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Children of Alcoholic Parents

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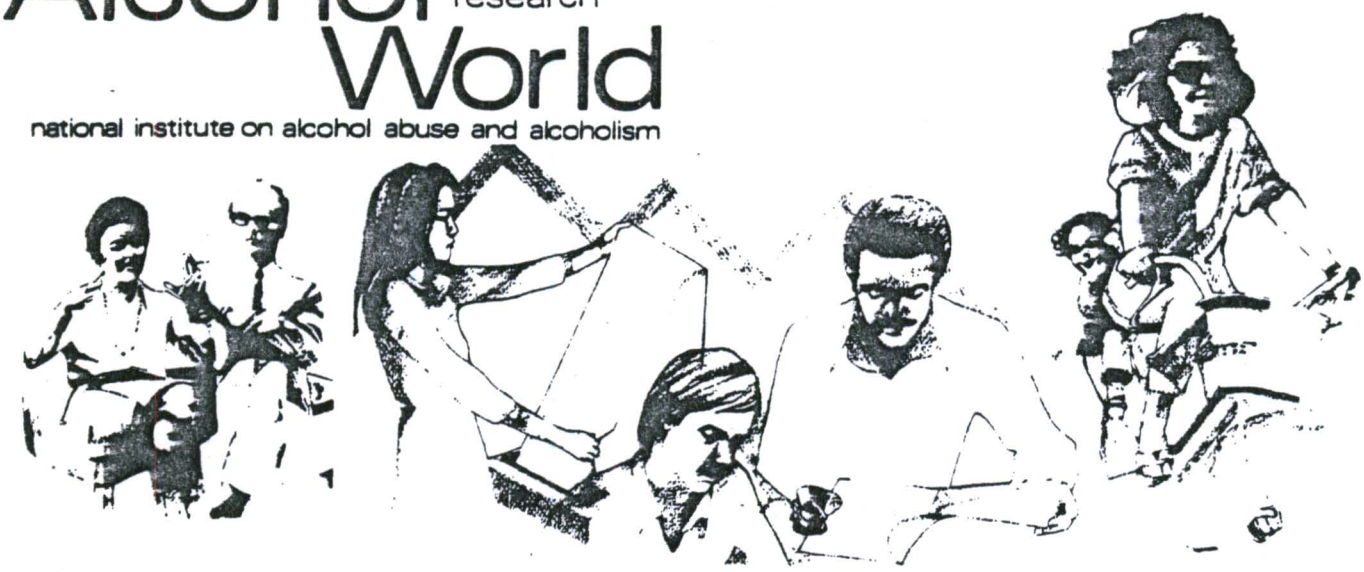

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children of alcoholic parents

Margaret Hindman
NCALI Staff Writer

"Mostly I'm by myself—there isn't anyone I really know. We've moved a lot and I don't want to make new friends. Even if I had a friend, I wouldn't bring him home. I wouldn't want him to know what my family is like. I'm afraid he'd hear the fighting or see my dad, and then he wouldn't like me. Mom says we shouldn't tell anyone (about Dad's alcoholism). Anyway, I'd hate for them to know. I'm too ashamed. . . . People shouldn't know your business. I wouldn't want them to feel sorry for me."

With these words,* Jerome, 12, bares the heartaches of a child with an alcoholic parent and speaks in a sense for the millions of other children with an alcoholic father or mother. All too often, children like Jerome are the unseen casualties of alcoholism.

It has been recognized for some years that the children of alcoholic parents are subject to a high risk of developing alcoholism in their adult years. More recently, attention has focused on the alarmingly high incidence of emotional and behavioral disorders among this group (Chafetz et al 1971, Fine et al 1975). This is not hard to understand, since life in the home of an alcoholic parent can be chaotic, confusing, and unpredictable, and frequently involves parental neglect and even physical abuse of the children.

Research Efforts

Researchers are seeking to broaden society's knowledge of the needs of these children—examining such questions as the link between drinking and child abuse and the broad social and psychological effects of parental alcoholism on children, while they are living in the home as well as later when they begin families of their own. Preliminary research data confirm the observations of professionals in the field that these youngsters have a poor self-concept, are easily frustrated, often perform poorly in school, and are more likely than their peers to suffer from adjustment problems, particularly during adolescence.

In general, resources to meet the needs of these children are sadly lacking. Those community agencies and individuals which might logically be expected to help the children of alcoholic parents are too often not aware of the problem, much less geared to provide help. And because of the nature of the illness of alcoholism and its social stigma, the child is seldom able to actively seek help. Without the aid or intervention of helping persons, a child's access to the limited available resources is itself limited.

And yet, since there is a high risk that the children of alcoholic persons will develop alcoholism, they are a logical target for prevention and early casefinding

* From *The Forgotten Children: A Study of Children with Alcoholic Parents*, by Margaret Cork (1969).

efforts. They require effective treatment resources which have a strong outreach component and offer comprehensive medical and psychological care. In order to demonstrate what can be done to aid these children, several innovative programs have been initiated. In some cases, these programs combine the prevention and treatment functions to identify children who need help and offer them appropriate remediation in the family setting.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) recognizes children of alcoholic parents as a high risk group, according to Judith Katz, Director of the Youth Branch of the Institute's Division of Prevention. "Increasingly, these children are receiving the special attention they deserve," she says, adding that the early results of prevention and treatment efforts aimd at this populaion are a promising beginning.

Researchers estimate that between one-fourth and one-half of all alcoholic persons have had an alcoholic parent or close relative (Bosma 1975, Schuckit 1973, Fox 1968). According to University of Alabama sociologist Gerald Globetti (1973), the children of alcoholic parents are twice as likely to become alcoholic as the children of nonalcoholic parents. This is especially alarming in the light of estimates that the children of alcoholic persons in America today exceed 28 million, according to estimates based on a survey made for the NIAAA (Booz Allen & Hamilton 1974).

Nature vs. Nurture

This latter statistic figures in the continuing "nature vs. nurture" controversy over the etiology of alcoholism. While there is widespread agreement that alcoholism is linked to familial factors, researchers continue to debate the relative importance of genetic and environmental influences. Evidence assembled to date provides support for both views, and many researchers agree that the final answer will lie in a combination of genetic and environmental factors (Schuckit 1973, Goodwin 1973).

As they have begun to look more closely at the effects of parental alcoholism, researchers like W. R. Weir (1970) have found that the children of alcoholic parents have fewer peer relationships and show a greater trend toward maladjustment than their peers from nonalcoholic homes. "The adjustment problems of adolescence appear more difficult for the student with a family alcoholism problem," he says.

Contributing to the emotional problems of such a child is the fact that the behavior of the alcoholic parent, and often that of the nonalcoholic spouse as well, tends to be erratic and inconsistent. The focus of family life is on the alcoholism, the experts note, and children are often ignored or neglected, disciplined inconsistently, and given few concrete limits and guidelines for behavior. In addition, the family is generally isolated from other members of the community. Because of the alcoholism problem, there are few family outings or group activities at home. Friendships are often avoided by both the nonalcoholic spouse and the children because they are ashamed of the presence of alcoholism in their family.

The child who acts out his problems—by engaging in vandalism, fighting, or other disruptive behavior—may get attention at school, but it will often be in the form of punishment rather than referral to treatment resources. On the other hand, the child who reacts to a parent's problem drinking by withdrawing is often completely ignored by resource persons.

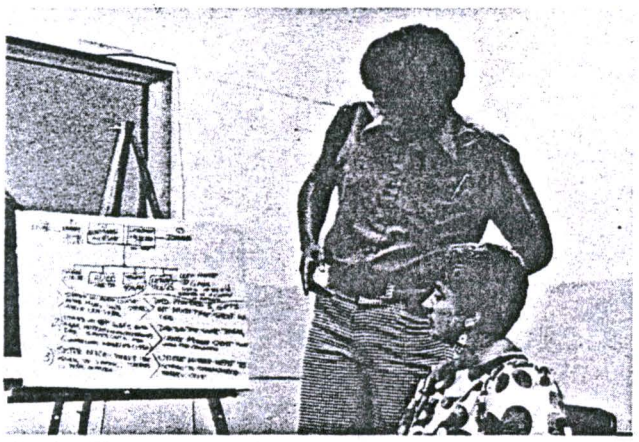
"When children become aware of the social stigma surrounding alcoholism, they feel different, estranged, isolated, and ashamed, and often do not wish to go out as a family," comments Dr. Ruth Fox (1972). "This isolation further intensifies their already low self-esteem, confirming their inner sense of worthlessness." A poor self-concept, which most authorities agree characterizes alcoholic persons as well as their children, is considered to be a primary trait of persons who engage in self-destructive behavior.

Although the children of alcoholic parents may manifest disturbances throughout their development, they are most symptomatic in first grade and in early and late adolescence, according to Dr. Willem G. A. Bosma (1975) of the University of Maryland. He has observed a high incidence of parental alcoholism among children in treatment for behavioral problems at clinics in both suburban and inner city settings in Baltimore.

Toronto Project

Margaret Cork, a psychologist at the Addiction Research Foundation of Ontario (ARF) in Toronto, interviewed 115 children with alcoholic parents (1969). She identified underlying personality disturbances in all of the children, and concluded that the prevalence of such disturbances "suggests that should any of them turn to alcohol to meet some of their emotional needs, there is a very real possibility that they will become alcoholic."

A significant number of the children interviewed and tested by Ms. Cork reported they felt rejected by the nonalcoholic spouse as well as by the alcoholic parent. "The personal needs of the alcoholic and spouse are, to them, overwhelming," she says. "They do not willfully neglect their children, but their constant quarrelling, their inability to recognize or meet their children's needs, and their failure to love wisely and to understand their children would seem to con-



At the University of Maryland Hospital's program for treatment of families and children of alcoholic people, family therapist Elena Manzarera discusses a family chart with trainee Paul Ewing.

stitute a form of rejection that clearly amounts to neglect."

A variety of research projects are being pursued in an attempt to further illuminate the effects of parental alcoholism on children. One of the more comprehensive assessments currently underway is a 10-year followup study of children whose parents were alcoholic. The study is being conducted by Scientific Analysis Corp. of California, funded by the NIAAA.

Unlike most studies of the problem, this project does not focus on persons in treatment. Rather it is a followup of children from multiproblem families in an urban area of San Francisco. The researchers are looking at children of alcoholic people, to see how the children, now between 17 and 30 years old, cope with the stresses of their background. The researchers are especially interested in what effect parental alcoholism might have had on the development of coping mechanisms. This group will be compared with children from the same socioeconomic background and environment whose parents suffered from problems other than alcoholism, as well as with control groups.

Preliminary findings suggest that children of an alcoholic mother tend to have more behavioral and emotional problems than the children of an alcoholic father. Also, based on findings from earlier analyses of the families in the study, there seems to be a high interrelationship between alcoholism and mental illness in multiproblem families.

Child Abuse and Neglect

In addition to the social and psychological deprivation which is often the lot of the child of alcoholic parents, there is also a physical threat in some cases. According to staff members of the Washingtonian Center for Addictions, an alcohol and drug abuse treatment facility in Boston, drinking is very likely connected to child abuse and neglect in more than one way. While the alcoholism literature contains few specific references to child abuse or neglect, studies of family relationships indicate that violence is frequent within families of alcoholic persons (Krimmel and Spears 1964). Studies of child abuse and neglect in some areas implicate alcoholism in as many as 90% of reported cases (Borders 1974).

The Washingtonian Center is studying the relationship between substance abuse and child abuse and child neglect as part of a research grant from the Office of Child Development (OCD) of the U.S. Department of Health, Education, and Welfare. OCD has funded another project in San Antonio, Tex., which is examining the relationship between alcohol abuse and child abuse and neglect, and attempting to coordinate the delivery of community services to these children and their families.

Many authorities agree that treatment and early intervention programs for the children of alcoholic parents should offer services to all family members, with special emphasis on the needs of the children.

Alateen is a primary resource available to young people whose parents are alcoholic. Affiliated with the Al-Anon Family groups, Alateen serves young people between the ages of 13 and 20. The informal meetings of this group provide support and a forum for exchange of information for these young people. In some areas, another kind of group, known as Ala-Tot, is available for preteenagers as well.

Specialized Treatment

While these groups serve a valuable purpose, many children of alcoholic parents need more specialized treatment alternatives in addition to support groups.

Dr. Bosma observes that the needs of children of alcoholic parents are seldom considered by alcoholism treatment programs. "They tend to be totally ignored by the professionals treating the alcoholic parents," he says. "Except for an occasional individual, doctor, teacher, or minister who looks below the surface behavior, these children can expect little attention or comfort from society."

Treatment personnel, Dr. Bosma continues, need to change their attitudes and approaches before they can meet the needs of these children. Also, he suggests, existing alcoholism programs should add specialists in child treatment to their staff. "Perhaps the law should even provide that the children be placed in treatment against parents' wishes if necessary," he says.

Dr. Bosma heads an NIAAA-funded project in the

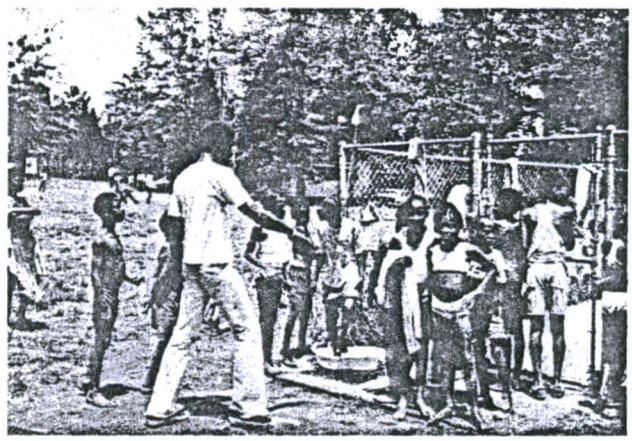
Alcoholism Division of the University of Maryland Hospital in Baltimore which takes a family-therapy approach in offering assistance to the child who is exhibiting a behavior problem. The alcoholic parent and other family members are involved from the beginning in treatment, and the child's problem is viewed as a symptom of malfunction in the family. Referrals to the program come from the hospital's general pediatrics clinic as well as private physicians.

The project staff focus on identification and treatment of the child as an individual as well as a member of the family unit. Essential psychological, physical, and sociological data are collected on the child, who is recognized as a person with a high potential for becoming alcoholic. Early data indicate that the strategy of using the child's problem to get the entire family into treatment results in earlier identification of the alcoholic parent. Authorities agree that the chances for recovery are greater in the alcoholic person who is in the early stages of the illness. The project therefore serves a dual purpose—to help the child overcome behavior problems and to draw the alcoholic parent into treatment while his illness is more treatable.

"Alateen is a primary resource available to young people whose parents are alcoholic."

The contention that treatment of the whole family is important is also supported by Ms. Cork. She recommends more intensive treatment of the non-alcoholic spouse as well as the children, and suggests that the children should be treated alone if the parents won't participate. Family therapy, she stresses, should not end when the alcoholic member becomes abstinent, since the family functioning and relationships often remain damaged. Children of alcoholic persons, she noted in her study, did not report that family life became significantly better when the drinking stopped in the absence of family therapy.

