

Substance abuse — It affects the whole family

BY SARA AHARON, EDD, CPSYCH



The fact that the cycle of addictive behaviour passes down through generations and is related to family dysfunctions is well known in the field of addiction. Indeed, substance abusers have a higher incidence of parental substance abuse. This is because alcoholism is a family disease that affects every member in a devastating way. No single family member can be understood in isolation from the others. In the substance abuse population there is a high prevalence of parental substance abuse. Living with active addiction is traumatic—it is often like living in a constant state of emergency—members are always prepared for the unpredictable.

The emotional dynamics in addicted families are complex. When parents cope with their feelings of anger, intimacy, shame, sadness, stress or disappointment by using substances, they are, in fact, teaching their children dysfunctional strategies for coping with life. Having learned dysfunctional ways of coping, these children later have difficulty with intimacy and communication. The cycle of dysfunction created in addiction further complicates matters as addictive behaviour, used initially to deal with psychological discomfort, becomes a means of coping as the negative effects of behaviour increase.

A family in which alcoholism is underlying the dynamics between individuals is called “an alcoholic family.” An alcoholic family is characterized by denial, together with shame, fear and tension. Such families are also identifiable by chaos, inconsistency, unpredictability, illogical and repetitious arguments and unclear parenting roles. Sometimes these characteristics coexist with the possibility of violence and incest.

According to the family systems theory, one of the four major family tasks is the management of the family’s emotional climate, which includes developing strategies to manage conflict. However, alcoholic families are more likely to develop conflict-detouring strategies, rather than ways to acknowledge and process conflicts. The most common means used in these families to achieve this end is denial. It includes covert and overt “rules” with “don’t talk” as possibly the most common. When children try to speak about the alcohol-related problems in the family they are likely to find their reality invalidated (i.e., “it’s not so bad”). Another detouring strategy scapegoats someone to shift the focus of the alcoholic to another family member.

Denial assists families in coping with and surviving their pain, while helping the disease coexist.

When children's perceptions are continuously invalidated, they learn to distrust their realities, repress their suspicions and subdue their feelings about it. Consequently, when conflict is denied and diverted, children are taught that such dangers must be avoided at all cost, resulting in the festering of emotional wounds. These children carry this lesson into adulthood, they view conflict as abnormal and unmanageable and deem themselves unable to deal with it.

In her doctoral thesis, R.F. Namie studied family factors in adult alcoholics and found significant similarities in their childhood experiences. Of particular relevance here are her finding of alcoholics recalling that in their families it was not normal to show both positive and negative feelings and that certain feelings were not allowed to be expressed at all.

Children growing up in substance-abusing families often do not feel safe or loved in their families, which creates issues that need to be dealt with beyond the substance abuse. This type of emotional environment can be the breeding ground for a problem such as alexithymia. Alexithymia is defined as the inability to name or describe feelings. The literal meaning of the term is "no words for feelings." It is often replaced with a pre-occupation with bodily symptoms and/or external events. An experiment conducted by Dr. Howard Berenbaum and James Taryn (1994) reported alexithymia to be related to retrospective reports of diminished family expressiveness and with feeling less emotionally safe during childhood. They also found alexithymia to be significantly correlated with dissociative experiences.

The management of emotions in early recovery

Being first an intern and then working in an addiction setting, I had the opportunity to learn a great deal from both clients and clinicians. One of the assertions of clinicians and returning clients I have met was that following the completion of treatment, or in early recovery, clients should avoid dealing with certain psychological issues. For

the most part, this refers to underlying psychological problems and emotionally loaded issues and memories stemming from factors such as childhood abuse, neglect and trauma. The rationale being that in the early stages of recovery, the client is most vulnerable and should concentrate on practical issues such as securing a job, finding a place to live and changing one's lifestyle.

Furthermore, many recovering clients suffer from post-acute symptoms related to the physical withdrawal from the substances abused. They face a daily struggle and need to focus all their energy on resisting the temptation to use. Once they manage to stabilize on most levels and make the necessary changes in their lives, they may be ready to address the ghosts of their past. If done too early, facing the psychological issues can cause a negative chain of reactions eventually leading to relapse.

understanding

The early stage of recovery is seen as biopsychosocial restabilization beginning with crisis management. It is seen by some as “putting out fires,” fires which may involve withdrawal symptoms, medical, job, legal and marital problems. At this point, many begin to realize how much harm they have caused their loved ones and may consequently experience intense guilt, low self-esteem, and a sense of worthlessness. They may also experience tremendous self-doubt about their self-efficacy in other areas of their lives.

In other words, once people fully recognize the magnitude and consequences of their addiction, they may become overwhelmed. At this point, the task of recognizing the consequences of one’s behaviour, without becoming overwhelmed by such knowledge, is difficult for most, but a critical step in recovery. For recovering substance

abusers, this is a monumental task as many of them initiated substance use as a means of avoiding such unpleasant realizations of negative emotions. Once the substance is removed, the recovering person is often left more emotionally vulnerable, compared to non-substance-abusing persons.

When people are overwhelmed by severe or constant crisis and conflicts, they may not be able to deal with them by rational means. At such a time, largely unconscious and irrational defense mechanisms may present themselves. These unconscious defenses, although they may be irrational, help to decrease or even eliminate the anxiety these conflicts and crises produce. One of the most common forms of defense in addiction is denial. Denial can be exercised on anything, from one’s own negative thoughts and feelings, consequences of the addiction to even the reality of the addiction. Being unable to identify and describe feelings can be viewed as a form of denial or at least as a defense mechanism in itself, protecting one from the experience of negative feelings.

Thus, one might say that alexithymia is, in fact, what many clients may “need” to get through the first stage of recovery. Once they have “enough sobriety under their belts,” the ability to talk about their feelings may become useful again. It is possible that those clients who tend to talk more about their feelings are too distressed to “work their program,” including attending aftercare and 12-step meetings. Therefore, in some situations, talking about feelings, identifying and describing them, may, in fact, be a liability. So, ironically, what is considered an unhealthy way of dealing with emotions (alexithymia) learned in alcoholic families may also be useful in the early phase of recovery from alcohol and other addictions. ■

Dr. Sara Aharon, is a psychologist and the manager of therapy and the PTSD/Addictions treatment program at Bellwood Health Services. Her work involves clinical practice and supervision of clinical staff, teaching clients and staff training, program development and research in a multi-disciplinary setting.