

The Set Up

Living With Addiction

Tian Dayton MA, PhD, TEP

What Happens to the Family When Addiction Becomes Part of It?

Families where addiction is present are oftentimes painful to live in, which is why those who live with addiction may become traumatized to varying degrees by the experience. Broad swings, from one end of the emotional, psychological and behavioral spectrum to the other, all too often characterize the addicted family system. Living with addiction can put family members under unusual stress. Normal routines are constantly being interrupted by unexpected or even frightening kinds of experiences that are part of living with drug use. What is being said often doesn't match up with what family members sense, feel beneath the surface or see right in front of their eyes. The drug user as well as family members may bend, manipulate and deny reality in their attempt to maintain a family order that they experience as gradually slipping away. The entire system becomes absorbed by a problem that is slowly spinning out of control. Little things become big and big things get minimized as pain is denied and slips out sideways.

During early childhood years, living in this intense emotional environment can set up a fear of feeling or patterns of attachment that are filled with anxiety and ambivalence. In their youth, children of alcoholics or drug dependent parents (COAs) may feel overwhelmed with powerful emotions that they lack the developmental sophistication and family support to process and understand. As a result, they may resort to intense defenses, such as shutting down their own feelings, denying there is a problem, rationalizing, intellectualizing, over-controlling, withdrawing, acting out or self medicating, as a way to control their inner experience of chaos. The COA may be difficult to identify. They are just as likely to be the president of the class, the captain of the cheerleading squad, or the A student, as they are to act out in negative ways.

A Tense Family Atmosphere: Emotional Disconnection

Families have a remarkable ability to maintain what family therapists call *homeostasis*. But when alcohol or drugs are introduced into a family system, the family's ability to regulate its emotional and behavioral functioning is severely challenged. The family will generally reach as a unit to balance itself. In alcoholic homes, this may become a dysfunctional sort of balance. Family members can become subsumed by the disease to such an extent they lose their sense of normal. Their life becomes about hiding the truth from themselves, their children and their relational world. Trust and faith in an orderly and predictable world can be challenged as their family life becomes chaotic, promises are broken and those they depend upon for support and stability behave in untrustworthy

ways. Both children and adults in this family may lose their sense of who and what they can depend upon. Because the disease is progressive, family members seamlessly slip into patterns of relating that become increasingly more dysfunctional. The children are often left to fend for themselves and anyone bold enough to confront the obvious disease may be branded as a family traitor. Family members may withdraw into their own private worlds or compete for the little love and attention that is available. In the absence of reliable adults, siblings may become “parentified” and try to provide the care and comfort that is missing for each other.

Alcoholic families may become characterized by a kind of emotional and psychological constriction, where family members do not feel free to express their authentic selves for fear of triggering disaster; their genuine feelings are often hidden under strategies for keeping safe, like pleasing or withdrawing. The family becomes organized around trying to manage the unmanageable disease of addiction. They may yell, withdraw, cajole, harangue, criticize, understand, get fed up; you name it. They become remarkably inventive in trying everything they can come up with to contain the problem and keep the family from blowing up. The alarm bells in this system are constantly on a low hum, causing everyone to feel hyper vigilant, ready to run for emotional (or physical) shelter or to erect their defenses at the first sign of trouble.

Because family members avoid sharing subjects that might lead to more pain they often wind up avoiding genuine connection with each other. Then when painful feelings build up they may rise to the surface in emotional eruptions or get acted out through impulsive behaviors. Thus, these families become systems for manufacturing and perpetuating trauma. Trauma affects the internal world of each person, their relationships and their ability to communicate and be together in a balanced, relaxed and trusting manner. As the “elephant in the living room” increases in size and force, the family has to become ever more vigilant in keeping its strength and power from overwhelming their ever weakening internal structure. But they are engaged in a losing battle. The guilt and shame that family members feel at the erratic behavior within their walls, along with the psychological defenses against seeing the truth, all too often keep this family from getting help. The development of the individuals within the family, as well as the development of the family as a resilient unit that can adjust to the many natural shifts and changes that any family moves through, becomes impaired.

It is no wonder that families such as these produce a range of symptoms in their members that can lead to problems both in the present and later in life. Children from these families may find themselves moving into adult roles carrying huge burdens that they don’t know exactly what to do with and that get them into trouble in their relationships and/or work lives.