Most efforts to identify and help the children of alcoholic parents are initiated either after the child has exhibited behavioral problems which require attention or after the parent has come to the attention of treatment personnel. Both of these approaches are effective ways of reaching many young people. But the alcoholic parent does not always get into treatment, and the child, though suffering from a variety of problems, often does not act out in such a way as to cause referral for treatment or evaluation. It is therefore important, the experts say, to consider other ways to reach such children and offer help in developing healthy personalities.



Junior counselor Robert Hemby supervises summer camp activities of youngsters participating in the recreation program offered by Orangeburg (N.C.) Elementary Children's Project.

School Intervention

A promising avenue for early intervention is through the schools. "Counseling and education in the schools could provide aid even before the parents are labeled alcoholic," according to researcher Dr. Beatrice Rouse and associates at the University of North Carolina (Rouse et al 1973). "School programs potentially could provide intervention during the student's formative years to enable him to develop more constructive methods of coping," they said.

Among existing programs which use the schools to draw young people into treatment is La Fe Youth Hostel, an NIAAA-funded prevention and treatment facility in Sante Fe, N. Mex. Counselors from this program visit public schools, bringing a message about responsible decisionmaking and offering to talk privately with young people who want more information or help with alcohol problems. School personnel cooperate by channeling to the program those youngsters whose parents are alcoholic or who themselves are alcohol abusers. Counseling and temporary residential care are offered by the facility. (See article on the La Fe program in NIAAA *Information Feature Service*, May 20, 1975.)

Alcohol education programs, followed by counseling for those who desire help with alcohol related problems, have been used successfully in other areas of the country as well. Dr. Weir suggests that such programs can serve a dual function. In addition to helping young people learn skills to cope with an alcoholic parent, these programs can often bring about an unexpected positive change in the functioning of the entire family. In some cases, the alcoholic parent may be motivated to seek treatment, Dr. Weir comments.

Another program centered around the schools uses both early intervention and prevention techniques for elementary school children in Orangeburg, S.C. An NIAAA-funded project operated by the local Committee for Economic Progress, Inc., it offers medical and psychological evaluation, recreational activities, and academic tutoring to children of a low socioeconomic status. Referrals come from the schools, the criminal justice system, and social services agencies. Many of the youngsters have an alcoholic parent, as determined by a staff social worker in visits to the homes.

By providing new adult models and offering help in learning new ways to relate to peers in an informal recreational group setting, the Orangeburg project attempts to counteract some of the negative effects of the parental alcoholism on the child, notes project coordinator Martin Williams. Psychological, social, and academic data are collected before, during, and after participation in the program. Children with alcoholic parents are then compared to other participating children who serve as controls for purposes of program evaluation.

The few scattered services which are available to children of alcoholic parents tend to ignore younger children, observes Mr. Williams. There are indications that children who are exposed to parental alcoholism at an early age show more severe social and psychological adjustment problems in later life than children who first face this problem during adolescence, he says. Therefore, it is especially important to reach the younger age group. While informal alcohol education is included in the recreation framework of the program, the primary focus is on development of healthy social interaction skills.

Many questions remain to be answered concerning the children of alcoholic parents, but genuine advances have been made—by both researchers and program officials—in the effort to clarify the problem and spell out the needs of this population. Among the more important points that the experts have found agreement on in this area are the following:

- Early intervention and prevention programs must use aggressive outreach to locate and assist the children of alcoholic persons before their problems become too severe. Working through the schools and other institutions or groups serving youth seems to be a promising approach to identifying these children at an early stage and directing them into treatment.
- The entire family, including the children, can benefit from treatment when one or both of the parents is alcoholic. As Dr. Bosma poses the question, "Do we continue to treat a disease such as alcoholism without making an effort also to treat the anguish of the family and, at the same time, prevent future alcoholic or mentally ill adults?"
- In order to adequately treat the children—and the rest of the family—existing services will need to be expanded and new services will have to be developed.

All who are familiar with the problem agree that the suffering of children of alcoholic parents has been ignored for far too long. However, emerging programs of prevention and treatment, as well as the research initiatives now underway, are promising signs that the needs of this population are finally being addressed. ■

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alcohol topics IN BRIEF

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Alcohol and the Family

INTRODUCTION

In 1980 the Gallup Organization released survey data collected for the White House Conference on Families, which indicated that alcohol abuse is a growing threat to the family. The Gallup report suggested that 60 percent of the U.S. population has identified alcohol abuse as one of the most harmful influences on family life today, and that 25 percent feel that an alcohol-related problem has adversely affected their family.[18] Studies have shown that most alcoholics are not isolated individuals nor do they inhabit only skid row. A significant proportion are members of intact families,[42,43] and their behavior affects several other people.[36] Only recently has the study and treatment of alcohol abuse and alcoholism expanded to include these previously neglected individuals.[1]

THE FAMILY

The family is a complex social unit and, in its various forms, is the basic building block of all societies.[1] It takes on the chief responsibility for caring for and training children and providing a stable reference point for adults. Although outside influences are important in how we develop and grow, the lessons we learn in our families have a sustained influence throughout our lives.[1]

Carrying such weight and responsibility, the family is highly vulnerable to stress.[1] People expect endless sympathy, understanding, and support from their families. The family develops as a system of many interlocking parts, each with its expected role. If one part malfunctions, roles must be changed and adopted by others. In order for the system to continue functioning, all the members need to remain flexible and ready to shift roles again, especially when the malfunctioning member recovers and rejoins the system.[1]

When a family member is an alcoholic, the family is often classified by therapists as a problem family. Problems occur because the family is not functioning well; the family may be trying to maintain the status quo with an alcoholic member, simply to avoid disrupting familiar, although difficult, life patterns.[32] It may even be that the alcoholism in the family helps to divert attention from other members' problems.[43] Adjusting to the abstinence of the alcoholic family member may be perceived as a new pain or threat to be avoided.[12] In this way, it can be said that the family may derive certain benefits from tolerating, and thereby supporting, the alcoholism no matter what the initial cause may have been.[5,8,12,16,43]

Although there is certainly not one type of problem family, there do seem to be similarities among families with an alcoholic member.[25,34] Just as the alcoholic may deny that a problem exists, the rest of the family may do the same for many years. The family may then become increasingly isolated from outside relationships, reorganizing their lives while excluding the alcoholic. Whenever the alcoholic recovers, the difficult adjustment of including the newly functioning individual must be made by the other family members if they are to remain together.[25]

FAMILY INTERACTIONS AND COMMUNICATION

In the past 20 years, researchers in the field of alcohol abuse and alcoholism have been interested in the nature of interactions in the alcoholic's marriage and family[26] and the relationship of these interactions to the progress of the illness and the outlook for recovery.[37] Some researchers, over the years, have characterized the partners in alcoholic marriages as more quarrelsome, less likely to settle disputes, more likely to be abusive to each other, and more likely to divorce.[8,23,39] Others have added that when little affection is expressed by the marriage partners and when the alcoholic has no part in family tasks, the outlook for recovery is poor. A closer marriage seems to be a predictor of good treatment outcome.[37] Only in the past 10 years have experts clearly stated that no single style of interaction is evident in marriages or families involving alcoholics.[43] Recent research has been conducted in controlled settings to assess the different types of interactions that actually occur.

Steinglass, at the Center for Family Research of George Washington University, tested the interactions of families using games and judged how the families cooperated and how they scored as a group.[43] Those families that included an alcoholic in a drinking phase scored highly, although they did not coordinate their efforts well. Their interactions were more animated and freer than those of families in which an alcoholic was in an abstaining phase, and they tried a greater variety of approaches to the problems. The families in which an alcoholic was abstaining coordinated their efforts at a fairly high level, but did not score well, nor were their interactions relaxed. They rigidly held to a family level of problem solving that seemed to be a reflection of their conception of togetherness. The researchers concluded that families that include an alcoholic fluctuate between these two types of interactions. Neither of these patterns works effectively alone so that the families rely on a combination of these patterns to continue to function.[43]

Earlier, Kennedy[29] had found similar interactions in couples, although the rigidly cooperative patterns varied by how much the alcoholic drank and for how long. Gorad,[21] on the other hand, found that the couple including an alcoholic was unable to function as a unit for their mutual benefit. In addition, the wife (in this case the spouse of an alcoholic) demonstrated behavior that effectively accepted responsibility for the problem solving while the husband (the alcoholic) avoided responsibility. They did not take risks in trying new approaches and their performance suffered.

FAMILY VIOLENCE

The prevalence of child and spouse abuse has attracted intense, nationwide attention in the past

few years, although the actual number of people involved is hard to determine.[4] It has been estimated that 28 percent of the adult population is involved in marital violence, and that possibly 3 to 4 percent of the adults in two-parent families abuse children.[45]

The question of alcohol's relationship to abusive behavior remains unanswered. Many people consider alcohol use to be a major cause of physical abuse, expecially child abuse, but a cause and effect relationship has not been established.[33] There does seem to be some connection.[9] Certain family situations, such as an alcoholic family or marriage, are high risk situations for abuse to occur toward a spouse, child, or elderly family member.[33]

Researchers disagree concerning the percentage of cases of marital violence that involve alcohol use; the findings have ranged from 6 percent[4] to 50 percent.[19] Estimates of child abuse cases involving alcohol use range as high as 25 percent.[27] The relationship between alcohol use and the physical abuse and neglect of the elderly is a more recent area of study; as a result, the statistics are not yet available. However, alcoholism seems to figure in a significant number of cases of abuse and neglect of elderly family members, whether the family caregiver or the elderly are alcoholic.[41] Research on the relationship between alcohol and violence is complicated by the fact that some researchers study alcoholics, some regular drinkers, and others simply the presence of some alcohol use.[9]

Certain trends are beginning to emerge. For example, contrary to popular belief, most alcoholics do not physically or sexually abuse their children; however, child neglect is strongly associated with alcohol abuse.[33] All children of the alcohol abusers surveyed by Black and Mayer[33] were neglected. There does seem to be a reduction in both child abuse and neglect with recognition by the alcohol abuser of an existing alcohol problem.[31]

Many stress factors are at work in the making of a violent home; all problems cannot be blamed on alcohol abuse.[9,33,45] However, while in treatment, intact families that include an alcoholic should probably be screened for cases of abuse and neglect.[33]

SPOUSE OF THE ALCOHOLIC (THE HUSBAND AND WIFE)

In the early years of alcohol research, the wife of the alcoholic was considered to be a seriously disturbed person with problems that predated the relationship with her alcoholic husband. The title "the wife of the alcoholic" had strongly negative connotations.[30] As research continued, theories developed that pictured these wives as disturbed owing to the stress of living intimately with an alcoholic and that they valued the status quo at any cost, even keeping their husbands alcoholic.[24]

Although modest support has been found for the later stress theories, an extensive review by Edwards in 1973[13] of the preceding 30 years of research revealed that there is no one type of woman who marries an alcoholic, that these women are experiencing problems under stress, that their problems show in their individual ways and are not as deeply rooted as assumed earlier. Women who participate in Al-Anon, a self-help group for adult relatives of alcoholics, show more constructive reactions to stress than other women married to alcoholics.[22] Wives who stay with their alcoholic husbands perhaps have encountered fewer difficulties or have more financial interests at stake, or may be more willing to seek help. But, those who leave or try to leave may be showing a high degree of self-preservation and better emotional health.[1] Even back in 1954, one researcher stated that wives of alcoholics react just as anyone would in an uncertain situation with conflicting loyalties and without support from outside relationships.[24]

The husbands of alcoholic women have been studied only recently and the information is limited.[39] In general, most experts agree that they are more likely to leave than an alcoholic's wife would be,[17] although others are unsure.[2] These men probably leave because they are more independent financially and have more ties outside the family.[34] In addition, the husband may not have any interest in caring for an alcoholic wife[17] and may be less likely to seek outside help to solve the family's problems, especially because many strongly deny the existence of the problem.[15] Those who do seek help are usually the husbands who stay; it is unclear if this is because they are able to be caregivers, have a strong sense of family stability, or think poorly of their ability to live outside the family.[2]

A 1973 study of husbands of alcoholic women indicated trends in who plays the dominant role in the alcoholic marriage.[6] In nonalcoholic couples, the husbands were generally the controlling family member throughout the marriage; in alcoholic couples, the wife initially played the dominant role, but the husband's authority increased with the wife's alcoholism. This shift in dominance foretells a possibly more difficult recovery rate for women because they must not only recover from alcoholism, but they cannot return to their formerly dominant position without disturbing the marriage.[6] Questions concerning this study remain, but it raises new ideas for research.[26]

CHILDREN OF ALCOHOLICS

Will children of alcoholics be more likely to suffer from alcoholism than their friends? Evidence seems to indicate that the answer is yes. Almost one-third of the alcoholics in any randomly selected group has at least one parent who was alcoholic.[10] A question that remains is how some children are at greater risk than others.

Some genetic basis for considering inheritance of alcoholism appears to exist. Goodwin[20] studied sons of alcoholics who had been adopted and who had a brother or sister still living with their biological parents. He and his colleagues found that alcoholism was much higher in both the adopted children of alcoholics and their brothers and sisters than in the rest of the population. Just living with an alcoholic did not seem to make the difference; who the "real" parents were and if they were alcoholic was important. Goodwin con-

cluded that the more severe the parent's alcoholism, the more likely that genetic factors were involved in the development of alcoholism in the children.[20]

Even without considering genetics, clearly children's socialization and family life is disrupted by the presence of an alcoholic in the family, and there are longlasting consequences. In addition to possibly learning from their parents to deal with stress by drinking and being at risk for developing alcoholism, children of alcoholics often have difficulty fulfilling their adult roles. They may lack the ability to form close relationships and may generally lack self-esteem and trust in others.[1]

Another possible consequence of parents' alcoholism is that adolescents may become runaways.[46] There seems to be a significant relationship between parents' alcohol abuse, parents rejecting their teenage children, and their subsequent running away. With an alcoholic in the family, the social isolation from friends and the added responsibility of taking on some of the disabled parent's roles may add to the likelihood of running away. In terms of teenage abuse of alcohol, runaway teenagers do not seem to drink more than their friends, but they seem to drink when upset or angry, whereas other teenagers tend to drink when feeling good or partying.[46]

The nature of the disruptions in the family life of children of alcoholics is being investigated by Wolin and his colleagues at George Washington University. They are studying the importance of certain family rituals, principally the way holidays are celebrated.[47] Family rituals are a form of communication, a way for families to establish themselves as a unit separate from the rest of the world and, at the same time, as a cohesive unit of related members. It appears that if a family preserves its holiday rituals, such as the way they celebrate Christmas each year, despite the disruptions caused by an alcoholic family member, then the family can preserve a sense of stability for its children. This ability seems to be possible if the family confronts tha alcoholic directly with their displeasure or shares complaints about the alcoholic, even if the alcoholic is absent. Silence concerning the alcoholic's behavior seems to be more disruptive of these critical rituals and family stability.[47]

Looking at statistics concerning the incidence of alcoholism in families, a few researchers have suggested that because women alcoholics are more likely than men alcoholics to come from families where alcoholism has occurred, it follows that girls are more vulnerable than boys to the impact of family alcoholism.[10] Although this point may be valid, it should be noted that a large percentage of alcoholics do not have any alcoholic parents. Alcoholism is not determined solely by early life experiences.[10]

PREVENTION

The education of the general public in terms of the family and its impact on the development of alcoholism has gained momentum in recent years. Theories and facts concerning the influence of families are publicized through pamphlets and the media, by the NIAAA[36] and State government programs.

