000). The child in an alcoholic home is likely to be dealing with multiple stressors that reduce the ability of protective factors to work effectively. It is often not only the parent's drinking that a child deals with but also various forms of physical, emotional, and/or sexual abuse and neglect; traumas related to health issues of family members; repeated separation or the outright divorce of the parents; problematic behavior of siblings; involvement of law enforcement or social services agencies in the family; academic problems; and the child's own personal difficulties (i.e., attention deficit hyperactive disorder -ADHD, learning disorders, childhood depression; physical illnesses). These additional factors compound problems and exacerbate the negative effects of growing up in an alcoholic home.

Research has suggested that an understanding of the key processes that serve to strengthen the ability to withstand crises or prolonged stressors is preferable rather than trying to prescribe a blueprint (Luthar et al., 2000; Walsh, 1996). The same can be said

of the resilient individual. Resilience is not a blueprint that spells out what one should or should not do in various situations. Rather it is flexibility in assessing and implementing strategies and tactics to handle life stressors in a changing world. It requires knowing about one's own personal emotional resources and trusting in those resources as well as having trust in others to provide assistance when needed. Beyond the components of autonomy and trust is the need to be able to take the initiative. Resilience is more than problem solving; it is also preparing oneself to meet future challenges in a positive way without developing a rigid mindset.

Dysfunction and Heightened Vulnerability

Developing resiliency in an alcoholic home is not an easy task because the home environment often undermines the basic learning processes necessary for developing adaptive behaviors. This creates situations where individuals are likely to be more vulnerable to life stressors. Research has shown ACOAs report higher levels of stress, more difficulty initiating the use of mediating factors in response to life events, and more symptoms of personal dysfunction than their peers who did not experience either trauma or alcoholism during childhood (Hall & Webster, 2007; Hall & Webster, 2002; Hall, Webster, & Powell, 2003).

As noted by Rutter (1979), individuals may be able to cope with two risk factors simultaneously but three or more will in all probability have a highly and cumulative negative impact. If the ACOA is already at a more vulnerable level for stress to impact his/her life and has been unable to develop or utilize the resiliency necessary to cope effectively with life stressors, he or she is at a significantly higher risk for problems to develop. ACOAs are a very heterogeneous group and this is not to say that all ACOAs will develop emotional or adjustment problems, but there is supportive evidence of a heightened vulnerability (Centofanti, 1999; Hall & Webster, 2007; Menees & Segrin, 2000).

In a review of 200 cases of ACOAs seen in a counseling center from 1997 to 1999, Rubin (2001) noted one of the major reasons for referral centered on the family's fear of dealing with presenting problems. Familial fears included fear of mistakes, vulnerability, rejection, stress, conflict, abandonment, social disappointment, criticism, losing control, and love. In a further analysis of ACOAs exhibiting symptoms of perfectionism, Rubin (2001) applied functional analysis that included operational definitions, antecedents/contingencies applied during childhood, and the irrational belief system that often resulted.

Rubin's (2001) functional analysis provides a great deal of insight into how a dysfunctional family system can lead to subsequent problems and a lack of appropriate coping mechanisms (i.e., resiliency) for the ACOA. For example, the operational analysis for an individual who experiences problems dealing with criticism may lead to operational definition of being "phobic of conflict." Childhood antecedents and consequences likely centered on deprivation and punishment with the mistaken belief of "criticism means rejection." In this case, resiliency is undermined throughout the child's

early development by the family dynamics. The child learns not to trust himself/herself to make reasonable choices since his/her choices are not "correct". There is also no adult the child can trust to help learn how to make "better" choices. Without the basis of trust in one's own ability to learn or trust in others to help one learn how to make "good" choices, the normal development of learning functional behaviors and the initiative in implementing one's own life choices are seriously stunted. The bases of resilient behavior become eroded and positive coping mechanisms are undermined (Hall, 2004).

Knowledge of the interplay of multi-stressors can help aid in a better understanding of risk and resiliency factors and ACOAs. Family structures are highly complex systems and a better understanding of how multiple factors interplay to foster resiliency or to hinder it can prove very helpful as we develop future interventions.

Assessments/Interventions

Treatment interventions can follow many different formats ranging from behavioral and cognitive-behavioral interventions (Larimar & Cronce, 2002; Rubin, 2001), family interventions (Bepko & Krestan, 1985; Cable, 2000), multicultural interventions (Coyhas, 2000), to utilizing harm reduction models (Marlatt, Blume, & Parks,2001; Parks, Anderson, & Marlatt, 2001). There are numerous assessment and intervention methods that are applicable to ACOAs and other dysfunctional family systems in general. The following discussion represents only a small overview of available options. The assessments and interventions highlighted in this discussion were chosen as examples because of their emphasis on the development of both coping styles and/or resiliency. Regardless of the intervention model chosen, a key component needs to be helping the ACOA understand the increased vulnerability that may come with growing up in an alcoholic home.