The Importance of Talking about What’s Going On

When what is going on within the family is never talked about, children are left to make sense of it on their own. Talking need not be constant, but avoiding talking altogether can lead to confusion and disconnection. Talking about and processing pain is also an important deterrent to developing post traumatic symptoms that show up later in life. Intense emotions such as sadness, that are an inevitable part of processing pain, can make family members feel like they’re “falling apart” and consequently they may resist experiencing the pain they are in. And the problems in an alcoholic family system are perpetual. For the child in an alcoholic system there may be nowhere to run, as those they would normally turn to are steeped in the problem themselves. Seeing the problem for what it is may alienate them from other family members.

If addiction remains untreated, dysfunctional coping strategies become very imbedded in the general behavior of the family. Family members may find themselves in a confusing and painful bind, e.g., wanting to flee from or get angry at those very people who represent home and hearth. If this highly stressful relational environment persists over time, it can produce cumulative trauma. Trauma can affect both the mind and the body. Intense stress can lead to deregulation in the body's limbic system – that system that helps us to regulate our emotions and our bodily functions. Because the limbic system governs such fundamental functions as mood, emotional tone, appetite and sleep cycles, when it becomes deregulated it can affect us in far ranging ways. Problems in regulating our emotional inner world can manifest as an impaired ability to regulate levels of fear, anger and sadness. This lack of ability to regulate mood may lead to chronic anxiety or depression. Or, it can emerge as substance or behavioral disorders, for example, problems in regulating alcohol, eating, sexual or spending habits.

The Effect of Familial Trauma on Children: A Mind/Body Phenomenon

Trauma in childhood can seriously impact development and can have pervasive and long lasting effects. We arrive in life only partly hardwired by nature. It is nurture that finishes the job. Each tiny interaction between parent and caretaker actually lays down the neural wiring that becomes part of our brain/body network. This is how our early experiences inscribe themselves onto our nervous systems. It is how our environment shapes our emotional being and our limbic system. All of us arrive as infants needing to learn the skills of emotional regulation and self soothing. We learn limbic regulation by being in the presence of adequate external regulating relationships, such as parents and siblings.

The amygdala, which is a brain center for the fight/flight/freeze response, is fully functional at birth. (Uram 2004) This means that a baby is capable of a full blown trauma response. The hippocampus, which is where we assess stimuli as to whether or not it is threatening, is not fully functional until the age of four to five.(Uram 2004). In addition, the prefrontal cortex is not fully mature until around age eleven or older. This means that when a child is frightened, they have no way of understanding what is going on around them. They do not have the developmental capability of assessing frightening stimuli as to its level of threat, nor do they have the cognitive capability to understand what's happening. They need an external modulator, namely a parent, to help them to regulate themselves and calm down. Even a sibling, caretaker or pet can help an anxious child to even out their emotions. Without this help, the content of the memory has a significant unconscious component because reason has not elevated it to the thinking level. It is stored within the body/mind as a sensory memory without reason, insight, and understanding integrated into it.

Our nervous systems are not self-contained; they link with those of the people close to us in a silent rhythm that helps regulate our physiology. Children require ongoing neural synchrony from parents in order for their natural capacity for self-directedness to emerge. In other words, it is through successful relationships that we achieve a healthy sense of autonomy. When the family environment is less than optimal and does not model good balance and regulation, children can have trouble acquiring these skills. They internalize what surrounds them. And not only do they internalize it mentally and emotionally, it becomes part of their neurological wiring. (Schoore 2004)

Emotional Repair

Repair is an important deterrent to relationship problems having lasting and repeating effects. But repair in alcoholic systems is not necessarily forthcoming and, if there is repair, it does not necessarily last. Repair allows our shame/pain response, for example, to become part of personal growth. We see that something went wrong and we learn ways of setting it right, of mending what was broken or

restoring a lost sense of connection. This process, that occurs within the context of a relationship, actually creates new learning, hence new neural wiring in the child. When we cannot repair, our feelings of shame, pain, fear, and confusion go underground and can affect the way in which we function in intimate relationships.

The ability to escape perceived or real danger is one of the factors that determines whether or not one develops PTSD. For the child in an alcoholic home, escape is often not possible. For this reason, ACOA issues often times surface in adulthood as a *post* traumatic stress reaction. That is, the symptoms that stem from childhood pain and abuse, surface after the fact, in adulthood.