Education programs geared toward individual families have been generated to help parents create a home atmosphere where children can learn to make responsible decisions concerning alcohol use.[11] These programs acknowledge the powerful effect that parents have on their children's development, and the program developers hope that by educating parents, children will benefit. Parents who participate are encouraged to become aware of the verbal and behavioral messages they give to children concerning their feelings about alcohol. Programs are directed at a general audience, not only at families that are considered most likely to foster alcoholism. Often the curricula consist of informal workshops using experiental learning, such as role playing, as a learning technique.[11]

The National Center for Alcohol Education has produced an example of an alcohol prevention education course for parents of young children.[40] It provides information on the physical and psychological effects of alcohol as well as information more specifically for parents. The sessions, conducted by a lay facilitator, center around such concerns as the media's influence on children, the importance of nurturing a positive self-image in children, and the need to develop an awareness of one's own reason for drinking or not drinking. The goal is to enable parents to provide a positive model of responsible decisionmaking.[40]

TREATMENT

Family therapy has been called the most noteworthy recent advance in psychotherapy for alcoholics.[35] This form of therapy became part of alcoholism treatment in reaction to the realization that all family members suffer when an alcoholic is in a family and that the family itself can be called alcoholic.[1]

It is necessary in treating the family as the patient to determine what patterns of interacting a family uses and how the family behavior supports the alcoholic. Family therapy attempts to improve the alcoholics' home environment as well as help make available the crucial family support for the alcoholic. If an alcoholic's family and spouse are involved in therapy, the recovering alcoholic can rejoin the family as an equal, not as the problem.[1]

Many different types of family therapy have been developed and studied. Some early work in family therapy used group therapy as a followup both for the nonalcoholic spouse who had been in individual therapy and for the alcoholic who had been hospitalized.[32] Often alcoholics and their wives attended different groups with different strategies for treatment. Improvements in family relationships and the drinking behavior of the alcoholic were often not significant, but they led the way to later developments.[42]

In the late 1960's, interest in simultaneously treating the members of an alcoholic family developed

in order to fight any family resistance to change.[16] Drinking was seen as a stabilizing force in the family, and therapy was seen as a means of enhancing family flexibility and growth.[42] Therapists realized that the family had to learn how it benefited from the alcoholic's behavior and what alternate family behavior would work better.[12]

More recently, some therapists and researchers have tried joining several families or couples in one group.[7] As a therapy format, it takes advantage of fairly well-established group techniques, while recognizing family factors in alcoholism.[42] A followup evaluation of members of a multicouples group at 6 months illustrated the benefits of the therapy; considerably more alcoholics were abstinent than those in regular treatment programs.[7]

There seem to be differing opinions about whether an alcoholic can be drinking while undergoing therapy treatment. Some suggest that a change in the family's rigid pattern of actions and reactions is more critical for long-term results than is the alcoholic's abstinence.[44] Steinglass maintains an interest in observing the family's interactions while the alcoholic is drinking and in using a strong, forceful therapist to cause dramatic changes in the way the family communicates on a daily basis.[44]

Others seem more interested in immediate interruption of drinking before beginning therapy. These therapists believe that only when drinking patterns are broken can alternative reactions be properly learned and implemented. The whole family becomes involved in supporting the detoxification program and subsequently is part of the therapy.[28]

Hard evidence to prove the benefits of family therapy is still lacking.[38,42] The alcoholics in these studies are necessarily those still involved with their families, and they are generally middle-class families. These alcoholics often recover and have a good outlook because of the available emotional support and their lack of serious financial problems.[38]

The subject of treatment programs for families cannot be closed without mentioning Al-Anon and Alateen. Both groups provide supportive, sharing atmospheres, similar to that of Alcoholics Anonymous groups. Al-Anon is for spouses, relatives, and friends, Alateen for teenagers. In this atmosphere these friends and relatives can look at themselves and their effect on the alcoholics in a more objective way. They learn to take responsibility for their own lives. They learn a less moralistic attitude about alcoholism and also how to treat alcoholics as being responsible for themselves.[1,3,22]

CONCLUSION

The interest in the relationship between alcoholism and families is recent and, as a result, the work in the field is scattered and not conclusive. A repetitive theme that occurs in reports and studies is that the hard evidence is not yet in. Much of the work is based on broad theory and small numbers of people.[26,38] Still, the questions being raised and looked at from the relatively new perspective of the family are important to answer, especially for the large percentage of Americans who are concerned about family life and health.[18]

No longer can the alcoholic who is part of an intact family be viewed only in isolation. Perhaps the whole story of the family should be studied, from courtship onward, to determine what helps create problem families and to decide what the family members can change, learn, or accept to make the family functional.[38,43] Wives were once the center of attention; now they rightfully share the spotlight with husbands, parents, and children, and the relationships among them.[15,43]

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CHILDREN IN NEED: consent issues in treatment

John McCabe

Introduction by Willard O. Foster, Special Assistant to the Director, National Institute on Alcohol Abuse and Alcoholism

An increasing recognition of the need to provide services to children of alcoholic parents almost immediately raises the issue of parental consent versus the rights of children. The potential moral or legal risk to the caregiver (or his/her organization), who may seek for good reason to intervene in this nebulous area in any manner short of a court order, must be considered. The issue becomes particularly sensitive in those instances where the alcoholic parent is unwilling to admit having a problem with alcohol and is not in treatment or where there is need for intervention on behalf of the child and the granting of parental consent is not a reasonable expectation. In these situations, the caregiver may be confronted by a hostile parent whose denial or fear of exposure may be sufficiently intense to intimidate the caregiver and even place the child in further jeopardy. This article explores the risk status of the caregiver in cases of children, even when need is personally and aggressively expressed, and serves to clarify the issue so that the nature and degree of risk involved in such intervention can be intelligently assessed. Its conclusions might lead a concerned caregiver to the assumption that the risk is minimal where intervention is professionally justified, is sought in good faith, and services are rendered with professional integrity.

The Status of Children in Family and Law

The nuclear family is a legal organization in the same sense that a business corporation or a partnership is. The law permits powers and duties to people in the organization, and places limitations upon them at the same time. The family arises in a concept of marriage, and acquires new parties through the biological process of birth, or through adoption. Perhaps that is the quality which most distinguishes it from other organizations recognized in the law. Birth and child raising are the basis for the parent and child relationship.

The rule which fundamentally governs this relationship gives most of the powers and obligations to the parents. The children obtain some of the obligations, but have few powers inside the family circle. The parents are regarded as the joint natural custodians of their children (1), and are legally charged with their care, welfare, education, nurture, and raising of them (2). In turn, the children must submit to the parents' custody (3). Parents have the right to compel obedience, even to the point generally of administering reasonable corporal punishment (4). If a child becomes too obstreperous or difficult to handle, the parents can even call upon the assistance of the state to control incorrigibility (5).

Notwithstanding these generally accepted rules, the status of children in the family appears to be changing. There is evidence of a trend towards legal capacity and independence at an earlier age. A large step was taken when the 26th Amendment to the Constitution of the United States lowered the voting age to 18 years of age (6). The states responded generally, in kind, by lowering voting and other age standards. The age at which a person may buy and consume alcoholic beverages, for example, has generally dropped. These examples are but part of the pattern.

A series of Supreme Court decisions in the 1960's concerning the delinquency proceedings in juvenile court are another contribution to the trend (7). These cases realigned juvenile court procedure with criminal court procedure, thus providing juveniles with the same general due process protections that adults enjoy. They recognized substantial constitutional rights for children, a fact not in itself so unusual (8). They also erased a significant difference in the law between adults and children, thus signifying the emancipatory trend. That is a significant change.

The question of individual consent to anything on behalf of a child, was touched on by the Supreme Court of the United States first in Wisconsin v. Yoder (9). This was the case in which the Amish challenged compulsory school attendance to age 16 in the state of Wisconsin. The Amish won, but the interesting material for this discussion appears in Justice Douglas' dissent (10). Douglas concurred in the findings of the court pertaining to religious liberty. His objection went to the question of whose religious liberty? He desired to protect the children's preferences, not the parents', and desired that the case be returned to determine the choices of the children.

In 1976, the Supreme Court of the United States ruled directly on a question of parents' versus children's consent. This occurred in Planned Parenthood of Missouri v. Danforth, which is the most recent case regarding abortion (11). In this case, the Court ruled that the state of Missouri could not require by statute the consent of parents to the abortion of an unmarried female under 18 years of age. The ruling follows directly from the original and well-known case on abortion, Roe v. Wade, in which abortion in the first trimester became a decision only for a woman in conjunction with her physician (12). The court based the Roe v. Wade

Due to the number and complexity of the references accompanying this article, they are not printed here. They are available on request by writing:

Dept. AWREF
Alcohol Health and Research World
National Clearinghouse for Alcohol Information
P.O. Box 2345
Rockville, Maryland 20852

decision on the constitutionally protected right of privacy for every person.

At this point in time, the Planned Parenthood ruling can be definitely cited only for its specific holding. Clearly, no state can impose a blanket parental consent requirement upon minor females desiring abortion. There may be some kind of permissible parental consent requirement, however. The Court stated, "We emphasize that our holding . . . does not suggest that every minor, regardless of age or maturity, may give effective consent for termination of her pregnancy" (13). In a companion case, the Court said, ". . . Not all distinction between abortion and other procedures is forbidden . . . The constitutionality of such a distinction will depend upon its degree and the justification for it" (14). There may be permissible parental consent requirements.

The abortion cases also say nothing about a physician's liability in the event he or she performs an abortion on a child without parents' consent. The statute had provided criminal penalties for physicians. These, of course, were eliminated, but these statutes never specifically concern civil liability. The legislative power of a state is not the same thing as the common law derived from court cases. Civil liability comes mainly from the common law. The physician can still be liable, until there is a ruling that liability adversely influences constitutional rights.

However, the Planned Parenthood case breaches the sanctity of childhood. It regards the pregnant female, whether a child or not, as an individual. If the state cannot treat the child differently from adults, that is an emancipating step in the law, and one in the most secure bastion of parental consent, the performance of a surgical procedure. Planned Parenthood also stimulates considerable speculation about the ultimate limits of its holding. Surely, the right of privacy is not effective only as it affects the right to contraceptives or abortion (15). Other rules restricting the rights and powers of children may also be challengeable, particularly as these pertain to the body. There are certainly other vulnerable statutory provisions, and common law rules may ultimately be questioned. The full impact of Planned Parenthood will not be known for a very long time to come.

The legal status of children appears to be changing in other regards also. In personal injury law, one significant trend has been the abrogation of the special standard of care for children who operate any motor vehicle (16). Another significant change which has occurred is the statutory tribute paid to the child's preferences in child custody proceedings following divorce or separation (17). There also is a trend to provide separate legal counsel or a separate guardian to represent the child's interest as a separate interest in custody and child support proceedings (18). These changes have an emancipatory effect and influence.

John McCabe

It is very easy to overestimate and misinterpret how social trends affect the law. The purpose of this paper is to discuss the capacity of children to seek certain kinds of treatment and assistance on their own, without parents' consent. It would not do to discuss the current specifics of the problem without discussing the possible future trends. Everyone who deals with specific situations has to be able to judge the individual risks. Sometimes the calculated risk wins, but it must be recognized for what it is. Future trends are important in calculating a risk. The law pertaining to family relationships is old and tenacious, however, and that too must be considered. Anyone who deals with children's problems is, therefore, advised to proceed with caution, when parental disfavor may be threatened.

The Need for Parental Consent

Within the conventional rules concerning parental control over children, it is difficult to define precise limits for the child's consent powers in his or her own right. Obviously, a child may consent to

the normal contacts of daily life. There is also, obviously, no barrier to a child's consent to the inoffensive contact of children playing. Also, in commercial transactions, there is no need to obtain parents' consent for the sale of small items such as candy or other items in the commerce of children. These are transactions based upon the child's proof of his or her capacity to pay. At what point the importance of a contact or transaction escalates, so that others must first seek parents' consent is just not well pinpointed.

Much of the law relating to children, as they face the outside world, is designed to protect them with specific legal privileges. A child or minor, for example, can enter contracts with other persons (19). The child can enforce its contracts, but has the privilege to disaffirm them against the other parties (20). Other parties enter a contract with a child, then, under considerable peril. It is to be assumed logically that a child consents to a contract, as well as a decision to disaffirm, without parent interference. The law presumes no parental role with respect to contracts.

There is one field in which consent of parents is required most of the time. There is ample case law which provides that surgery applied without the consent of the patient, or a proper standin, establishes the physician's liability for Battery (21). A Battery is simply an intentional, offensive bodily contact (22). The physician commits a technical Battery, since his liability is not contingent upon the effectiveness of the procedure or its good faith application. The basic principle is supplemented by the further principle that a child or minor cannot consent to his or her own operation (23). Only a parent or legal guardian can do so.

Even with respect to the operation or surgical procedure, the situation is not clear. There are a number of so-called mature minor cases (24). These cases have permitted children in their late teens to consent themselves to less dangerous operations. Then, too, the principle of emancipation intervenes. A child on his own, living away from the parental residence, may be emancipated and capable of acting as an adult for all things (25). Certain events in a child's life, such as marriage or childbirth, traditionally result in legal emancipation (26). An emancipated child has the power to consent to an operation.

What of other medical or therapeutic treatment? There is no definite answer to be derived from the existing cases. Some commentators have postulated a general rule pertaining to all treatment (27). However, surgery dominates the cases, and Battery is the fundamental theory. Consent has meaning in the cases because it vitiates the tort—or wrongful act—which is Battery (28). It is logical to expect other physical and manipulative treatment, especially if there are possible drastic physical effects, to follow the same rules. As we digress, however, away from such treatment, the picture blurs more and more. The legal theory becomes less and less applicable. When we reach treatment modalities of a pure communicative nature, such as psychotherapy, the rules would seem entirely in doubt.

It is worth looking into this a bit further. Psychotherapy is very generally defined (29).

> A method or system of alleviating or curing certain forms of disease, particularly diseases of the nervous system or such as are traceable to nervous disorders, by suggestion, persuasion, encouragement, the inspiration of hope or confidence, the discouragement of morbid memories, associations, or beliefs, and other similar means addressed to the mental state of the patient, without (or sometimes in conjunction with) the administration of drugs or other physical remedies.

The essence of psychotherapy is communication between therapist and patient. The patient reveals, and the therapist encourages and interprets the revelations. It is a focused and directed communication, and it seeks deep insight, but it is in kind no different from much commoner communications carried on in everyday life.

It may fairly be stated that counseling or advis-

John M. McCabe is the Legislative Director of the National Conference of Commissioners on Uniform State Laws (NCCUSL) in Chicago. In that capacity, Mr. McCabe, who is an attorney, is responsible for dealing with all aspects of liaison pertaining to the uniform acts produced by the NCCUSL.

ing is probably different from psychotherapy, by the definition, only in being less formal and systematic. These are still forms of communication between parties. The advisor or counselor hears the stated problem, and offers advice. It just may not be as systematic and it may not be as probing as formal psychotherapy.