An intervention format proposed by Sumner (1996) that deals with childhood physical abuse is also applicable to many of the issues and assessment considerations of ACOAs. This intervention speaks well to the recent research on multiple stressors in dysfunctional family systems as well. There are two components involving both individual assessment and quality of relationship assessment. The individual assessment focuses on the following components – assessing the individual's self (capabilities and resources available to the client to maintain trust in his/her skills and/or abilities); assessing traumatic memories; and assessing needs and schemas (schemas being those stimuli that the individual has learned for generalization and discrimination among various situations). Included within this framework is the assessment of coping styles and anxiety responses as well as the client's ability to adapt and be flexible.

Sumner's (1996) approach takes on special relevance for ACOAs who have often experienced unclear rules for behaviors and excessive punishment. In a supportive home environment, clear and consistent rules lead to appropriate learning and an internalization of adaptive self-evaluatory statements on the part of children. For example, children internalize adaptive behaviors by being able to say "this is the problem and this is what I need to do either now or in the future to have a different outcome." ACOAs, however, have internalized inaccurate self-evaluatory systems that are maladaptive in dealing with

current and future challenges. ACOAs frequently see themselves as the problem and see themselves as having no viable resources that they can utilize. The change in ACOAs self-evaluations is crucial to learning more adaptive behavior patterns.

The assessment of couples and families emphasizes: boundaries, role expectations, and communication/conflict resolution styles (Sumner, 1996). Each of these provides a framework for assessment and intervention that gives insight into the social coping behaviors of ACOAs, especially those who have also dealt with additional traumatic events beyond alcoholism in the home.

Interventions developed by Marlatt is based on research studies with college- age students and does not specifically identify ACOAs (Marlatt, et al, 1998; Marlatt, Blume, & Parks,2001; Parks, Anderson, & Marlatt, 2001). Marlatt focuses on skill training in alcohol use, and this approach could be very advantageous for college and universities where large percentages of the student body drink and frequently binge drink. Skills that are taught include self-monitoring of actual alcohol intake as well as monitoring the circumstances under which alcohol consumption occurs. Given the COA (child of an alcoholic) is between two and ten times more likely to develop alcoholism than a non-COA (Sher, 1997), this approach is very advantageous for the ACOA who may have an increased vulnerability from the learning environment as well as possible genetic influences. This approach may help the ACOA self monitor his/her own behaviors and be more aware of red flags denoting potential problems (i.e., having a bad day and "needing" a drink; needing a drink to start the day; feeling that alcohol is necessary to "have a good time"). Emphasis can also be placed on teaching COAs not to use alcohol as a means of self-medication for anxiety, depression, and guilt. Marlatt's (1998) harm reduction model has been shown to be successful in reducing the negative consequences of alcohol in college populations, but it would also be advantageous to assess the effectiveness of this approach with ACOAs who do drink.

Rubin (2001) offers assessment and intervention strategies based on a functional assessment model, and he developed the ACOA behavior profile to assess and plan interventions. This model is especially beneficial in looking at interpersonal factors and coping mechanisms of ACOAs. The model also addresses the areas of frequent concern among ACOAs. Included within this model are assessments of how absorbed the ACOA finds himself/herself in the opinions of others; need for high arousal versus ability to relax; caretaking attitudes (martyr-like versus more normal response); need for control in situations; history of failed relationships; use or past use of drugs and alcohol; specific and unspecified fears; and parent relationships. The benefit of this assessment tool is that it can help pinpoint specific areas of concern as well as identify situations where target behaviors are likely to be displayed. Interventions based on this model provide the ACOA with support in relearning more effective means of dealing with stressors and building resiliency. In addition, the initial research on the ACOA Behavior Profile demonstrated the scale's ability to differentiate low-risk, asymptomatic individuals from medium to high-risk individuals who obtained scores that were considered significant for the presence of symptoms (Rubin, 2001).

Summary

In summary, the factors intertwined with alcoholism are highly complex and interact in a multiplicative fashion. It goes well beyond a simple stimulus-response framework or antecedent-behavior-consequence paradigm. The stimuli are complex and often unclear, the antecedents have multiple cues and there is no consistent and clear rules that can be incorporated. Understanding the factors that allow for the development of resiliency is important. It is a matter of looking at the individual and his/her circumstances and setting the stage for change to occur (Larimar & Cronce, 2002). The better our understanding of how learning factors impact adjustment and resiliency, the more likely we may be to help individuals move beyond maladaptive behaviors and irrational beliefs. The key is to help the individual who is dealing with adjustment issues to see the possibilities of change and move toward that change.