Characteristics of Adult Children of Trauma and Addiction

1. **Learned Helplessness:** A person loses the feeling that they can affect or change what's happening to them. They give up and become "helpless" which can also affect other areas of life.
2. **Depression:** Unexpressed and unfelt emotion can lead to flat internal world – or an agitated/anxious defense against feeling internal pain. Or anger, rage and sadness that remain unfelt or unexpected in a way that leads to no resolution and becomes turned inward within the self.
3. **Anxiety:** Free floating anxiety, worries and anxieties that have no where particular to pin themselves and may look for a place to project themselves or phobias, sleep disturbances, hyper-vigilance etc.
4. **Emotional Constriction:** Numbness and shutdown as a defense against overwhelming pain; restricted range of affect or lack of authentic expression of emotion.
5. **Distorted Reasoning:** Convolutioned attempts to make sense and meaning out of chaotic, confusing, frightening or painful experience that feels senseless. Or magical childhood meaning due to the developmental level a child is at when painful or confusing circumstances occur.
6. **Loss of Trust and Faith:** Due to deep ruptures in primary, dependency relationships and breakdown of an orderly world.
7. **Hypervigilance:** Anxiety, waiting for the other shoe to drop – constantly scanning environment and relationships for signs of potential danger or repeated rupture.
8. **Traumatic Bonding:** Unhealthy bonding style resulting from power imbalance in relationships and lack of other sources of support.
9. **Loss of Ability to Take in Caring and Support:** Due to trauma's inherent numbness and shutdown along with fears of trusting and being let down all over again.
10. **Problems with Self Regulation:** The deregulated limbic system can manifest in problems with regulating many areas of the self system such as thinking, feeling and behavior. The tendency to go from 0 – 10 and 10 – 0 without intermediate stages, black and white thinking, feeling and behavior, no shades of gray as a result of trauma's numbing vs. hi-affect.

11. **Easily Triggered; hyper-reactive:** Stimuli reminiscent of trauma, e.g., yelling, loud noises, criticism, or gunfire, trigger person into shutting down, acting out or intense emotional states. Or subtle stimuli such as changes in eye expression, physical position or feeling humiliated, for example.
12. **High Risk Behaviors:** Speeding, sexual acting out, spending, fighting or other behaviors done in a way that puts one at risk. Misguided attempts to jump start numb inner world or act out pain from an intense pain filled inner world.
13. **Disorganized Inner World:** Disorganized object constancy and/or sense of relatedness. Internal emotional disconnects or fused feelings (e.g., anger & sex, intimacy and danger, need and humiliation)
14. **Survival Guilt:** From witnessing abuse and trauma and surviving, or from “getting out” of an unhealthy family system while others remain mired within it.
15. **Development of Rigid Psychological Defenses:** Dissociation, denial, splitting, repression, minimization, intellectualization, projection, for some examples or developing rather impenetrable “character armor”
16. **Cycles of Reenactment:** Unconscious repetition of pain-filled dynamics, the continual recreation of dysfunctional dynamics from the past.
17. **Relationship Issues:** Difficulty in being present in a balanced manner; a tendency to over or under engage, explode or withdraw or be emotionally hot and cold. Problems with trusting, staying engaged, or taking in love and caring from others.
18. **Desire to Self Medicate:** Attempts to quiet and control turbulent, troubled inner world through the use of drugs and alcohol or behavioral addictions.

From *Trauma and Addiction*, Dayton 2000 (van der Kolk 1987, Krystal 1968)

What Happens When ACOAs Have Their Own Families?

When ACOAs enter intimate relationships in adulthood, their feelings of dependence and vulnerability that are an important part of any intimate relationship may make them feel anxious and at risk again. Beneath the level of their awareness, the ACOA may worry that chaos, out-of-control behavior and abuse may be looming around the corner, because this was their early childhood experience. They experience mistrust and suspicion if problems are solved smoothly. They may over react in ways that actually create a problem that might otherwise have been handled more smoothly. They may perceive themselves as helpless even if they are not. And so the pattern of strong feelings leading to emotional danger, chaos, rage and tears is once again reinforced. When the feelings of dependency and vulnerability trigger the ACOA into unconscious, historical feelings, what is getting triggered may be a felt memory from childhood that has little reason and understanding attached to it. At these moments, the survival parts of the brain are in gear while the more advanced parts of the cortical brain where thinking and reasoning take place become temporarily overwhelmed. Consequently, the ACOA becomes locked in a reaction that is filled with unresolved emotions from the past that are getting triggered by and layered onto present circumstances with little understanding that this is what is going on.