It seems hardly plausible that a child cannot consent to certain advisory kinds of communications. No one would seriously question the power of the student to solicit advice from a teacher on schoolwork. Advice from the clergy to children is accepted as a natural incident of life. Children often turn to other adults for advice and information, and it is given without thought of parental consent. It is difficult to conceive that a court would interfere with these communicative events within the ordinary course of life by establishing a blanket requirement of parental consent.

Why, then, should counseling or even psychotherapy, for alcoholism, drug abuse, family problems, or any of a range of emotional problems be forbidden any more than these other communicative events? Is religious counseling or school counseling less important? It is arguable that nonphysical forms of treatment, such as psychotherapy and counseling, are not in the same category as surgery. Lumping all treatment modalities together, then, establishes a very crude misalliance. The argument is bolstered by the relation of consent to the physical nature of Battery. It would be anomalous to extend rules from a tort concerned only with physical contact to situations involving no physical contact.

Based upon these arguments, it is tempting to postulate that the absence of cases and the weight of logic establishes the obverse of the usual, overcasually stated rule. Unfortunately, that states the case too simply. There are possibilities which these considerations do not exhaust, and these must be spun out and considered. In order to spin them out, it is necessary to look at two other personal injury or tort theories.

The question of parents' consent is a bit more complicated than the question of consent per se, and liability flowing from the simple act of not seeking that consent or acting against explicit consent. There are two potential torts or personal injury actions which theoretically may arise from therapy or counseling of a child without parents' consent. There may be injury to the family unit itself and the relationships within it. Remembering that the family is a legal organization, a remedy can arise from substantial interference with its legal relationships. The other kind of injury which may give rise to liability is negligent injury to the

child arising from improper disclosure concerning the treatment or therapy. Both kinds of tort can develop from facts which include the failure to obtain the consent of a parent.

As noted before, the parents are regarded as the joint natural custodians of their children. Custody includes a right to the services and companionship of the child (30). An outsider who interferes with the custody of the parent, depriving the parent of the child's services and companionship, may be liable for the tort of "Enticement" (31).

Enticement is an intentional tort. It requires a knowing interference with a parent's custody of a child (32). The interference generally involves abduction, persuasion to leave the family circle, or harboring the child away from the family home (33). The basis of the injury was originally loss of the child's services to the parent (34). It signified the economic interest which once supported this action, the necessity for the child's labor in the family. Loss of services is a modern damage element, but it is no longer essential to recovery. Courts have either rejected the notion, or have substituted a right to services fiction if actual services have not been rendered (35). The legal injury now involves pure disruption of the family unit or loss of consortium. Damages can include emotional distress and mental anguish (36). Since this is an intentional tort, punitive damages may also be asked (37).

Enticement might be committed by a counselor or therapist, if treating or counseling without parents' consent. The probability of liability seems very remote in such a case, however. The cases dealing with Enticement require a very definite interruption of a parent's custody. The direct abduction of the child provides the usual fact situation. There are two common patterns. In one, a child is taken from one parent by another, or by other relatives, violating a custody decree favorable to the first parent (38). The second common pattern involves a minor daughter who is taken across state lines to marry (39). The abductors, except for the husband, are liable. The common element is a knowing severance of physical custody against the parents' wishes.

Another common fact pattern develops from harboring a child against the parents' wishes. The classic harboring case involved a hospital which refused to give up the custody of a baby until the treatment bill was paid (40). The body of the child could not be held as security for the debt, and the hospital was liable. Again, the element of physical custody and its severance were clear elements of the tort.

For the counselor and therapist, the usual services do not directly sever physical custody. So long as the child remains physically in the custody of the parent, liability is not possible. Mere alienation of affections is not sufficient (41). This means that a counselor could encourage direct hatred of the parents, but would still not be liable until a more substantial physical interference with custody occurred. The probability of liability seems very remote in the ordinary good faith offer of counseling or nonphysical therapy.

The most likely possibility for liability involves harboring. Harboring could arise in a care facility, for example, in which a child comes to live. In such facilities, obviously, it is important to ascertain parentage and solicit consent, or to take the necessary steps to sever parental custody legally. Even here, however, the mere act of giving shelter is not enough for liability. Other intentional acts keeping the child from the parents must be asserted.

Beyond Enticement, the other principal basis for legal action on behalf of parents for counseling or nonphysical therapy without consent is professional malpractice based upon lack of disclosure of the nature and effect of treatment. The gravamen of any malpractice case is negligence (42). A person is negligent when he or she does not meet the standard of care appropriate to the circumstances, thereby causing injury to another person (43). There are numbers of cases in which negligence has been found when a patient or client has not been informed sufficiently of the risks in a particular course of action, and has been injured as a result. There must be enough disclosure of information so that the patient or client may give "informed consent" to the act or procedure (44).

Corollary to the general doctrine of informed consent, is the need for the consent of parents in the case of a child. There is case law which requires, in the case of a child, disclosure to a parent or legal guardian (45). To disclose to a parent, thus becomes a per se part of the professional duty

and any effort to treat a child without knowledge of the parents constitutes a complete nondisclosure of information. A case of negligence based on the theory of improper disclosure might then exist.

Adequate disclosure, however, does not mean complete disclosure. Always, the interests of the patient determine the scope of the requirement. If the patient's well-being or recovery would be jeopardized, the disclosure may be limited to prevent harm. The counselor or therapist must look for justification, then, in the best interests of the child. It may be possible, in certain cases, to ground nondisclosure to parents in the adverse effect upon the condition of the child. There are no cases to that specific effect, but the possibility is contained within the terms of the rule itself.

There is, however, a general saving grace in these malpractice possibilities. In fact, there is great difficulty in establishing damages when there is no tangible harm. Demonstrable physical injury to the body or other calculable monetary losses generally are necessary (46). Negligence requires the proof of damages. Emotional disturbance and mental anguish alone are not sufficient damages. The Restatement of Torts, Second Edition, states the rule:(47).

> If the actor's conduct is negligent as creating an unreasonable risk of causing either bodily harm or emotional disturbance to another, and it results in such emotional disturbance alone, without bodily harm or other compensable damage, the actor is not liable for such emotional disturbance.

It is very difficult to deal with negligence in psychotherapy, counseling, or other nonphysical therapies, as a result.

There are very few negligence cases dealing with psychiatrists, psychologists, or other such therapists. Most negligence cases involving these specialists arise from physically applied treatment such as electroshock or chemotherapy, and are no different in kind from cases of surgical malpractice (48). Only a few cases of nonphysical treatment appear, and these usually involve drastic or outrageous harm which results from the alleged negligence.

Zipkin v. Freeman is the classic (49). The psychiatrist used psychotherapy over a long period of time to influence a woman patient to become his mistress, to invest money in his projects, to leave her husband and family, and to engage in a number of bizzare acts against her family. It was against this background of blatant misuse of his professional position that his negligence could be found. In Fernandez v. Baruch, and Weglary v. New York, patients committed suicide (50). One case involved negligent supervision of the patient. The other concerned negligent disclosure of information to the police about the patient's condition when he was transferred to police custody. For the purposes of finding damages, death provides a separate cause of action under the statutes in most jurisdictions. When suicide occurs under treatment, the question of its prevention always leaves open the possibility of negligence.

The most notorious and recent case involving negligence is Tarasoff v. Regents of the University of California (51). A psychologist learned of a patient's desire to kill another person. Further, the patient was diagnosed as capable of the killing. No effort was made to warn the possible victim, and a homicide finally resulted. The California court found a duty to warn the possible victim, and negligence in the failure to warn. Here again, the risk was death and physical harm, and the duty arose from information received during therapy.

Counselors and therapists are largely protected by the fact that the damages they are mainly capable of inflicting are emotional and are not in themselves compensable. Their actions must result in injury so remarkable and tangible that the courts will award money damages as compensation. This is a tremendous benefit in the malpractice sweepstakes. It is probably true, also, that most people do not even think of suing for emotional injury as they might immediately sue for a physical injury. In the event the injury is to a child and the negligence rooted in nondisclosure of treatment to a parent, the damage rule is exactly the same. Long term mental illness may permit recovery, but only because courts convert it into a physical disease (52). Damages will still be measured in terms of describable physical effects.

Statutory Efforts Regarding Consent

While there are facts and circumstances which may result in the liability of therapists and coun-

selors for nonphysical treatment modalities, we have seen that the probabilities are remote. The question remains then to consider what might be done to modify those probabilities, if it appears to be good policy to encourage modification. Modification can be pushed in two directions. Rules which are barriers to liability can be changed to increase the potential for liability. Or, the rules can be varied to decrease the liability potential. Too much or too little creates a disbalance. A rational system of determining liability compensates everyone who is actually injured by the fault of another, and assesses the compensation against the person at fault. In the real world, there is no such system, but it is the test against which all changes ought to be measured.

There have been efforts to modify the capacity of children to consent to medical treatment. These statutory efforts can be treated as part of the emancipatory trend which was discussed earlier in this paper. If we look at some of the statutes, it may assist us in determining what the statutory pattern ought to be. The statutory efforts, so far, have the common purpose of limiting the liability of physicians and sometimes others, who administer various kinds of treatment. They all suffer from the presupposition that all treatment is medical, and the same in the law. There is very little consistency from state to state.

There are three categories of treatment in which relaxation of the rules pertaining to a child's consent to treatment occurs. By far the most common category is treatment for venereal disease. Only five states have not permitted a child to consent to treatment for venereal disease (53). The second most common exception in the statutes concerns drug abuse (54). Alcoholism is a distant third category (55). These statutes do not exist equally in every State, nor do they have the same effect where enacted.

The state with the most comprehensive statute is Minnesota. It allows any minor to give consent without restriction "for medical, mental and other health services to determine the presence of or to treat pregnancy and conditions associated therewith, venereal disease, alcohol and other drug abuse, and the consent of no other person is required" (56). There are absolutely no age barriers to the giving of consent. The language appears to include the full range of possible services. Only Pennsylvania seems to extend this aspect further in its drug abuse exception statute, and does so by including the term "counseling" (57). The Minnesota statute also covers both drug abuse and alcoholism. The language of the Minnesota statute may not reach as far as consent for treatment in the event the drug abuse or alcoholism is not the child's, but a family member's, and the child is seeking a means to cope. However, a broad reading of the language would include even such services.

None of the statutes encountered refer to any specific tort. Within the limits the language of each imposes, technical Battery as a result of physical treatment would be eliminated. The question of informed consent as a basis for malpractice is left hanging. If the statute's language defines treatment narrowly, in physical terms, then informed consent may be a problem clearly for anything nonphysical. Whether, more basically, transmitting adequate information to a child will suffice as adequate disclosure of the risks of treatment under these statutes is a question largely unanswered. Much ambiguity prevails in most of these efforts, and much will depend upon court in-

terpretations. For example, Florida states, "The disability of nonage minors is removed. . ." (58). What that means is a great question of interpretation. Compare this language to that of Pennsylvania and Minnesota, which state merely that a minor may give effective consent (59). These variations and their inherent ambiguities leave much to be desired.

No statute encountered would alleviate any liability for Enticement. None of the language in any of the jurisdictions deals with a tort against the family order. Although a child might be able to consent to drug abuse or alcoholism treatment, it is doubtful that any court will interpret it to the extent of condoning abduction, haboring, or active persuasion to leave the family circle. Courts are not likely to buy such actions as a part of reasonable treatment.

It is arguable that there is no need for statutes protecting anyone from liability for counseling, psychotherapy, or any non-physical treatment. The liability probabilities are small. Those situations which do occur are usually so far beyond the pale, a rational policy would attach liability to them as a matter of basic justice. A rational system would clearly continue Enticement as an available action. Only the most blatantly obnoxious actions of any therapist or counselor will ever be subject to liability, anyway.

With regard to the malpractice probabilities, the argument is somewhat different. (The same argument is applicable to physical treatment and Battery.) The rules governing parental consent are, for the most part, wholly arbitrary. Arbitrarily assigning every child to the vast pool of legal incompetents, which these rules do, doesn't make much sense. It also does not make sense to hold every physician, therapist, or counselor liable per se for not obtaining parents' consent or for disclosing information about treatment to children instead of to parents. A flexible rule would make more sense. The rule should allow children to give consent, including informed consent, when it reasonably appears that they are capable of giving it. If anybody has a reasonable doubt about a particular child's actual capacity to consent to and to understand, then parents or guardians should be brought into the process. For example, a 4-year-old child is not in the same position as a 16 year old, and the

range of capacity to understand and act vary among children of the same age. A good flexible rule should take all of this into account.

A good flexible rule should also apply to all medical and social services. It makes no sense to single out drugs, alcohol, or venereal disease. It seems logical that children ought to be able also to consent to treatment for strep throat, or depression, or any one of the possible range of afflictions and illnesses, if the actual capacity to consent and understand exists. The rule ought to be a general rule applicable in all circumstances.

The idea of a general rule raises once again the entire question of the status of children in the law. This paper has noted several instances of changes in that status, and we have considered a possible emancipatory trend. The intervening materials represent an analysis of a small part of the total existing law. The existing, piecemeal changes have come about because of immediately perceived needs and the expression of them to state legislatures. Thus, the various drug abuse crises have stimulated the enactment of the statutes allowing a child to consent to drug abuse treatment. One

thing appears to be common to all these piecemeal efforts. They all increase the capacity of children to fend for themselves, alone and unsupported. What that means as to family relationships and general social needs is beyond the scope of this paper. Perhaps we ought to pause before suggesting more piecemeal legislation, though. With that admonition, this reviewer simply cites to readers the various proposals for a children's bill of rights. As fine a starting point as any is the article, "A Bill of Rights for Children" by Henry H. Foster, Jr., and Doris Jonas Freed, originally published in the New York Law Journal, July 28, August 25 and September 22, 1972. It also appears in the American Bar Association publication, The Youngest Minority, edited by Sanford N. Katz. That publication, dated 1974, can be obtained from the American Bar Association, Section of Family Law. The authors propose a set of rights for children against family and state. It is a concept in need of study and refinement, but one which merits much consideration.

Challenging Parental Authority

When a therapist or counselor feels that personal liability or the best interests of a child require it, there exists legal means to challenge parental authority. The situation can arise in a case of alcohol or drug abuse on the part of a child when the parents refuse or neglect to do anything about it. The situation can also arise in the case that parents' abuse of alcohol or drugs is the problem, and there is a need to protect children from it. There is not a jurisdiction in the United States which does not have a court of special jurisdiction for juvenile matters. It may be called the juvenile court, or the family court, or it may be a department or division of the courts of general jurisdiction. These courts are well known for their jurisdiction over delinquent children, but such matters are not their only concern. Jurisdiction generally exists over several categories of children. The category with which we are concerned may be labeled differently from jurisdiction to jurisdiction. The common labels used to describe the children are "dependent" or "neglected" (60). The Uniform Juvenile Court Act, which has had little acceptance in the states, establishes another category—the "deprived child" (61). Its characteristics parallel those of the dependent or neglected child in most jurisdictions. There may be other labels used also, but applying to the same general circumstances.