References

Antonovsky, A. (1987). *Health, stress and coping: New perspectives on mental and physical well-being*. San Francisco, CA: Jossey-Bass.

Baker, D. E., & Stephenson, L. A. (1995). Personality characteristics of adult children of alcoholics. *Journal of Clinical Psychology, 51*, 694-702.

Bepko, C., & Krestan, J. (1985). *The responsibility trap: A blueprint for the alcoholic family*. New York: Free Press.

Black, C. (1982). *It will never happen to me.* Denver, CO: Medical Administration Company.

Bonanno, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely averse events? *American Psychologist, 59*, 20-28.

Brewin, C. R., & Holmes, E. A. (2003). Psychological theories of posttraumatic stress disorder. *Clinical Psychology Review, 23*, 339-376.

Cable, L. C. (2000). Kaleidoscopes and epic tales: Diverse narratives of adult children of alcoholics. In J. Krestan (Ed.), *Bridges to recovery: Addiction, family therapy, and multicultural treatment* (pp. 45-76). New York: Free Press.

Cardozo, B. L., Vergara, A., Agani, F., & Gotway, C. A. (2000). Mental health, social functioning, and attitudes of Kosovar Albanians following the war in Kosovo. *Journal of the American Medical Association, 284*, 569-577.

Centofanti, M. (1999, March 30). Alcoholics' children: Living with a stacked biochemical deck. Science Daily. Retrieved from http://www.sciencedaily.com: 80/ releases/1999/03/990330141757.htm.

Garmezy, N. (1985). Stress resistant children: The search for protective factors. In J. E. Stevenson (Ed.), *Aspects of current child psychiatry research. Journal of child psychology and psychiatry, book supplement 4* (pp. 213-233).

Goertzel, V., & Goertzel, M. G. (1962). *Cradles of eminence*. Boston: Little Brown & Co.

Goodwin, D. (1991). The etiology of alcoholism. In D. J. Pittman, & H. R. White (Eds.) *Society, Culture and Drinking Patterns Reexamined* (pp. 598-608). New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Hall, C. W. (2004). *Manual for Hall Resiliency Scale*. Greenville, NC: TCC-Publishing, Inc.

Hall, C. W., & Webster, R. E. (2007). Multiple stressors and adjustment among adult children of alcoholics. *Addiction Research and Theory,15*(4), 425-534.

Hall, C. W., & Webster, R. E. (2002). Traumatic symptomatology characteristics of adult children of alcoholics. *Journal of Drug Education 32*(3), 195-211.

Hall, C. W., Webster, R. E., & Powell, E. J. (2003). Personal alcohol use in adult children of alcoholics. *Alcohol Research, 8*, 157-162.

Hamberger, L. K. (1997). Female offenders in domestic violence: A look at actions in their context. *Journal of Aggression, Maltreatment, and Trauma, 1*, 117-129.

Harter, S. L., & Taylor, T. L. (2000). Parental alcoholism, child abuse, and adult adjustment. *Journal of Substance Abuse, 11*(1), 31-44.

Hassija, C., & Gray, M. J. (2007). Behavioral interventions for trauma and posttraumatic stress disorder. *International Journal of Behavioral Consultation and Therapy, 3*, 166-175.

Honig, A. S. (1986). Stress and coping in children. *Young Children*, May issue, 50-63.

Jacob, T., & Windle, M. (2000). Young adult children of alcoholic, depressed and nondistressed parents. *Journal of Studies on Alcohol, 61*, 836-844.

Jahn, M. F. (1995). Family secrets and family environment: Their relation to later adult functioning. *Alcoholism Treatment Quarterly, 13*, 71-80.

Johnson, J., Sher, K, & Rolf, J. (1991). Models of vulnerability to psychopathology in children of alcoholics: An overview. *Alcohol Health Research World, 15*, 33-42.

Johnson, J., & Tiegel, S. (1991). Treating adults raised by an alcoholic parents. In M. Galanter (Ed.), *Children of alcoholics* (pp. 347-359). New York, NY: Plenum.

Kendall-Tackett, K. A., Williams, L. M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin, 113*, 164-180.

Kingree, J. B., & Thompson, M. (2000). Twelve-step groups, attributions of blame for personal sadness, psychological well-being, and the moderating role of gender. *Journal of Applied Social Psychology, 30*, 499-517.

