

## Alcoholism and Family Secrets: Implications for Clinical Practice

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Listening  
with a "third ear"

Some pediatricians  
say they have difficulty putting psychosocial concepts  
into practice because they lack the expertise to diagnose  
and treat families' emotional difficulties.

May I suggest  
that we don't need special training, beyond our own  
clinical competence, to provide good help to families  
in conflict? What is needed is a willingness to listen  
with a "third ear" -- i.e. hearing not only  
the parent's general statement but also the language  
chosen and the feelings, or absence of feelings, accompanying  
their words.

A pediatric  
case study

Mrs. R. was  
concerned that her 6 year old daughter, Janet, was  
becoming "heavy." She came in asking for  
a diet so that Janet could avoid the painful experience  
of being overweight that Mrs. R had encountered when  
she was a child.

I was puzzled.  
Janet was in the 50th percentile for height and weight.  
I asked Mrs. R to enlighten me about her own weight  
history.

"I  
was teased a lot as a child ... I was a butter ball  
until I was 15 ... If only my parents had helped  
me ... I'd like her to have better eating habits  
than I did ... What can I do to help her avoid the  
problem I had?"

I asked her  
to describe Janet's eating habits.

"When  
she gets hungry, she turns into an animal! Before  
anybody gets up, she'll attack the kitchen cabinet  
and devour a box of crackers. She goes on these  
binges ... Sometimes she'll hide a piece of bread  
under her pillow ... Food is an important thing  
for her ... I've tried not to make a big thing about  
it."

In taking the family history, I learned that Mrs. R's grandfather died of cirrhosis, her father had not dealt with his own alcoholism, and her sister was also an alcoholic. When I later pointed out that the words she used to describe her daughter's eating habits were similar to those one might use for an alcoholic, her face registered complete surprise. She had no idea she had used words like "binges" or "hiding under the pillow" in reference to her daughter.

It turned out that no one in Mrs. R's family had been able to confront how painful alcoholism had been for all of them. In many ways, everyone had sidestepped the issue, but Mrs. R's anxiety and preoccupation about it spread to many unrelated situations, not the least of which was her daughter's eating habits.

As Mrs. R. was able, over time, to unburden herself of these concerns, the problem gradually resolved itself without a diet imposed by me. Listening with a "third ear" allowed me, as pediatrician for the parent, to be receptive to the subtle message Mrs. R was conveying. I needed to be willing to use my feelings and intuition, as well as intellect, to grasp the essence of what the parent was sharing.

The unseen visitor to pediatric practice

Many of the children we see with emotional or developmental problems may have parents who are "adult children of alcoholics" (ACOA). Alcoholism in one or more grandparents of our pediatric patients is an unseen but influential visitor to pediatric practice.

Who are ACOA parents?

What do we mean by ACOA parents? I am referring to those parents who grew up in families where their own parents were victims of the disease of alcoholism, which may leave a lasting effect on their parenting styles.

Consider  
alcohol abuse history

How often,  
in the average day, do we ask ourselves:

"What's wrong with this parent?  
Why doesn't she understand what is going on?"

"Why  
does he have such a hard time making decisions?  
Why does he seem so insecure?"

"What  
is the reason for her child's low self-esteem?"

A typical history of an ACOA parent

Many parents  
describe a childhood history similar to this one:

"My  
sisters and I worried every day about how serious  
the drinking would become, how much screaming and  
hitting would take place. Would it ever come to  
an end? We never knew what would happen the next  
moment. There was constant tension. We all felt  
embarrassed that it was somehow our fault. We felt  
like orphans."

The frequency  
of alcoholism in family histories

The story  
above can be recognized by millions of children who  
live with an alcoholic parent, and by parents in your  
practice who grew up in similar households. If the  
average pediatrician meets 16 parents in a typical  
day, two of them might be such ACOA parents.

What is  
the emotional inheritance of ACOA parents?

"Adult  
children of alcoholics guess at what normal behavior  
is."

They often  
"lie when it would be just as easy to tell  
the truth."

They "judge  
themselves without mercy."

They "have difficulty with intimate relationships."

They "usually feel they are different from other people." They can be "super-responsible or super-irresponsible."

(from Janet Woititz, Adult Children of Alcoholics, 1983)

ACOA parents and the pediatrician

Consider the burden this inheritance must be for a parent who wants to have normal relationships -- with a spouse, with a child, or with a pediatrician who might be unaware of the coping styles of the ACOA parent. Think about what must be going on in the minds of such parents when you give seemingly self-evident advice about child-rearing practice. How do you think such parents respond to you when, at best, they can only guess at what a normal family life is like?