A deprived child under the Uniform Juvenile Court Act is one who is "without proper parental care or control, subsistence, education as required by law, or other care or control necessary for his physical, mental, or emotional health, or morals, and the deprivation is not due primarily to the lack of financial means of his parents, guardian, or other custodian. . ." (62). A neglected child may be very simply defined as it is in Delaware, as one whose custodian refuses to provide him or her with adequate care (63). It may also be particularly defined as in Minnesota and Iowa (Iowa's term is "child in need of assistance") (64). Very detailed description exists in those states, including a child "who is in need of special care and treatment required by his physical or mental condition which the parents, guardian, or other custodian is unable to provide." Also included is a child "who is without proper parental care because of the emotional, mental, or physical disability, or state of immaturity of his parents, guardian or other custodian." The difference in elaboration between these statutes may make a difference as to their vagueness and the difference that might make with respect to constitutionality. Probably, the Uniform Act represents the language of greatest economy which is constitutionally secure.

Under the juvenile or family court statutes, a judicial finding of dependence, neglect, or deprivation, as applicable, can result in a custody transfer from the parents or existing guardian to the state or other guardians (65). It is not necessary, with the flexible powers of such courts, that a full severance of custody be the only remedy. It might, perhaps, be enough to order specific acts on behalf of a child. Section 53 of the Uniform Juvenile Court Act provides an instructive example (66). For a deprived child, it permits "the child to remain with his parents, guardian, or other custodian, subject to conditions and limitations as the court prescribes. . ." the discretion vested in these courts in most jurisdictions would allow similar actions.

To obtain an order of the court to sever or govern parental or guardian's authority, a proceeding must be initiated by the proper party (67). There must be sufficient evidence that the child is neglected, dependent, in need of assistance, or deprived, as the standards of the statutes require (68). Only upon proof of a sufficient nature can the court interfere with the parents or legal guardians. In short, this is a full dress judicial proceeding, requiring proper legal counsel and due process to the contestants (69). To resort to it, one must have substantial justification and motivation—in the child's actual and best interests. No such action is to be undertaken lightly. If the facts warrant it, the procedures are there to be utilized.

The less drastic the remedy sought, the more likely that a court will rule favorably for it. Severance of custody is drastic, and a court will be more critical and exacting in such a case. However, requesting a limited remedy will be more likely to gain court favor. The courts do not like to assert the power of the state over family relationships, in general. This attitude favors the least possible interference.

However, neglect or dependency is generally viewed in a broad sense. It is not confined to lack of material things (70). It includes a concern for the spiritual and moral life of the child (71). The child is entitled to the advice, counsel, affection, understanding, and sympathy of the parent. It is entitled to proper guidance (72). A substantial deprivation of any of these constitutes neglect. There are cases in which alcoholism and drug abuse have been used to sever custodial rights. In the case of the Application of Anonymous, a New York court noted, "And quite obviously, a parent who is a drunkard and incompetent, a notoriously immoral person, cruel, or unkind toward his child . . . may have the child taken from him" (73). In Darlington v. Cobb, a mother lost custody until she could prove that she had overcome a morphine habit (74). In In re Carstairs, a child was declared neglected when his mother did not take care of or seek treatment for mental disturbance (75). Other cases, based upon findings that children's physical illnesses were not taken care of, have resulted in findings of neglect (76). A mere showing of drug abuse, alcoholism, or mental illness on the part of a parent may not be enough. In the case of In re Daniel C., custody was not taken from a mother on grounds of neglect based on a mere showing that she had suffered mental illness (77). There had to be linkage between her behavior and actual detriment to the child. Injury to the child is the basis of neglect and dependency, and must be shown.

Although a proceeding in a juvenile court is a drastic measure, it can be initiated and successful in cases of parental neglect when alcoholism or drug abuse is a factor. No court action is simple to initiate and conclude successfully. It should not be attempted unless there is a great need. Further, it is doubtful that a challenge to parental authority and custody will ever be simple. There are constitutional guarantees of due process which underlie the procedures. These statutes will always be a recourse of last resort.

Summary and Conclusion

This paper has reviewed, in general, the state of the law with respect to children and treatment of a nonphysical nature, with a primary focus on the fields of alcoholism and drug abuse. We have specifically explored the nature of treatment which may be offered without or against parents' or guardians' consent. We have seen that the law is changing, and that new levels of independence for children appear to be developing. We have also seen that there are possible liabilities for treating children without parents' consent, but that the probabilities of liability are not great. Also, we have noted that statutory efforts at changing liabilities have had only limited effect. Any statutory changes should take into account some broader perspectives than currently is the case. We also have considered the challenge to parental authority that is possible in the juvenile courts.

There will undoubtedly be a greater and greater need for opening the gates of treatment to children independently of considerations of parental consent. If further change in the law is to follow, it should be systematic and comprehensive. Without such change, liabilities may be created which should not exist and people who need treatment and assistance may not receive it. Individual concerns need to be combined to accommodate the entire problem.

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Child Abuse and Neglect: The Alcohol Connection

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CHILD ABUSE AND NEGLECT: The Alcohol Connection

Margaret Hindman

Last year, public agencies across the nation received over 300,000 reports of suspected child abuse. Each year 2,000 children die in circumstances in which abuse or maltreatment is suspected (Besharov 1976). No one knows for sure how many more children suffer abuse which isn't reported to the authorities.

For many years, child abuse was virtually ignored. Publicity generated by the more sensational cases has increased public awareness of the problem and highlighted the tremendous need for prevention and remediation. Only since the 1960s have researchers and service agencies begun to look at the reasons behind child abuse and the people who are the abusers. And it is only very recently that researchers have begun to look at the relationship between alcoholism and child abuse and neglect.

Child abuse is a term which varies widely in meaning. The Child Abuse Prevention and Treatment Act of 1974 defines child abuse and neglect together as "the physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of 18 by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby." This definition does not distinguish between abuse and neglect although other definitions do focus on whether the act is one of commission or omission. However, either neglect or abuse can lead to fatal results.

The Alcohol Connection

Studies reveal that parents with alcohol problems have a high potential for exhibiting neglect of their children, especially through erratic and inconsistent parenting.

Margaret Cork (1969), in interviews with 115 children of alcoholic parents, observed that many of the youngsters said they felt rejected, not only by the alcoholic parent, but also by the nonalcoholic spouse. Older children in these families are often forced to assume the parent role, caring for younger siblings and parents as well. These children seem to run a high risk of developing not only emotional and behavioral problems, but alcohol problems too, later in life (Cork 1969, Fox 1972,

Miller 1975). A connection between alcoholism and physical abuse of children appears repeatedly in reports by protective service and social workers, as well as in research reports on abused children.

Dr. Henry Kempe (1972), first to describe the "battered child syndrome," maintains that alcohol plays a part in approximately one-third of child abuse cases. In many more cases, he adds, alcohol can be related in some way to the family problem that led to the child abuse.

Some researchers suggest that alcohol may play a major role in specific types of child abuse. In a study of incest victims, Y.M. Tormes (undated) reports that alcohol frequently seems to be a factor in father-daughter incest occurrences.

In general, however, these studies and reports are based on subjective impressions rather than hard data. Surprisingly, although alcoholism has been singled out as a factor in child abuse, parents are rarely questioned directly about drinking practices in investigations of child abuse cases. Traditionally, the attention of social agencies and researchers who are involved with child abuse cases has been focused mainly on the protection of the child, resulting in a paucity of data about the abusers.

More recently, researchers have begun efforts to isolate the factors involved in child abuse in order to pinpoint pathways to prevention, early intervention, and family rehabilitation. Attention has been focused on situational factors, personality factors, and characteristics of the homes of abused children.

Child Abuse Factors

In examining situations in which child abuse and neglect are most likely to occur, recent research has consistently pointed to families which are socially isolated, have a parental history of abuse as a child, have youthful and inexperienced parents, and greater than average complications with pregnancies (Smith, Hanson and Noble 1974; Kent 1975). It is interesting to note that social isolation and, in many cases, childhood abuse experienced by parents are both factors common in alcoholic families.

Personality characteristics associated with child abusers are also strikingly similar in some respects to personality characteristics which describe alcoholic persons. Child abusers are most often described as having a low frustration tolerance, low self-esteem, impulsivity, dependency, immaturity, severe depression, problems with role reversals, difficulty in experiencing pleasure, and lack of understanding of the needs and abilities of infants and children (Spinetta and Rigler 1972).

Low self-esteem and low frustration tolerance are also mentioned often in connection with alcoholic people, as are most of the other characteristics cited above for child abusers. Role reversals, too, are not uncommon in alcoholic families, in which children often are expected to function as adults while the parents are engaged in an almost childlike preoccupation with self (Cork 1969, Fox 1972).

Researchers in the child abuse field have also identified characteristics which are common to children

who have been abused. Whether these factors precipitated the abuse or emerged as a consequence is unknown. These factors include: retardation, deformity, illness, behavioral problems including hyperactivity, disobedience, and delinquency; and emotional problems (Caffey 1972). Certainly, such characteristics as behavioral problems, disobedience, and emotional problems are common among children of alcoholic parents as well (Bosma 1975, Chafetz, et al. 1971, Kammeier 1971, Fox 1972).

In addition, a link has been suggested between the "fetal alcohol syndrome" and child abuse. The birth defects and growth deficiencies said to occur in some children of women who drink alcoholically during pregnancy may well make the child more susceptible to abuse and neglect by a parent, researchers suggest (Mayer and Black 1976).

The similarity in situational as well as in personality factors between child abusers and alcohol abusers provides substance to the inference that there is a connection between the two problems. Still, there has been virtually no research directly addressing the relationship.

New Studies Underway

Two studies, funded recently by the Office of Child Development, Department of Health, Education, and Welfare, are currently underway aimed at determining whether the relationship exists. Although neither of the projects has produced enough data on which to base firm conclusions, both seem to offer evidence to support the connection between alcoholism and child abuse and neglect.

In Boston, the Washingtonian Center for Addictions (a private multi-modality treatment center for drug addiction and alcoholism) is engaged in a study of the child care practices of 100 alcoholic persons and 100 drug addicts. The subjects are persons in treatment at the Center.

In a preliminary report of the study findings, researchers Drs. Joseph Mayer and Rebecca Black note that "not all alcoholics seriously abuse or neglect their children, although the majority have difficulties in child rearing." As might be expected, many of the alcoholic persons are themselves children of alcoholic parents. In addition, the researchers found that many alcoholic males report they were physically punished by their parents and several reported they were abused as children.

The researchers suggest that "a substantial proportion of those families in which children are either abused or neglected are families in which there is an alcoholic parent . . . although the proportion of child abuse cases in which alcoholism may play a role varies widely depending on as yet unknown factors." Alcoholism "may be somewhat more frequently associated with neglect than abuse," they say.

In many situations alcoholic fathers recognize that drinking creates the potential for physical abuse of their children, and some have developed conscious ways of avoiding this potential physical abuse, report Drs. Mayer and Black. "These fathers report making a deliberate decision not to discipline their children while they are drinking," the researchers have discovered. They point out that these fathers, while drinking, are considerably more likely to abuse their wives than their children.

On the other hand, there are cases of child abuse by alcoholic parents who fail to recognize the risk of abuse while drinking and who have not devised ways of protecting their children. "Interestingly, none of the alcoholics who were reported as abusing a child were in treatment at the time the abuse occurred," Drs. Mayer and Black point out.

"This suggests that recognition of the drinking problem and of problems likely to be associated with the drinking problem may help to reduce abuse of children during drinking," they suggest. Such a finding has obvious implications for child abuse prevention, adding to the reasons for providing treatment for drinking problems in families.

In looking at the question of child neglect in families with an alcoholism problem, the Boston researchers have found "considerable evidence of the occurrence of emotional neglect and inconsistency in care." Fathers who are alcoholic report total withdrawal from the children when they are drinking, and inconsistency in the amount of attention they give even when not drinking. Often, discipline is inconsistent and communication is poor.

Significantly, Drs. Mayer and Black report that their clients are eager to accept help in dealing with their child rearing problems. Alcoholic parents "welcome the opportunity to discuss their children and their relationships with their children."

In another research project in San Antonio, Texas,

Margaret Hindman, a former staff writer with the National Clearinghouse for Alcohol Information, is now director of public information at Hood College in Frederick, Maryland. She is also a free lance writer on alcohol issues and a member of the Task Force on Children of Alcoholic Parents of the Alcoholism Council of Maryland Citizens of Montgomery County, Inc.

DOES CHILD ABUSE CAUSE ALCOHOL ABUSE?

An interesting, but disturbing, sidelight which has received little attention in the literature is the contention by some that children who are physically abused by their parents are at high risk for turning to alcohol and drug abuse as they grow older. A New York psychiatrist, Dr. Arthur Green, testified before the New York State legislature that abused and neglected children are characterized by "self-destructive thought, anxiety, and impairment of self-concept," and that these youngsters are more likely to engage in self-destructive actions.

A recent study of female alcohol and drug abusers in residential treatment communities indicated that 44 percent had been sexually assaulted, often by a father or relative, before the age of 15. In reporting the study results, Dr. Judianne Jensen-Gerber noted, "We never look at it (sexual assault and incest) as a very important factor that brings women to alcoholism, drug abuse, acting out, running away, prostitution, illegitimacy, venereal disease. We never see trends" (MacClennan 1975).

the Mexican American Neighborhood Civic Organization is looking at relationships between alcohol and drug abuse and child abuse/neglect with an eye to developing cooperative relationships among various agencies working with young people. The study's target area is densely populated, with a very high percentage of young people and a high proportion of low income families. The majority of the area's residents are Spanish surnamed.

Although no information from the study will be available until Spring 1977, project director Bario Chapa points out that parents who have abused their children appear to be very open in discussing their drinking behavior.

The San Antonio researchers will question 1,200 persons including a control group, a group of child abusers, and a group of substance abusers.

Treatment Gaps

The idea of cooperative arrangements between agencies dealing with child abuse cases and alcoholism treatment centers is a new concept. The bulk of treatment services for problems associated with alcohol are often focused solely on the alcoholic client. Few alcoholism treatment programs take into consideration the problems alcohol has caused for the nonalcoholic spouse and the children, although there is a growing trend toward family treatment (Hindman 1976). Child abuse, particularly, is a possibility rarely mentioned even by those providing services to children of alcoholic parents.

In the field of child abuse treatment, services designed to protect children from abuse and neglect are provided through a network of State and local agencies including hospitals, courts, the police, and public and private social welfare agencies. Often services are directly exclusively at helping the child rather than being aimed at the entire family.

Despite the association between child abuse/neglect and alcoholism that has been made by researchers in the child abuse field, there is seldom an effort to address the alcohol problem specifically in dealing with child abuse, even when the focus is on rehabilitation of the family.

Dr. Douglas J. Besharov, director of the Office of Child Development's National Center on Child Abuse and Neglect, advocates a new focus on parents, directing efforts toward rehabilitation of the family rather than relying on the tactic of removing children from the home to foster care or institutions. As an integral part of this focus, attention must be given to the factors, such as alcoholism, which may be associated with the abuse.

Most people react to seeing an abused child with "utter disbelief, denial, and avoidance," Dr. Besharov observes. "Finding the cruel and tragic conditions of the child beyond their capacity to understand, they deny the injury was deliberate." However, because child abuse is receiving more publicity, people are not likely to continue denying that it takes place, he says, warning that "now there is a danger that denial will turn to outrage and overreaction.

"But such reactions must be tempered if any progress is to be made," Dr. Besharov says. "Only with the application of objective and enlightened policies can treatment, research, prevention, and education be successfully performed. We must come to realize that there are two victims of child abuse—the child and the parent."

Well-known pediatrician Vincent J. Fontana agrees.