Krestan, J. (2000). *Bridges to recovery: Addiction, family therapy and multicultural treatment*. New York: Free Press.

Krestan, J., & Bepko, C. (1993). On lies, secrets, and silence: The multiple levels of denial in addictive families. In E. Imber-Black (Ed.), *Secrets in families and family therapy* (pp. 141-159). New York: Norton & Co.

Larimar, M. E., & Cronce, J. M. (2002). Identification, prevention and treatment: A review of individual-focused strategies to reduce problematic alcoholic consumption by college students. *Journal on Studies of Alcohol, Supplement No. 14*, 148-163.

Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A clinical evaluation and guidelines for future work. *Child Development, 71*, 543-562.

Lyon, M. A., & Seefeldt, R. W. (1995). Failure to validate personality characteristics of Adult Children of Alcoholics: A replication and extension. *Alcohol Treatment Quarterly, 12*, 69-85.

Marlatt, G. A., Baer, J. S. Kivlahan, D. R., Dimeff, L. A., Larimer, M. E. , Quigley, L.A., Somers, J. M., & Williams, E. (1998). Screening and brief intervention for high-risk college student drinkers: Results from a 2-year follow-up assessment. *Journal of Consulting & Clinical Psychology, 66*, 604-615.

Marlatt, G. A., Blume, A. W., & Parks, G. A. (2001). Integrating harm reduction therapy and traditional substance abuse treatment. *Journal of Psychoactive Drugs, 33*, 13-21.

Menees, M. M., & Segrin, C. (2000). The specificity of disrupted processes in families of adult children of alcoholics. *Alcohol & Alcoholism, 35*, 361-167.

Parks, G. A., Anderson, B. K., & Marlatt, G. A. (2001). Relapse prevention therapy. In N. Heather, T. J. Peters, & T. Stockwell (Eds.), *International handbook of alcohol dependence and problems* (pp. 575-592). New York: Wiley.

Rapee, R. (1997). Potential role of childrearing practices in the development of anxiety and depression. Clinical Psychology Review, 17, 47-57.

Ross, L. T., & Hill, E. M. (2001). Drinking and parental unpredictability among adult children of alcoholics: A pilot study. *Substance Use & Misuse, 36*, 609-638.

Ruben, D. H. (2001). *Treating Adult Children of Alcoholics: A behavioral approach*. San Diego, CA: Academic Press.

Ruben, D. H., & Ruben, M. J. (1984). Interviewing skills: Implications for vocational counseling with alcoholic clients. *Alcoholism and Treatment Quarterly, 1*, 133-140.

Rutter, M. (1979). Protective factors in children's responses to stress and disadvantage. In M. W. Kent & J. E. Rolf (Eds.), Primary prevention of psychopathology: Social competence in children (vol. 3, pp.49-74). Hanover, N.H.: University Press of New England.

Rutter, M. (1987). Psychosocial resilience and protective mechanisms. American Journal of Orthopsychiatry, 57, 316-331.

Salovey, P., & Grewel, D. (2005). The science of emotional intelligence. *Current Directions in Psychological Science, 14*, 281-285.

Seligman, M. (1990). *Learned optimism*. New York: Random House.

Sher, K. J. (1997). Psychological characteristics of children of alcoholics. *Alcohol Health and Research World, 21*, 247-254.

Sher, K. J., Walitzer, K. S., Wood, P. K., & Brent, E. E. (1991). Characteristics of children of alcoholics: Putative risk factors, substance use and abuse, and psychopathology, *Journal of Abnormal Psychology, 100*, 427-448.

Sumner, K. (1996). Adult survivors of childhood physical abuse. In D. M. Busby (Ed.), *The impact of violence on the family: Treatment approaches for therapists and other professionals* (pp. 149-184). Boston, MA: Allyn and Bacon.

Sutker, P. B., David, J. M., Uddo, M., & Ditta, S. R. (1995). Assessment of psychological distress in Persian Gulf troops: Ethnicity and gender comparisons.
U.S. Department of health and Human Services and SAMHSA's National Clearinghouse for Alcohol and Drug Information. Retrieved August 6, 2007, from http://www.oas.samhsa.gov

Walsh, F. (1996). The concept of family resilience: Crisis and challenge. *Family Process, Inc., 35*, 261-281.

Wegscheider-Cruse, S. (1986). *Understanding me.* Pompano Beach, FL: Health Communications.

Werner, E. E. (1995). Resilience in development. *Current Directions in Psychological Science, 4,* 81-85.

Wright, D. M., & Heppner, P. P. (1991). Coping among nonclinical college-age children of alcoholics. *Journal of Counseling Psychology, 38,* 465-472.

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