Children who have been traumatized by living with addiction become very adept scanners; they are constantly reading their environment and the faces of those around them for signs of emotional danger. If they sense emotions in another person that make them feel anxious, they may lapse into people pleasing in order to alleviate potential “danger.” They may have learned as children that if they could calm and please their acting out parent, their own day might go more smoothly; i.e., they might experience less hurt. Such people pleasing strategies also get carried into intimate relationships in adulthood. The upshot of all this is that ACOAs sometimes lack the ability to live comfortably with the natural ebb and flow of intimacy.

Traumatic Bonds

The intensity and type of connectedness in addicted/traumatizing families can create the types of bonds that people tend to form during times of crisis. Alliances in addicted families may become very critical to one's sense of self and even survival. Alliances can become very intense among children, for example, who are feeling hurt and needy and without proper parental support. Or traumatic bonds may simply get seared into place as family members repeatedly face threatening, frightening and overwhelmingly painful experiences and hunker down in emotional dugouts together until the barrage of explosions passes. As the family member's fear increases so does their need for protective bonds. Trauma may lead people towards opposing responses in which they both withdraw from close relationships and seek them desperately.

The deep disruption of basic trust, the feelings of shame, guilt and inferiority combined with the need to avoid reminders of the trauma may foster withdrawal from close relationships and community. But the terror of the traumatic event, such as living with addiction and the chaotic behavior that surrounds it, intensifies the need for protective attachments. The traumatized person therefore frequently alternates between isolation and anxious clinging to others. Factors that can contribute to bonds becoming traumatic are:

- If there is a power imbalance in the relationship.
- If there is a lack of access to outside support.
- If those who we would naturally go to for caring and support are unavailable or are, themselves, the abuser.
- If there are wide inconsistencies in styles of relating that induce both states of high need/anxiety alternating with high need/fulfillment.

All too often the confusion in these types of relationships is that they are neither all good nor all bad. Their very unevenness can make the nature of the bond all the more difficult to unravel. In the case of addiction this is an all too familiar dynamic. The addicted parent, for example, may swing between being attentive, generous and caring to being abusive, neglectful and rejecting. One minute they are everything one could wish and the next they are miserably disappointing. Without supportive interventions – usually from outside the family – these types of bonds become styles of relating that get played out in relationships throughout life. Traumatic bonds formed in childhood tend to repeat their quality and contents over and over again throughout life.

Co-Occurring Disorders of Addiction and Mental Illness

If there is a dual diagnosis, which is so often the case in addiction, the diagnosis of addiction is properly dealt with by removing the substance, but the underlying diagnosis, for example of depression, anxiety or PTSD, may not be dealt with. Recovery is more than recovering from substance abuse. It is also about recovering from the other diagnosis or the symptoms that may have been self medicated in the first place. And finally, the addict will still need to engage in a full recovery process in order to deal with the emotional and psychological complications that stemmed from their addiction. If they do not accomplish this, they are asking both themselves and their family members to live with emotional and psychological burdens that can keep the family and the individuals within it mired in dysfunctional patterns of relating that get passed along through the generations. This is commonly referred to as “passing on the pain”.

Recovery is equally important for those who have lived in, developed their sense of self and learned relationship skills in an addicted/traumatized family. Without a rigorous program of treatment and recovery for all concerned, the dysfunctional personality styles and relationships developed in the addicted family environment will tend to recreate themselves over and over again. Sobriety needs to happen on all levels and in all family members, emotionally, psychologically and physically.

<u>Characteristics of the Addicted/Traumatized Family System</u>		
<u>Extreme R.O.F</u>	<u>Balanced Range of Functioning</u>	<u>Extreme R.O.F.</u>
High Intensity	<i>emotional modulation</i>	Shutdown
Over-functioning	<i>balanced functioning</i>	Under-functioning
Enmeshment	<i>balanced-relatedness</i>	Disengagement
Impulsivity	<i>self regulation</i>	Rigidity
Grandiosity	<i>healthy self image</i>	Low self worth
Denial	<i>reality orientation</i>	Despair
Caretaking	<i>balanced care of self and other</i>	Neglect
Abuse	<i>talking things out rather than acting them out</i>	Victimization

High Intensity vs. Shutdown/Dissociation

When family members become emotionally overwhelmed with too much *intense* emotion and they have no way of staying safe, they may *shut down or dissociate* (freeze/flight) in an unconscious attempt to preserve themselves much in the way a circuit breaker flips when the wattage overwhelms the capacity of the circuit and threatens to cause damage. Shutting down is a trauma response. (Van der kolk 1987) This alternating pattern of *high intensity vs. numbing* becomes a quality that underlies many personal and family dynamics. It is the black and white pattern spoken of so often in addiction circles, the Jekyll/Hyde syndrome that characterizes the alternating worlds of the addicted family system. These swings between high intensity and shutting down or dissociating that characterize the trauma response become central to the operational style of the family. All or nothing tends to characterize the family that contains trauma.