Dr. Fontana, who is associated with the New York University College of Medicine and the New York Foundling Hospital for Parent and Child Development, says, "Few parents would willfully injure their children. However, during stressful situations some parents lose control and lash out—physically and verbally—at their children. With the many stresses all of us experience these days, there is more adult frustration and anger that can trigger child abuse." Such maltreatment can be stopped, he believes. "First, society must recognize that child abusers are not criminals but rather people badly in need of help."

Treatment Alternatives

One mode of response to this perception of parents as victims of child abuse is the voluntary self-help group, Parents Anonymous, founded in California in 1970. Patterned after Alcoholics Anonymous, the organization works through groups that provide child abusing parents with an opportunity to talk over their common problems.

Unlike AA, Parents Anonymous groups have as a sponsor a social worker or another professional concerned with child abuse. Sessions are led by members and focus on group discussions. The sponsor suggests possible resources for persons who voice a need for counseling or other assistance outside the group sessions.

A spokesperson for the nationwide organization said that many members of the 500 chapters are also members of Alcoholics Anonymous. "Alcoholism seems to be a pretty common problem among our members," she commented, although no statistics are available to support this observation. She noted that many child abusers are reluctant to seek treatment for problems such as alcoholism because of a fear of social agencies. "Many of them have had previous contact with agencies and are afraid of legal repercussions if they talk about child abuse," she observed.

In its literature, Parents Anonymous stresses the need for a family focus in preventing and treating child abuse. The organization points out that many parents who abuse their children also can and do relate to their children in healthy, loving ways. "Abuse is often only a small part of the parent-child relationship, but a part that a parent must have help in resolving if it is not to become overwhelming," the group notes.

The National Institute on Alcohol Abuse and Alcoholism supports efforts to coordinate alcoholism and child abuse treatment services more closely. "We are acutely aware of the problems faced by children of alcoholic parents and recognize that child abuse in this population is an issue that deserves more attention," comments Dr. Ernest Noble, NIAAA Director.

"Child abuse and maltreatment are family and community problems," Dr. Besharov agrees. "If we are to prevent and treat these problems, we must have a community commitment to foster the emotional and behavioral hygiene of the individual, the family, and the community. Child abuse must be understood as a function of controlled or uncontrollable personal, familial, and social stress."

Often it is a symptom of "deep personal, psychological, and social dysfunction," Dr. Besharov continues. "Similarly, alcoholism can be characterized by the same sorts of dysfunction. While there is no hard evidence, it seems clear that the person who is debilitated by

alcoholism will have difficulties in caring for his or her children.

"We must teach parents that when they are under stress, their children can be in danger. We must offer help in an understanding atmosphere, even though further abuse or maltreatment cannot be condoned. Often these parents are difficult to reach, for they are usually isolated people, fearful of the possible community response to their behavior."

The social isolation of families in which both alcoholism and child abuse are present results in a double stigma, presenting special problems in early intervention and requiring the development of carefully coordinated strategies by community agencies, Dr. Besharov says.

It is clear that alcoholism treatment facilities must increase their awareness of the potential for child abuse by alcoholic parents and work to develop a similar awareness among agencies working with abused children.

As more is learned about the relationship between alcoholism and child abuse and neglect, alcoholism workers must direct greater attention to the need for:

- Incorporation of children's services into the alcoholism treatment setting, emphasizing family involvement in the treatment process, and paying special attention to the possibility of child abuse and neglect.
- Education of social agencies which deal with child abuse and neglect to the need for comprehensive family services and treatment of alcoholism and alcohol abuse problems when they are detected in abusing parents.
- Education of alcoholism workers to recognize the potential for child abuse by alcoholic parents and training to deal with the reality of child abuse in a manner which focuses on rehabilitation of the family. Professionals who come in contact with these children must be trained to recognize the early signs of potential child abuse.
- Continuation of research about the dynamics of the association between alcohol abuse and child abuse/neglect in order to develop effective and timely strategies for prevention, intervention, and rehabilitation.

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FAMILY VIOLENCE

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table of contents

Cover art was drawn by a young participant in Claudia Black's art therapy group for children of alcoholic parents (see article, p. 23).

Alcohol Health and Research World is a quarterly produced by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) through the National Clearinghouse for Alcohol Information. The Secretary of Health, Education, and Welfare has determined that the publication of this periodical is necessary in the transaction of the public business required by law of this Department. Use of funds for printing this periodical has been approved by the Director of the Office of Management and Budget through March 3, 1981. Opinions expressed in this publication do not necessarily reflect the views of the NIAAA. The U.S. Government does not endorse or favor any specific commercial product or commodity. Trade or proprietary names appearing in this publication are used only because they are considered essential in the context of the studies reported herein. Manuscripts concerning research, treatment, or prevention of alcoholism and alcohol abuse are solicited and should be sent to the Editor, *Alcohol Health and Research World*, P.O. Box 2345, Rockville, Md. 20852. Subscriptions and changes of address should be sent to the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Subscriptions are $6.40 per year, or $8.00 if mailed to a foreign address.

Margaret H. Hindman, NCALI Staff

"Eddie was watching a football game on TV and drinking beer. He had been drinking all day. Angry that his favorite team lost, he switched off the set and turned on Pat. His eyes were wide and bloodshot. He looked menacing, like a madman, as he charged across the room toward her. . . ."[1]

"When my father gets drunk he beats me. My mother says she will do something about it, but she never does. When you get slung against walls, stepped on, then just plain beat, it's not funny. . . I can't get along with my parents. I thought about killing myself. . . ."[2]

Stories such as these have a familiar ring to police and social workers who are involved every day in family violence situations. While research in this area is scarce and findings are contradictory, service providers report a clear association between alcoholism and all kinds of domestic violence.

Scope of the Problem

"No subject receives more study than the family and no aspect of family life is studied less than family violence," observes sociologist Barbara Star (1978). There is a high degree of acceptance of family violence in American society and an unwillingness to uncover the serious incidents of physical abuse occurring in many homes. Victims often hide the fact that they are being abused, for reasons ranging from fear of reprisals to lack of appropriate response on the part of the traditional helping community.

While many cases of child and spouse abuse go unreported, it is estimated that each year there are as many as 1.7 million spousal assaults (Straus 1977). The National Center on Child Abuse and Neglect estimates that there are one million cases of child abuse and neglect, at least 200,000 of which are assaults. The FBI Uniform Crime Reports show that 25 percent of all murders are intrafamilial and that over half of these were spouse killings (U.S. Department of Justice 1975).

A national survey (Straus 1977) concluded that over six million incidents of serious physical abuse occur in families each year. This survey found wives beating husbands almost as frequently as husbands beat wives, although this pattern is not supported by reports from police and other professionals who deal with family violence. The general picture which

[1]From: *Family Circle*, April 24, 1979 "The Case of Patricia Gross" by Bonnie & Charles Remsberg.
[2]From: Letter to the director of the NIAAA

emerges from these sources is that women are overwhelmingly the victims in marital disputes. Abusive behavior ranges from pushing and slapping to the extreme of murder. It appears that while both husbands and wives may be aggressors equally often, the wives—because of physical disadvantages—are most often the victims of serious injury. In spousal homicides, men are almost as likely as women to be victims, although women who murder their husbands cite constant physical abuse as their motivation (McCormick 1977). It is not uncommon that the victim of murder will initiate the fatal incident, observes Palmer (1975). "The spiral of conflict is broken by a final clash, physically initiated by the victim. . . . victim and offender are cooperating in the former's death." It should be recognized that couples who are not married have rates of violence that are as high or higher than those who are married, according to Straus (1978). Especially if regular sex is involved, the violence rate is quite high, he notes.

Child abuse also leads, in many cases, to tragic results. An estimated 37,000 to 50,000 child abuse incidents cause serious injury each year and 2,000 result in death (Gil 1970). In fact, more children under the age of 5 die from injuries inflicted by parents than die from tuberculosis, whooping cough, polio, measles, diabetes, rheumatic fever, and appendicitis, combined (Viano 1973).

Alcohol Abuse and Child Abuse

Popular opinion has long held that the wifebeater or child abuser is "a lower class, beer-drinking, undershirt-wearing Stanley Kowalski brute" (Langley and Levy 1977). In fact, family violence is not limited to any social, geographical, economic, age, or racial group. But family violence is consistently linked to alcohol abuse.

According to the American Humane Association (1978), alcohol dependence was a factor in 17 percent of the families in which child abuse or neglect occurred, based on nationwide data from 1974 to 1976. Dr. Henry Kempe, who coined the term "battered child," estimated that alcohol plays a role in about a third of all cases of child abuse (1972). On the other hand, a study of child abuse incidents involving infants and small children indicated that alcoholism was not a significant factor (Steele and Pollack 1968).

The reality is that little research has been done in this area, and results are not consistent. A review of

the alcohol literature on this subject, prepared in 1977 for the NIAAA, concluded that "alcohol involvement in child abuse and neglect has not been of significant or central concern to researchers" and noted that "when information on the relationship of alcohol and child abuse is available, it is generally not considered by researchers in terms of any specific alcohol theory" but is viewed as "symptomatic of a generally socially maladjusted personality" (Epstein et. al. 1977).

There is evidence linking parental alcohol abuse to sexual abuse and incest, according to the National Center on Child Abuse and Neglect (in press). However, it appears that alcoholism may be more clearly associated with child neglect—both physical and emotional—than with abuse. (See *Alcohol Health and Research World,* Spring 1977 "Child Abuse and Neglect: The Alcohol Connection.")

Two recent studies have uncovered new evidence that links alcohol abuse and child abuse. A study conducted at an Arkansas community-based alcoholism treatment center indicated that more than half of the alcoholic parents studied were child abusers (Spieker 1978). A project aimed at early detection of family pathology in a medical outpatient clinic at the Long Beach Naval Hospital uncovered "a highly significant relationship between the family in conflict and alcohol abuse and child abuse" (Behling 1978). In other words, families referred because of spouse abuse were also having problems with actual or potential child abuse; and many of these violent families were characterized by alcohol abuse problems.

Violence is not an isolated phenomenon, affecting only one victim in a family. The "battering family" is frequently encountered by counselors who report that a husband who beat his wife is often a battering father; and he may well be the target of violence from his wife and even the children. Abused wives may also be child abusers (Scott 1974).

Researchers who questioned women whose sons were in treatment for child abuse at a psychiatric clinic found that 65 percent of the mothers who had abused their sons had themselves been abused by their husbands (Stewart and deBlois 1978). An Arkansas study of battered wives indicated that 31 percent of the abusing husbands also abused the children (Spieker 1978).

Until very recently, family violence was synonymous with child abuse, sociologist Star observes. While public attention was turned to the problem of child abuse and neglect in the 1960's, it was not until the early 1970's that service providers and the media began to call public attention to marital violence. "We actually knew about wife battering at the time of our initial investigations of child abuse," she says. "Testimony is replete with statements that began, 'It was bad enough when he was beating on me, but when he started on the children I really became frightened.' We only responded to the last part of that sentence. It took ten years before we could acknowledge the first part."

Despite clear indications that child abuse and spouse abuse are closely linked, treatment programs are inevitably fragmented because reported cases of child abuse are channeled to the protective services system while most reported marital disputes fall within the jurisdiction of the criminal justice system.

States set up protective services components of the social services system in the 1960s, developing laws which mandate that all cases of child abuse be recorded in a central registry. The early response to child abuse was to remove the child from the home and in extreme cases to jail the abusing parent. More recently, the social services system has begun to develop programs which seek to rehabilitate the parent as well as protect the child. For example, a privately funded, volunteer parent-aide association in New York, called SCAN (Suspected Child Abuse and Neglect), offers support to abusive and/or neglectful mothers. These mothers generally must agree to participate in the program to get their children back after a child abuse incident. The volunteers are primarily women who are not employed, so that they are available at odd hours. The volunteer spends time each week with the mother and children, teaching her skills in caring for the children and offering support in times of crisis.

A self-help group, patterned after Alcoholics Anonymous, also offers support to abusing parents. Parents Anonymous is based on the premise that child abusers love their children and do not want to injure them but that they need support in dealing with the lack of control which leads to child abuse. Many members of PA are also members of AA, according to a spokesperson for the parents' group.

Three recently funded demonstration programs focus specifically on helping families in which both substance abuse and child abuse are occurring. (See "Reflections on Family Violence," pg. 12).

Alcohol Abuse and Marital Violence

Popular opinion has linked alcohol abuse with spouse abuse much more clearly than with child abuse; and research, though conflicting, appears to lend credence to this belief. "There's no shortage of evidence that alcohol and drugs—particularly alcohol—have a lot to do with wifebeating," according to authors Roger Langley and Richard Levy (1977). Maria Roy, who founded Abused Women's Aid in Crisis (AWAIC) in New York City, reports that the

husband's alcohol and other drug abuse was an underlying factor in over 80 percent of the cases AWAIC dealt with during 1976 (Roy 1977). In marriages or relationships exceeding 7 years' duration, the abusing men were reported to have alcohol problems in 90 percent of the cases,she said. These men "seemed to beat their wives more often both when drunk or sober," she said, and "very often, the assaults came during sobriety." In long-term relationships where there had been no prior violence, generally the men had developed a drinking or other drug problem which "seemed to act as a catalyst for the violence in these cases."

A Minnesota study of nearly 100 abused wives who called a community agency hotline found that 87 percent of the abusing men were alcohol users—35 percent daily drinkers and another 10 percent weekend drinkers. In addition, 71 percent of the women said they also were alcohol users and most reported frequent drinking (Carder 1978).

Another survey of women who sought emergency aid in Ann Arbor, Mich., following abuse by their husbands showed that 60 percent of the abusing men abuse alcohol and that more than 66 percent of the assaults involved the use of alcohol (Congressional Record 1978). At least one study, however, reported that the incidence of alcohol abuse in family disputes was overestimated by the victims (Bard and Zacker 1974).

Most of the evidence linking alcohol abuse and wife beating is quite recent, perhaps reflecting the fact that this hidden tragedy has come under public scrutiny only recently. An exhaustive review of the literature published prior to 1977 on alcohol problems and wife abuse revealed that empirical research into the problem was scarce and that which did exist presented conflicting conclusions (Epstein et al 1977). "Research focused specifically on the use of alcohol in situations involving physical aggression between husbands and wives reveals widely differing reports of the extent to which alcohol is present," the reviewers note.

Researchers who have looked at the connection between alcohol abuse and marital violence reflect a preoccupation with the dynamics of the relationship, most often attempting to answer the perplexing questions "Why does he beat her?" and "Why does she stay?"

Most existing research seems to support the conclusion that alcohol abuse does not cause marital violence—that the link is not one of cause and effect. Currently, the most widely accepted viewpoint is that alcohol abuse is a disavowal technique used by abusive husbands. In other words, some men may drink when they feel like beating their wives because they know that by being drunk they will be released from responsibility both by their wives and by the rest of society (Gelles 1974).

Another point of view is that alcohol acts to lessen inhibitions. According to Natalie Shainess (1977), "The alcoholic is a particularly dangerous man because rage is an important component of his personality, and often, the drinking is related to an attempt to 'anesthetize'—to lessen the rage. But alcohol affects the higher centers of the brain and is actually a depressant of function. The result is that the rage increases—or at least the ability to contain it is lost—and assault becomes more likely." The disinhibition theory is not, however, supported by the available evidence, other researchers argue, since most alcoholics do not beat their wives. Coleman and Straus (1979). report that the "deviance disavowal theory" advanced by Gelles is reinforced by findings that drunkenness can provide a "time out" period when the norm regarding appropriate behavior can be disregarded. "Following this argument, individuals do not become violent because they are drunk, but get drunk so they may become violent," the researchers contend.