At the time when the ACOA parents in your practice were children, the problem of alcoholism was "the family secret." The rule was never to share the secret with outsiders in order to "protect the good name of the family." Think of what it must be like for parents who struggle with sharing the secret with you, a trusted professional but an "outsider" nonetheless.

What can you, as a pediatrician, offer to such parents?

When pediatricians sit down with parents to figure out whether their child has a behavior problem and why, it is important to remember that there may be "an elephant in the room." What I am referring to is a family secret which may be playing a significant role in the development of the child's problem. Family secrets loom large and occupy much space in the emotional life of the family, but may never be acknowledged, like the metaphorical elephant that everyone must accommodate, at great inconvenience, but no one ever mentions.

One of the most important "family secrets" that I have come upon is the past (or present) history of alcoholism in one or more members of the family. We have already

acknowledged that many feelings may be associated with the history of such a secret in a family member. They may include feelings of shame, guilt, anger, or fear.

If you can help parents acknowledge such a history and its significance, in the context of a caring professional relationship, parents will have made a significant first step not only in understanding their child's problem but also in beginning to resolve it.

If knowing about alcoholism history is potentially so important, how might you discover it? Of course, you might simply ask! But there are also indirect ways of exploring alcoholism history.

For example, you might ask why a child's grandparent died when he or she did, particularly at a relatively young age.

A parent's parents might be divorced. You might ask, "Why?" and the parent might reply, "My father was abusive to my mother ... He was an alcoholic."

A parent might reveal that one of his or her siblings had a "drug problem." You might ask if anyone else had a problem of "addiction," at which point the parent might say, "My father was an alcoholic ..."

A parent's sister might have been "anorectic." Because you are aware of an association between that condition and a family history of alcoholism, you might ask if that was the case.

Perhaps a parent might reveal that she became pregnant as a teenager. You might ask, "What happened?" She might reply "I was drinking at the time."

In short, finding out if there is a family history of alcoholism may come out in the course of taking a family history, and by skillful listening. On the other hand, if a parent seems overly distraught about certain habits in his or her child, e.g. persistent thumb sucking, nail biting, or prolonged use of a pacifier, that also may be an opening to obtaining a family history of alcoholism.

I have often observed associations between a child's minor, but problematic, behavior with the behavior of an older alcoholic relative. The alcoholism may have left a legacy of anxiety which may become expressed

in parents' exaggerated concerns about the minor behavioral issues of their children.

In summary, you should assume that a family history of alcoholism may exist in any parent with whom you work. Think of eliciting such a history if the timing is appropriate and if parents give you permission to inquire. You might consider encouraging the parent to share feelings about what it was like to grow up in such an environment. It will require time and compassion on your part.

When you do discuss these sensitive issues, you create a model of listening between two adults (assuming that there are "healthy boundaries" between you and the parent) that can serve as a corrective experience. In turn, the parent may then be able to use this experience in interactions with her spouse, her child, and even her own parents as she struggles to undo the effects of past experience.

When to refer

Sometimes in the course of discussing a family history in a matter-of-fact way, the parent may begin to look like she or he is undergoing some very painful memories.

I would encourage pediatricians not to be afraid to ask further, but to proceed slowly and compassionately. It is worth asking, periodically, "Do you mind if I ask you...?" "Is this OK what I am asking you ...?" "Would you like to talk about this another time with me or another person?"

Despite your skillful interviewing, you may sometimes feel like you are on the verge of opening up Pandora's Box. You may think that the parent is about to share things she or he has never brought up before. If the parent feels great trust in you and you have confidence in yourself, you may wish to discuss it on another occasion. On the other hand, you may conclude it would be more appropriate to refer the parent to a mental health counselor. The parent should feel that you are doing so out of respect for his or her pain, and that you feel counseling would be helpful for the parent.

The ideal outcome

If you can offer this corrective experience, it is possible that such parents may, in time, give up the useless task of always trying to "rescue" the people they love, whether it be their parents or their own children. Preferably, they will encourage both to take responsibility for their actions.

If pediatricians could play such a role, they might help ACOA parents interrupt a family pattern of addiction and dysfunctionality. Their children,

when they become adults, and particularly when they become parents, might be better able to get in touch with past memories and, hopefully, develop healthier relationships and more successful methods of managing life's challenges.

Children as "agents for change"

ACOA parents often raise child development concerns with their pediatrician because they secretly worry that their child will "inherit" the family illness. Ironically, it is their concerns about their own children, your pediatric patients, that can provide the parents with a second chance to revisit their own past. If you assist them, these parents may be able to start life anew even though their first concern originated with their child!