Emotional modulation is a skill that becomes internalized through regular exposure to modulating relationships such as mothers, family members or one to one and group therapeutic relationships. It can also be aided through regulating activities like meditation, yoga, massage, deep breathing and exercise; activities that quiet and soothe the limbic system.

Over functioning vs. Under Functioning

In a maladaptive attempt to maintain family balance, some family members *over function* in order to compensate for the *under functioning* of others. Over functioning can wear many hats; parentified children may try to take care of younger siblings when parents drop the ball or strive to restore order or dignity to the family who is rapidly slipping. Spouses may over function to maintain order and “keep the show on the road” while the addict falls in and out of normal functioning. Others in the system may freeze like deer in the headlights, unable to get their lives together and make useful choices. The learned helplessness associated with the trauma response, in which one comes to feel that nothing they

can do will make a difference, can become an operational style that manifests as under functioning. It is possible that the addict themselves, along with others in the system, may do both, over functioning to make up for periods of under functioning.

Balanced functioning is the obvious in between of over and under-functioning. It is when we do what is appropriate to the circumstance and when we have conscious choice around the degree to which we function. The program slogan, “take the next right action” can help the under-functioner who becomes overwhelmed with the thought of taking care of themselves or undertaking tasks, to break down any task into manageable components or the over-functioner to modulate their frenetic activity. “One day at a time” can assist both the over-functioner and the under-functioner to manage feelings of being overwhelmed.

Enmeshment/Disengagement

Enmeshment or fusion is generally seen as an attempt to ward off feelings of abandonment. It is a relational style that lacks boundaries and discourages differences or disagreement, seeing them not as healthy and natural but disloyal and threatening. Dissension is not well tolerated and disagreement discouraged. The unspoken rule is “don’t rock the boat.” *Disengagement* is the other side of enmeshment or fusion. Family members see the solution to keeping pain from their inner worlds from erupting as *avoiding* subjects, people, places and things that might trigger it. This leads to an emotional *disengagement*. Family members move into their own emotional and psychological orbits and they don’t share their inner worlds with each other. This may give rise to covert alliances where a couple of family members ally and form covert bonds.

Balanced relatedness is neither a withdrawal from another person nor a fusion with them. It allows each person their own identity and to move in and out of close connection in a natural, modulated fashion.

Impulsivity vs. Rigidity

When emotional and psychological pain cannot get talked out, it often gets *acted out* through impulsive behaviors instead.

Impulsive behavior can lead to chaos, wherein a pain filled inner world is surfacing in action. Painful feelings that are too hard to sit with explode into the container of the family and get acted out. Blame, anger, rage, emotional, physical or sexual abuse, collapsing into helplessness, withdrawal or yelling, over or under spending and sexual anorexia or promiscuity are some are ways of acting out emotional and psychological pain in dysfunctional ways that engender chaos.

Rigidity is an attempt to manage that chaos both inwardly and outwardly. Adults in an addictive/traumatizing family system may tighten up on rules and routines in an attempt to counteract or ward off the feeling of falling apart inwardly or outwardly. And family members may tighten up in their personal styles becoming both controlled and controlling. There is no middle ground where strong feelings can be talked over or even explode momentarily but then be talked through toward some sort of tolerable resolution. Impulsive behavior is a manifestation of high intensity and rigidity is a manifestation of shutting down, clamping down or being physically present but psychically absent, following empty forms and rules. Again, the tendency is to alternate between black and white in

thinking, feeling and behavior, with no shades of gray, which reflects the family's problems with regulation.

Self regulation is a basic developmental accomplishment that allows the growing child and eventually the adult to regulate their thinking, feeling and behavior so that it is within an appropriate range for the situation they are engaged in.

Grandiosity vs. Low Self Worth

Feelings of *low self worth* and shame can plague those within the addicted family system. Not feeling normal, experiencing themselves as different from other families, and hiding the painful truth of family dysfunction can all contribute to those in an addicted family system feeling bad about themselves.