Societal Factors

Much recent research and analysis tends to place external influences such as alcohol abuse in a position of secondary importance to cultural and societal factors. Certainly, some wifebeaters have

psychological problems, but the majority appear to be 'normal' in most respects. Sociologists such as Steinmetz and Straus (1974), point to society's acceptance of violence as a legitimate way to solve problems. "Conflict is an inevitable part of all human association," Straus says. "Somewhat paradoxically, the more intimate the ties between members of a group, the higher the average level of conflict. Since the family is one of the most intimate types of groups, the level of conflict is particularly high within the family." He believes that "as long as conflict within the family is viewed as atypical, wrong, or illegitimate, there will be reluctance to learn techniques for engaging in conflict nonviolently." Violence in the family, he believes, reflects cultural norms and social violence—such as physical punishment in schools, the acceptance of the death penalty, and media portrayals of violence.

Martin (1976), articulating the view of many who have worked to establish shelters for abused wives, argues that the problem lies with the institution of marriage itself "and the way in which women and men are socialized to act out dominant and submissive roles that in and of themselves invite abuse. Husband/assailants and wife/victims are merely the actors in the script that society has written for them," she says.

"Instead of asking the all too frequent question 'Why does a woman stay in a violent marriage?,' we should be asking 'What is it about marriage and society that keeps a woman captive in a violent marriage?' ," she asserts. Historically, society has accepted wifebeating as a husband's right. The

expression "rule of thumb" derives from a common law ruling that a man could strike his wife as long as the stick he used was no greater in diameter than his thumb. Although this view is somewhat tempered, marital violence is still condoned by society, she says, and reinforced by the policies of police and public agencies which consider wifebeating to be a "private domestic matter."

These cultural and social attitudes are viewed not only as the underlying causes of violence, but also as a significant force in perpetuating many violent situations. "A common response to a woman's plea for help is 'Why did you stay?', often followed by 'If you didn't like being beaten, you would have left long before this.' "

Often, women don't report the beating until the threat of serious injury or death appears imminent. "Battered women, like rape victims, are silent victims," says Elaine Hilberman (1978). In working with battered women, she discovered that there was a uniform response to the violence, a "paralyzing terror which is reminiscent of the rape trauma syndrome, except that the stress was unending and the threat of the next assault was always present." These women are characterized by "overwhelming passivity and inability to act on their own behalf . . . there was a pervasive sense of helplessness and despair about themselves and their lives. They saw themselves as incompetent and unworthy and were ridden with guilt and shame. They felt that they had gotten what they deserved, had no vision that there was another way to live and were powerless to make changes."

Periods of Caring

In many cases, the violence may be interspersed with periods of calm, encouraging the victim to believe the abuse won't happen again. Dr. Lenore Walker (1978) comments, "It is wrong for us to consider that violent relationships are always characterized by violence. That is not true. In every violent relationship that I have studied there are periods of love and tenderness and caring for one another.

"In fact, that is the insidious victimization part. That is the part that makes it impossible for that woman to give up that relationship. Because she keeps hoping that somehow she'll do something better to make those periods of love be longer and longer and longer, and the period of violence shorter. Unfortunately, the data shows that it is the exact reverse, that the periods of violence become longer and longer and longer and the loving part becomes shorter and shorter."

Coupled with these devastating psychological factors are often some very real physical barriers to seeking help. Often, battered wives are financially dependent on their husbands and they may have children to care for. "Women without money, transportation, or a job are literally trapped," according to Langley and Levy (1977). "If they don't have the money, they don't have the power," agrees Georgene Noffsinger (1978), founder of a Montgomery County, Md., shelter for battered women. "You must remember that a woman whose husband's income is perhaps $75,000 a year can be just as penniless and, therefore, just as powerless as a woman whose husband is a day laborer . . . And it's characteristic of the syndrome that most of these women are usually kept penniless and powerless," she says.

If and when an abused wife does decide to seek help, what happens? Very often, women who complain of abuse are treated "cavalierly" by the police, the courts, and other elements of the criminal justice system, according to the U.S. Commission on Civil Rights (1978). "Little effort has been made in most jurisdictions to provide the necessary specialized facilities to serve victims of domestic violence," according to a report by the Government agency.

Some advocates for abused women link the reluctance of police to deal with domestic disturbance cases to the fact that 20 percent of police officers killed in the line of duty die while answering such calls (U.S. Department of Justice 1975). Police generally follow a policy of arrest-avoidance which emphasizes conciliation—an approach which is useful when there is not a threat of physical violence but which can lead to escalation of the violence by the husband who retaliates against his wife once police have left. "Unless the victim's injuries are so severe

and obvious that the fuzzy line between simple and aggravated assault has been crossed (in the judgment of the police), the assailant is left with the victim," Ms. Noffsinger points out. "Compare this to what happens to two strangers in a subway station. One is assaulted and robbed. The woman claims to be the victim, even though she can't prove it. At least both are taken down to the police station to sort it out, but not in a case between husband and wife." In some states a 5-day "cooling off" period is required before a wife may even file charges in a case of marital assault.

On the other hand, police and prosecutors argue that many women who file charges later drop them, wanting only to teach the husband a lesson. Bard (1978) reports that between 56 and 81 percent of all family dispute cases which come to police attention involve no assaultiveness of any kind. He points out that family violence is a complex phenomenon and the police must use flexibility in dealing with such cases. He suggests that improving police skills and knowledge will best protect the rights of battered women.

The role of the police remains a hotly disputed point. In New York City, a group of married women who had been beaten by their husbands and refused assistance by the police, filed a lawsuit which resulted in the signing of a Consent Agreement by the police department in 1978. It obligates police officers to arrest men who commit felonious assaults against their wives, as long as there is reasonable cause to believe that the husband committed the crime. The police can no longer refuse to arrest because the woman has not filed a previous complaint in family court. The agreement also compels police to enforce protective orders issued by the family court, by arresting a husband who has threatened or assaulted his wife in violation of such an order. And finally, the police must follow the same procedure for locating an assaultive husband who has left the premises as would be followed in cases of nonfamily crimes.

Bard and others who view the role of police as "managers of human crisis and conflict," see this consent agreement as limiting the discretionary authority of police. "It would be unfortunate if in our zeal to correct the problems associated with the battered women, we ignored the needs of a larger segment of the population," he comments.

Even when police make arrests, there is no guarantee that the courts will take strong action against an abusing husband. In the majority of cases, the abuser is let off with only a warning not to repeat the incident. The courts reflect "society's attitude that the bigger issue—the right of privacy in the home—is more important than a few black eyes and broken noses," observe Langley and Levy (1977). "In the conflict between privacy and equal protection under the law, the latter is generally suspended."

Women who are abused can and do seek help from a variety of other sources—social service agencies, doctors, and friends. But all too often, the situation is minimized or the treatment is inappropriate. Elaine Hilberman (1978) reports that most of the battered women she treated had made frequent visits to emergency rooms and physicians with physical complaints, anxiety, insomnia, or suicidal behavior. "Most had been treated usually inappropriately, with sedatives and hypnotics, tranquilizers, and antidepressants," she said.

Often, these women seek help for problems related to the violence and abuse. But service providers tend to deal only with the "presenting problem," failing to look beneath the surface.

Emerging Resources for Battered Wives

There appears to be a growing interest in the criminal justice system in developing programs which deal more effectively with family violence, as evidenced by crisis intervention training for police officers and a variety of diversionary programs in family courts.

Social services and mental health providers are also beginning to acknowledge the need to train staff to recognize the symptoms of family violence and help them learn to deal with these emotionally difficult issues.

Perhaps the most effective response to the immediate needs of battered women, however, has been the development of hotlines and emergency shelters—often operating outside the parameters of the estab-

lished social service and justice networks. These crisis-oriented services have been developed by women who were themselves abused and in many cases have received their impetus from the feminist movement. Most offer 24-hour referral and crisis intervention service as well as emergency shelter, to provide immediate aid to women and their children.

A Los Angeles shelter worker points out that since most domestic violence erupts around evening hours and weekends, when agencies are not open, the 24-hour, around-the-clock services are "absolutely necessary."

Psychologist Lenore Walker observes that " . . . the battered woman needs a totally supportive environment temporarily before she can make decisions and act decisively on her own. Safe houses, shelters, immediate hospitalization, and long-term therapy can provide this environment. . . . .Most often safety needs must come first."

According to Del Martin (1976), the shelter network, "established by women's groups with its underground railway by which battered women can be transported from one State to another, affords the only real protection to the victim. Other measures—family crisis intervention training, strengthening of and enforcement of protective orders, victim-witness advocacy programs, emergency hotlines and couples therapy—all deal with the immediate crisis," she says, "but do not prevent the recurrence of the violence." In a shelter, "the battered woman gains confidence and strength through peer counseling sharing with other women who have suffered the same experience."

These shelters are often more flexible than traditional helping agencies in providing services both for women and their children, recognizing that many women stay in abusive situations partly out of fear that they cannot escape without losing their children.

At least one shelter, in Minnesota, has developed services specifically for children, since violence in the home is seldom limited to only one victim. "Like other shelters, when we opened we considered children to be the mother's responsibility and we focused on helping her," says Monica Erler of Women's Advocates in St. Paul. "To our knowledge, we were the first agency in the area to allow a mother to bring her children with her into a room and board situation. We soon learned that children share the mother's fear, insecurity, and lack of self-esteem." The program has since added two child advocates to its staff and has included special programming for the children. The shelter has been designated a day care center and special arrangements have been worked out with the neighborhood schools.

At least two well-known emergency shelters offer aid to battered women and their children when there is an alcohol problem as well. (See "Reflections on Family Violence," p. 12, for a review of treatment alternatives for the victim of the alcoholic attacker.) Few services aimed at abused children and battered wives focus on alcohol involvement. Even in cases where the abuser is identified as alcoholic, the issue of treating the alcohol abuse is not always pursued. This functions as a serious barrier to treatment in the view of some professionals. Lt. Commander Daniel W. Behling of the Naval Regional Medical Center in Long Beach, California, says that " . . . unless the alcoholism is treated, any apparent success in case management of domestic violence will be temporary and 'bandaid' treatment at best" (1978). While it is generally agreed that treating the alcohol problem does not necessarily stop the violence, it seems to be easier to treat the violence if the alcohol problems are resolved first.

In the words of a recovering alcoholic, "It was the influence of alcohol that precipitated all of the violent situations that we had. Since the drinking ceased, we don't get into complications like that anymore. We have also learned to deal with our problems in a mature way and to handle our problems in a different manner. . . . once I had conceded that I had a problem with alcohol, and I started dealing with the primary problem, then I could work to clear up the other situation. But as long as I drank, I couldn't deal with anything." (Langley and Levy, 1977).

In cases of child abuse as well, "recognition of the drinking problem and of problems likely to be associated with the drinking problem may help to

reduce abuse of children during drinking," according to researchers Mayer and Black (1977). They found that alcoholics who were in treatment for their drinking problem were able to recognize the potential for physical abuse of their children and to develop conscious ways to avoid situations which might lead to abuse. Willard O. Foster,Jr., NIAAA Special Assistant to the Director, comments, "All of these helping agencies need to take a good hard look at the dynamics related to the alcohol problem and how these affect the kid's behavior." He recalled a case in which an abused youngster had been placed in foster care. But the youngster kept periodically returning home, only to be beaten again by his alcoholic father. "The agency just couldn't understand this. The reason was simple," Foster says. "This kid had always protected the younger kids, so he felt he needed to go back home and make sure everything was under control. But no one focused on the problem with the alcohol and the way it was affecting the entire family, so they didn't understand his behavior."

Signs of Family Violence

On the other side of the coin, alcohol treatment and many other helping agencies fail to recognize, or in some cases ignore, signs that family violence is an underlying problem. Gelles reported that in many families where both drinking and physical abuse occur, the victim considers drinking to be the major family problem. "The Dr. Jekyll and Mr. Hyde syndrome is a recurring theme in the stories that battered wives tell," reports Del Martin (1976). "When the husband is sober he's 'pleasant' and 'charming'; when drunk he is a 'monster' or a 'bully.'Many wives say that they were beaten only when their husbands were drunk (and) . . . these women. . . . believe that if their husbands did not drink, they would not be violent."

By adopting this point of view, many abused women and their violent husbands can convince themselves that the family is "normal" and the drinking was responsible for a temporary lapse in normalcy. Gelles points out that families which interpret their domestic problems as caused by drinking and decide to seek help usually focus on the husband's drinking problem, often not even mentioning the physical abuse to the counselor.

"Within the therapeutic context, the most effective way to deal with violence is to *anticipate* it occurs and ask about it directly," advises Dr. Star. "I have often heard workers say that they deal with violence when the client mentions it. However, my experience has shown that clients are more likely to diminish than exaggerate the frequency and severity of physical abuse." Violence in a family may be only one of many underlying problems, she says, "but this symptom can kill." Her advice, directed to social services workers, is equally appropriate to alcohol counselors.

A recent study carried out jointly by the New York Children's Aid Society and the Council on Alcoholism revealed that many cases of child abuse and neglect could be prevented "if staffs of government and non-profit agencies were adequately trained to identify and deal with parents who have child-rearing problems." (Coltoff and Luks 1978). The report indicated that many parents with a high potential for child abuse are frequent clients at agencies which operate community centers, welfare departments, employment offices, pre-natal clinics, schools, courts, and substance abuse programs. The

danger signals which agencies should be on the lookout for include problem drinking, repeated job loss, unwanted pregnancy at a young age, poor utilization of medical care, birth complications, unrealistic expectations of the children, and an inability to maintain children on various behavior and school schedules, the report says. The authors point out that alcoholism is the risk sign most often seen as well as most easily identified by agency staffs.

"The solution to the child maltreatment problem lies in early identification and treatment of the at-risk parent," the report concludes. "Alcoholism counselors, for example, treat the parent's drinking problem but fail to deal with underlying child care problems. Meanwhile, child welfare workers are separating abused youngsters from their homes but not motivating alcoholic parents into treatment so that the needed 'family solution' can be achieved." The authors call for training programs for agency staffs and the development of a national registry of clients in need of help, in order to allow agencies to identify and track at-risk parents. (See "Joint Training Program," pg. 28, for a description of one such training effort.)

While individualized responses to the problems of child abuse and spouse abuse are obviously needed, there must also be more attention focused on the needs of the total family. The concept of the "battered family" is one which is only beginning to draw the attention of researchers and service providers. In the alcohol field, there is a growing recognition of the necessity to treat the illness as a family problem and to bring all family members—including children—into treatment. In testimony on family violence before the Senate Alcoholism and Drug Abuse Subcommittee in 1979, former Senator Harold Hughes said: " . . . I see this great abundant land of ours with resources beyond compare. I see the wonderful achievement of our science and technology; the miracles of modern medicine; the explosive growth of knowledge in numberless areas; the marvelous exploits of American industry and our own space programs. But I am sick to my soul by our response to alcoholism. And I am sick to my soul that even when we pass laws to help the alcoholic or the drug addict, we have remained blind to the illness that alcoholism brings to the spouse and the young children in the family."