Grandiosity is a common defense against feelings of worthlessness. Feelings of helplessness, frustration, shame and inadequacy get covered up with grandiose schemes and fantasies. Family members may not understand how to take baby steps toward success or getting their lives together. Frustrated and disheartened they may take refuge in grandiose ideas of themselves and their plans in life as a way of warding off ever-growing fears that their lives are somewhat unmanageable or they cannot seem to get things to work out for them.

A healthy self image can tolerate the normal flux in positive and negative feelings about the self without sinking into pervasive feelings of worthlessness or boomeranging into grandiose fantasies as a way of defending against those painful emotions. A healthy self image or good self esteem is probably one of the most important components of emotional immunity and well being.

Denial vs. Despair

Addicted or traumatized families are often very threatened by what they perceive to be the looming destruction of their family as they know it. Their very place in the world is being threatened; the ground beneath them is beginning to move. *Denial* is a dysfunctional attempt to put a good face on a bad situation by denying the impact addiction is having on the family system and the presence of the proverbial "pink elephant in the living room" who is taking up ever increasing amounts of space. Reality gets rewritten as family members attempt to bend it to make it less threatening; to cover up their ever growing *despair*. Family members often collude in this denial and anyone who attempts to turn the spotlight onto harsh reality of addiction may be perceived as disloyal. They run in place to keep up appearances (to themselves as well as others) while feeling a sense of *despair* constantly nipping at their heels. Again we witness the cycles between extremes that so characterize addicted/traumatized family systems.

Reality orientation or an ability to live with life on life's terms is an important part of recovering one's balanced sense of self and orientation toward the world.

Caretaking vs. Neglect

Caretaking can be an attempt to attend to, in another person, what needs to be attended to within the self *e.g.* personal, unconscious anxiety or pain may become displaced and projected onto someone else. Then we set about attending to "their" symptoms rather than to our own. It is a form of care that is motivated by our own unidentified needs rather than a genuine awareness of another's. Because this

is the case, *neglect* can be its dark side. We neglect or don't see what is real need in another person because we can't identify real need within the self. Neglect can take the form of, ignoring or not seeing another's humanness, withholding care, nurturing and attention, a shutting down of the relational behaviors that reflect attunement and connection. Neglect can be particularly difficult to treat because there is no easy behavior to pin wounded feelings on. Clients are left feeling they have too many needs to meet and mistrustful of deep connection.

Balanced care of self and others is part of living a healthy life.

Abuse vs Victimization

Emotional, physical and psychological *abuse* is unfortunately all too often present in families that contain addiction and trauma. Abuse is part of the impulsivity that characterizes families where feelings are acted out rather than talked out. The other side of abuse is *victimization*. The all too often dynamic in which the abused child becomes the abusing parent, having felt helpless and victimized as a child, for example, they act out their childhood pain by passing it on in the form in which they got it rather than identifying and feeling their own helplessness and rage at being a victim of abuse. In this way trauma related or addiction related familial patterns of relating become intergenerational.

Balance can be achieved when intense emotions can be tolerated both within the self and within the emotional container of the relationship or family. When this is possible, painful feelings, even if they explode momentarily, can be worked through toward some sort of resolution. After a disconnection occurs a reconnection can occur which will represent a slight step up in relating, healing or interpersonal awareness and understanding.

Trauma and Addiction as an Intergenerational Disease Process

Children of addiction are four times more likely to become addicts themselves and these statistics don't include multiple addictions such as food, sex, gambling, work addiction etc. Nor do they include those who marry addicts. There is certainly evidence that there is a genetic predisposition to addiction. However, even putting genetics aside, the emotional, psychological and behavioral patterns that get passed down through the generations put each generation at risk for perpetuating the trauma related dynamics that lead to emotional problems across a wide range of indicators. In this way, addiction and psychological problems become a family illness that is intergenerational. Those who have experienced trauma may experience some of the following issues when they attempt to re-enter adult intimate relationships. They may:

- Avoid intimate relationships because they unconsciously fear another interruption of the affiliative bond (isolation)
- Recreate relationship dynamics that mirror their original trauma (reenactment)
- Unconsciously project unhealed pain and anger from the original trauma into present-day intimate relationships (transference)
- Become enmeshed in intimate relationships in an unconscious attempt to protect against abandonment (fusing)
- Distance their partner when they enter a dependent relationship (withdrawal)
- Later respond to situations that trigger them by shutting down, or with an intensity of emotions appropriate to the original traumatic situation (triggering)
- See their partners in intimate relationships as alternately all good or all bad (splitting)
- Misread signals from others, overreacting to signals that threaten to stimulate old pain (Alexythimia)

- Lose the ability to let go and be playful in intimate relationships (loss of ability to fantasize, symbolize)
- Lose the ability to trust and have faith in intimate relationships (interruption of affiliative bond)
- Lose their capacity to accept support (numbness, shutdown, unresolved pain)
- Engage in sensation-seeking behavior (high intensity / shutdown)
- Self medicate with drugs and alcohol (self medication) (Dayton 1997)

Parents with a family history of trauma and/or addiction may tend to:

- Have trouble tolerating their children being rejected by anyone.
- Tend to violate their children’s boundaries by being unnecessarily intrusive and overly curious about their child’s affairs or push them away and withdraw or both.
- Have a difficult time negotiating the vicissitudes of intimacy with their children and establishing an overall evenness in relating.
- Overprotect their children even when it is not in their children’s best interest or push away the child’s needy/dependent sides or both.
- Not know what normal is and consequently have trouble understanding what behavior to accept or foster as normal in their children and what behavior to discourage.
- Have trouble having relaxed and easy fun with their children.
- Have impulsive features that they act out in their parenting.
- Feel somewhat different from other families.
- Attempt to over control family life and the lives of their children.
- Have trouble establishing healthy boundaries with their children, positioning themselves either too close or too far.
- Withdraw when hurt or become attacking, may have trouble modulating their responses.
- Have trouble generating healthy family rituals and allowing for the natural ebb and flow that accompanies them. They may become too important or minimized as to importance or both.
- Layer their unresolved historical emotions onto their relationships with their children.(Dayton 1997)

Resilience

In treating ACOAs it is very important to identify the qualities of strength and resilience that they possess. ACOAs can be marvelously adaptive and resourceful. As the Italian proverb goes “what doesn’t kill you makes you stronger.” Many COAs and ACOAs develop unusual personal strengths. One of the single most important thing that resilient children share in common, according to Wolin and Wolin, is a strong, bonded relationship with at least one other person, usually within the extended family network, often a grandmother, aunt or uncle.

Wolin and Wolin have created what they call a resilience mandala, or those qualities that are resilience enhancing. They are:

- Independence
- Creativity
- Relationships
- Insight

- Humor
- Morality
- Initiative

Some of the risk factors for children that can lead to psychological and emotional problems later in life are:

- Poverty
- Overcrowding
- Neighborhood and school violence
- Parental absence
- Unemployment or instability

These can be the children who are likely to wind up in the health care or penal system. However some children grow up in the middle of all this and still come to have productive lives and relationships. Wolin and Wolin studied these children and their growth into adulthood in order to identify the attitudes and qualities that resilient children and adults seemed to possess and what factors might have contributed to building them. They discovered that resilient children tended to have:

- Likable personalities from birth that attracted parents, surrogates and mentors to want to care for them. They were naturally adept recruiters of support and interest from others and drank up attention, care and support from wherever they could get it.
- They tended to be of at least average intelligence reading on or above grade level.
- Few had another child born within two years of their birth.
- Virtually all of the children had at least ONE person with whom they had developed a strong relationship, often from the extended family or close community.
- Often they report having an inborn feeling that their lives were going to work out.
- They can identify the illness in their family and are able to find ways to distance themselves from it; they don't let the family dysfunction destroy them.
- They work through their problems but don't tend to make that a lifestyle.
- They take active responsibility for actively creating their own successful lives.
- They tend to have constructive attitudes toward themselves and their lives.
- They tend not to fall into self destructive lives.

Wolin and Wolin in studying resilient adults found that they tended to have:

- Found and built on their own strength:
- Improved deliberately and methodically on their parents' lifestyles
- Married consciously into happy, healthy and or strong families
- Fought off memories of horrible family get-togethers in order create their own rituals.
- There tended to be what Wolin and Wolin refer to as the "magic two hundred mile" radius between them and their families of origin, enabling them to stay somewhat apart from the daily fray of potential family dysfunction.

Wolin and Wolin found that the price these persons tended to pay were:

- Stress related illnesses.
- A certain degree of aloofness in their interpersonal relationships.

Healing the Emotional Body along with the Mind and Spirit

Implications for Treatment

Because the types of trauma that occur in homes often constitute ruptures in relationships and often are at the hands of primary caretakers upon whom we depend for nurturance and survival, the implications for treatment are complicated. That is, the very vehicle that will lead us eventually back to health (i.e., relationships in therapeutic situations such as one-to-one or group therapy or twelve-step programs) are those situations that have become fraught with pain and anxiety.

Part of what addicts, ACOAs and codependents are doing in recovery is rewiring their body/mind systems to be able to tolerate increasing amounts of emotional and psychological pain without blowing up, shutting down or self medicating. The cerebral cortex "has more inputs from the limbic system than the limbic system has coming from the cortex" (Schoore 2004) Consequently our emotions highly impact our thinking and choice making processes.(Damasio 1999) Integrating these emotional messages with our reason is part of how we come to better understand ourselves and develop emotional literacy. But the body will also need to develop emotional strength; it will need to heal the nervous system that has become deregulated through trauma.

This limbic reregulation happens slowly and over time. A week or a month or even a year is not enough time to accomplish this intricate mind/ body task. It may take years for clients, to accomplish these deep changes and may require a combination of body work, therapy and twelve step programs. Talking about traumatic memories may be the very last phase of healing from them. Full healing may encompass:

- Developing the ability to manage levels of physiological arousal without becoming so anxious and fearful that one cannot tolerate the emergence of traumatic memory and the accompanying physiological sensations.
- Limbic rewiring, i.e. spending time with adept external regulating relationships in order to repattern the deregulated limbic system, e.g. therapy, twelve step programs, hobby groups, faith groups, relationships with animals.
- Getting sufficient rest and relaxation.
- Adopting good nutritional habits.
- Finding alternative ways self sooth and self regulate such as yoga, massage, exercise, meditation/relaxation/breath work that can stimulate the body's natural opoid or self soothing systems. heal the nervous system and bring it back into balance.
- Doing the family of origin, present day family work in order to work with issues that contribute to using and dysfunction.

Issues relating to addiction or being the adult children of addiction often get misdiagnosed. ACOAs may present across a wide range of symptoms such as depression, anxiety disorders, eating disorders, gambling, sexual or borderline symptoms. But it is difficult for healing to take place solely

on a psychological level without understanding the full picture of both trauma and addiction. When healing occurs, it can often be traced to a long term relationship with an empathic therapist and the sense of belonging and the patient reworking of limbic bonds that occurs through twelve step programs.

Often times, in searching out these original wounds therapists need to keep in mind that there will be what are referred to as model scenes (Lachman 2002) or scenes that carry an intricate web of symbolic meaning and dynamics for the client. These scenes may be a sort of amalgam of many overlays but, as in a dream, they have a depth of meaning and significance that the mind has shaped over a period of time. It is these sorts of scenes that we see emerge in the film, *The Process*. People who have been traumatized do not necessarily remember things perfectly or in order. Memories are fragmented and tend to fill out over a long period of time as the client becomes a little bit stronger each day. Consequently there is no one scene, no one conversation and no one method to use in trauma treatment. A combination of approaches that includes both group and one to one therapy, twelve step programs and body work has proven to be effective in the long term and can produce lasting healing. Oftentimes those in recovery report that “they do not wish to close the door on their pasts” because, through recovery, they experience a deepened capacity for living.

Tian Dayton M.A. PhD TEP is the author of *The Living Stage: A Step by Step Guide to Psychodrama, Sociometry and Experiential Group Therapy* and the best seller *Forgiving and Moving On, Trauma and Addiction* as well as twelve other titles. Dr. Dayton spent eight years at New York University as a faculty member of the Drama Therapy Department. She is a fellow of the American Society of Psychodrama, Sociometry and Group Psychotherapy (ASGPP), winner of their scholar’s award, executive editor of the psychodrama academic journal, and sits on the professional standards committee. She is a certified Montessori teacher through 12 years of age. She is currently the Director of The New York Psychodrama Training Institute at Caron New York and in private practice in New York City. Dr. Dayton has masters in educational psychology, a PhD in clinical psychology and is a board certified trainer in psychodrama. She is a guest expert on CNN, Montel, MSNBC and radio. For more information, on books, articles and handouts log onto tiandayton.com.

Note to Professor: It is very likely that there will be those in your classroom who have been deeply affected by addiction. It is important that therapists address their own addiction-related issues if they are going to be of any help to their clients. It may be helpful to point out resources such as AA and Al-Anon for anyone who has been affected by addiction or who may be working with addiction. These self help groups all have web sites that list local meetings and provide excellent information. The NACoA website is an excellent resource providing helpful information and links to relevant resources. The Film, *The Process* is available through HCIBOOKS.com or the process.info and can be used in conjunction with this article in order to give a picture of the immediate and long term affects of addiction.