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Reflections on Family Violence

Ruth Sanchez-Dirks, Ph.D., Special Assistant to the Director, NIAAA

Family violence has been defined in a number of ways. In one instance it is cited "as a mode of behavior involving the use of physical force among family members" (Lystad 1975). While the intensity of the violence is described as ranging from the extremes of murder on the one hand to mild spankings on the other, this definition does not include mental anguish or emotional neglect. Martin (1978) goes a step further by describing marital violence as "an act carried out with the intention of, or perceived intention of, physically injuring one's spouse." This definition, while focusing only on the spouse, seems to acknowledge the mental aspects of violence—that the perception or anticipation that the spouse will inflict harm is as much a form of violence as the actual beating.

The difficulty in defining and measuring mental violence has led researchers to focus on the more visible aspects of physical violence such as bruises, lacerations, and fractures. Yet, one should not and cannot forget mental cruelty and the mental consequences of physical violence on the victim. The agony a family experiences while it is waiting to see if the father comes home drunk or sober is very real. The fear a mother exhibits when she locks herself and the children in a room because her husband is breaking up the house is real.

Reasonably good evidence shows that in many instances alcohol is associated with family violence, although there are conflicting views as to the extent of alcohol involvement in wife battering and child abuse. This is not to imply that all alcoholic males will, by virtue of their alcoholism, beat their wives, nor that all alcoholics seriously abuse or neglect their children; we know, however, that many have difficulties in child-rearing and that alcoholic parents have a high potential for child neglect through erratic or inconsistent parenting (Hindman 1975).

Points of Interest

In reviewing the existing literature on alcoholism and domestic violence, three points emerge throughout: first, the repetitive cycle from generation to

generation of both the alcoholism and the violence; second, the fact that the spouse and the children are equally likely to be victims; and third, the similarity of the personality characteristics of the attacker, the alcohol abuser, and the children of alcoholics.

Mayer and Black (1976), Gayford (1975), and others refer to what Behling (1978) calls the "generational" domestic violence alcoholism phenomenon. He found that 63 percent of abused children had at least one grandparent who was alcoholic or abused alcohol. In 41 percent of the cases where both child and spouse abuse occurred, one or both parents had been abused by an alcoholic or alcohol-abusing parent. In 90 percent of the cases where a parent had been an abused child, alcohol was involved in the abuse. Mayer and Black (1976) reported that many of the alcoholics in their study of 100 alcoholics and 100 opiate addicts caring for children under 18 had parents who were alcoholic. In addition, male alcoholics frequently reported use of physical discipline by their parents, and several reported having been abused as children. These fathers in turn reported having high expectations of their own children and using physical punishment in disciplining them, although they felt they did not discipline as harshly as they had been disciplined.

This seems to indicate the importance of parental modeling in the formation of children's personality characteristics, even to the point that these children repeat the same violent behavior that has harmed them. It has been widely noted that children who are physically abused become the abusers of the future. In planning treatment and prevention programs, one needs to deliver services that will break both the alcoholism and violence cycles.

The second point which recurs in the literature is that the attacker seems to be just as apt to abuse the spouse as the child. According to Mayer and Black (1976), alcoholic fathers say they make a deliberate decision not to discipline their children while they are drinking and are considerably more likely to abuse their wives than their children. The authors suggest that recognition of the drinking problem may help reduce abuse of children during drinking. One hopes this would extend to the wife.

It would seem important that treatment personnel in agencies that come in contact with the victims of attackers recognize that there is more than one victim in the family who may be not only physically abused, but also most certainly emotionally abused. In turn, shelters for abused women must deal not only with the psychological problems of children who have seen their mothers beaten, but also with the reality that the children also may have been physically abused.

The third point of interest is the similarity in characteristics of the attacker, the alcoholic, and the children of alcoholics. Spinetta and Rigler (1972) describe child abusers as having a low frustration tolerance, low self-esteem, impulsivity, dependency, immaturity, severe depression, problems with role reversals, difficulty in experiencing pleasure, and lack of understanding of the needs and abilities of infants and children. It has been shown that children of alcoholics exhibit poor self-concept, are easily frustrated, often perform poorly in school, and are more likely to suffer from adjustment problems and problems with role reversals. Alcoholics are described as dependent, having poor self-images, depressed, angry, impulsive, frustrated, and immature. Sound familiar? Perhaps we are just talking about people with problems, or need to be more specific about what circumstances exist when we describe the child abuser as dependent, the alcoholic as dependent, and the children of alcoholics as dependent.

Implications for Treatment

Erin Pizzey, in a presentation to the staff at the public health service in Rockville, Maryland, stated that when the abuser was an alcoholic and beat his wife when he was drunk, the beating stopped when the alcoholism was treated. Even though this may be simplistic, the concept that family violence is reduced by treating the alcoholism is borne out by data collected by the National Institute on Alcohol Abuse and Alcoholism. An analysis of the National Alcohol Profile Information Service data, retrieved from almost 500 NIAAA-funded treatment programs, shows that 35 percent of persons entering these programs reported fighting and quarreling with others as a measure of their behavioral impairment. Six months after entering the program, there was a reduction of 39 percent in the number of people reporting this behavior (1978). Therefore, there is some indication

Ruth Sanchez-Dirks, Ph.D., is a special assistant to the director of the NIAAA. She has been active in supporting the development of programs to meet the needs of women.

that treatment for alcoholism can reduce violence by alcoholics.

We are quite aware that both alcoholism and violence affects the whole family. Therefore, it seems shortsighted that social service agencies, including alcoholism programs, can imagine they are providing quality care if provisions are not made to treat the entire family. It may not be feasible for a single agency to provide care directly to all family members, but it has the responsibility to see that the needs of the whole family are being provided for through coordination with other agencies. This does not mean dumping the client on another agency. In addition, there are many instances when family therapy offers no provisions to include the children. Young victims of abuse and neglect need to be involved in therapy and with the other family members.

Taking the children out of the home and placing them in a foster home is not always the answer either. The children of alcoholic parents feel responsible for the behavior of their parents and often take on the role of parents in the family system. Removal of the children from the home increases the guilt, the feeling that they have done something wrong, or have failed their parents. If the parents do not visit their children in a foster home, feelings of failure are intensified. Much work needs to be done both with the parents and the children so that children can return to the parental home. Many times, once children are in protective custody, agencies seem to forget that their mission is not only to protect the children but to return them to their parents as well. This is the very thing that alcoholic mothers fear and cite as a deterrent to coming for treatment.

Treatment Alternatives

There are few programs designed specifically for the victims of the alcoholic attacker. The primary source of help for the children of alcoholic parents is Alateen, which serves teenagers between the ages of 13 and 20. The more than 1,000 Alateen groups in the Nation are designed to provide teenagers with support and an opportunity to discuss how to cope with the family alcoholism problem. In some areas, Ala-Tot meetings are being formed to help preteenagers.

Although there is no way of knowing how frequently the issue of family violence comes up during Alateen discussions, the primary emphasis of the group is on helping youngsters "to cope with the situation in spite of the parent's actions," according to the Alateen coordinator at the group's headquarters in New York. If the parents fight, she said, the children learn to remove themselves. If one or both parents abuse the children, and the situation surfaces during an Alateen meeting, other group members often relate ways in which they have dealt with similar problems, such as seeking help from a school counselor or other adult, she commented.

Al-Anon, of course, offers similar support to the spouses of alcoholics. These meetings involve discussion of a range of problems, including violence, which are related to the alcoholism of the spouse. As in the Alateen meetings, the focus of the groups is on encouraging the spouse to change his or her own behavior.

There are an increasing number of alcoholism treatment programs that involve the entire family—including children—in therapy. Seneca House and the University of Maryland Hospital, both in Maryland, run therapy sessions for adolescents. Women's alcoholism treatment programs, especially, have been very cognizant of the need to treat the children and many have made provisions for this treatment as part of the total program. Few programs focus specifically on family violence, however, unless the subject is surfaced by the young people.

There are two nationally known programs serving battered women who are victims of alcoholic husbands—Rainbow Retreat in Phoenix, Ariz. and Haven House in Pasadena, Calif. Both of these provide services to the children as well as to the battered women.

Rainbow Retreat serves women and children who are abused or displaced. Even though alcohol involvement is not a criteria for admission, the executive director, Joanne Rhoads, states that even when a woman denies that alcoholism is involved they find that in 8 out of 10 cases drinking is a factor. Rainbow Retreat offers shelter for up to 25 women and children at a time and, in its first 2½ years, housed more than 1,000 persons. Families are referred by doctors, counselors, and protective services. The first concern is to deal with the crisis that brought the women to the shelter. Residents receive individual and group therapy, job training, and placement. In 64 percent of the cases, husbands subsequently seek treatment for their alcoholism. A new component of the program offers shelter to abused children, referred by protective services, who are admitted with the mother—an attempt to treat the abuse problem without destroying the family unit, Ms. Rhoads said.

Haven House, Inc. provides short-term, crisis-oriented residential treatment programs to families of alcoholics. As with Rainbow Retreat, the House accepts clients from anywhere in the country. Since the receipt of its first public funds in 1974, the program has served approximately 150 families a year, including about 375 children. Most clients are self-referrals. The largest referring group is Al-Anon,

and other referrals come from the police, hospitals, and welfare and other social service agencies.

The philosophy of Haven House is that alcohol abuse upsets the balance of family dynamics as well as the life of the abuser himself. The family can either aggravate the problem with its internal pressure or support the alcoholic in a program of recovery.

Haven House has found that the family's leavetaking often precipitates a crisis for the alcoholic spouse who in turn seeks treatment for his alcoholism. In about half of the cases at Haven House, the family is ultimately reunited.

The approach taken by these two shelters deals with the total problem of family violence, rather than treating spouse and child abuse as two separate problems. As awareness of family violence has increased in the last few years, so have the number of shelters and other services offering aid to these women. While few focus specifically on families with an alcohol abuser, many offer referral for alcohol treatment, and some include an alcohol treatment component.

In St. Paul, Minn., a chemical dependency counselor spends 2 days each week working with women and their children at a shelter for battered spouses operated by the city's Family Services Agency. Counselor Donna Chicone reports a fairly high incidence of alcohol problems among the husbands of the battered women. She has found that treating the alcohol problem does not necessarily stop the family violence, but once the alcoholism has been treated, the chances of successfully treating the violence are much greater than in families where there was no alcoholism. "The alcoholic gains a lot of tools while he's in alcoholism treatment and he can use these tools to work on changing his abusive behavior," she says.

Another multi-service agency, the Family Renewal Program in Edina, Minn., uses a similar tactic in helping families in which there is sexual abuse of a child. Affiliated with a local hospital, Family Renewal operates both a chemical-dependency treatment program and a separate program to treat sexual abuse. Both take a family approach, involving all children over 5 with the parents in group treatment. Counselor Kari Barth reports that she sees a fairly high incidence of alcohol problems in families referred for sexual abuse of children—in at least half of these abuse cases, the abuser has alcohol problems. The agency focuses on treating the alcohol problem first and then dealing with the child abuse. In attempts to treat the problems simultaneously, she reports, the agency has found that the alcohol problems are often used by the family as an excuse to avoid dealing with the child abuse. "The two issues get confused and neither is resolved," she comments.

Treatment Must Address Alcohol Problems

The experience of these two programs confirms the need to look for and treat alcohol problems in dealing with family violence, an approach which forms the basis for three clinical demonstration projects recently funded by the National Center on Child Abuse. These are the first NCCA grants dealing specifically with substance abuse issues, the result of collaboration with both NIDA and NIAAA's Division of Special Treatment and Rehabilitation.

The Arkansas Alcohol/Child Abuse Demonstration Project is the only one dealing exclusively with alcoholic families. The project, operated by the University of Arkansas Graduate School of Social Work, offers help to a population of teenagers abused by parents who have drinking problems. In addition to the problems of child abuse and neglect, the social workers observed a high correlation between alcohol abuse in parents and sexual abuse of teenaged children in the initial small population group.

Project director Jerry Flanzer says the Arkansas program will compare the effectiveness of family management techniques with other individualized and family treatment approaches. "The project offers exciting opportunities for discovering better ways of

helping families who are caught in a web of alcohol abuse and violence," he comments.

In New York City, the Parent-Child Treatment Program at N.Y. Medical College is developing ways to provide services to families in which child abuse has been identified and where substance abuse is also present. Director Harrison Lightfoot says that many of the substance abusers who were being treated by the Medical College had problems with child neglect and, to a lesser extent, abuse. In most of these cases, parents were abusing both alcohol and other drugs. Clients are referred to the child abuse program from other treatment components of the Medical Center—the methadone maintenance program, the detoxification program, and a program for pregnant substance abusers—as well as by outside agencies who have identified child abuse or neglect in a family. While the first priority is the safety of the child, the program takes a comprehensive approach to improving the physical, social, and emotional health of all family members.

At the University of Michigan, the Child Abuse/Substance Abuse Family Evaluation and Therapy Investigation uses structural family therapy to treat families in which one or more of the children has been abused and at least one parent has a substance abuse problem. The program is in its formative stages, with referrals expected to come from various community agencies.

"Family therapy has been successfully used to treat substance abuse," comments Dr. Jaime Vazquez, "but hasn't been used in child abuse cases very often." Therapists in the university's Department of Psychiatry will conduct the therapy sessions, while a social worker attached to the project will work with referring agencies to coordinate services to these multi-problem families. Dr. Vazquez says the project will also include a research component aimed at learning more about the interactional patterns in the families who are receiving therapy.

Suggestions for Future Action

What can be done to address the issue of alcohol problems and family violence?

- Alcoholism workers generally lack training to recognize the potential or existing problems of family violence in families they are counseling, nor do they know how to handle the violence. Therefore, training curricula should be developed to teach alcoholism workers to identify and handle the potential for family violence.
- Health professionals, protective service agencies, and criminal justice personnel generally lack the training to recognize alcohol problems in families in which abuse occurs, nor do they know how to handle the alcoholism. Therefore, training curricula should be developed to train health and social service professionals in the identification and handling of alcoholism.
- There exist few data on the relationship between alcoholism, alcohol usage, and family violence. Therefore, research should continue into the relationship of alcohol to child abuse and wife battering.
- Children with parents who are alcoholic or child abusers have a greater potential of becoming alcoholics or abusers themselves. Therefore, treatment and prevention programs need to be developed that aim to break that cycle.
- The alcoholic attacker seems just as apt to attack the child as the spouse. Therefore, even in families where there is violence or the potential for violence directed toward only one family member, treatment and protective personnel need to deal with the violence from a total family perspective.
- While not all families of alcoholics experience physical violence, all families of alcoholics experience mental anguish. Therefore, all members of the alcoholic family need help in dealing with themselves and the alcoholism as a family and as individuals.
- The reported characteristics of attackers, alcoholics, and children of alcoholics are similar. Therefore, it is necessary to research further the personality characteristics and the role of social and environmental circumstances, in order to differentiate between these troubled persons for purposes of diagnosis and prevention.
- In these times of limited funding, agencies are unable to provide in one program all the services needed to rehabilitate a family. A single agency cannot be expected to have the expertise to treat both the alcoholism and family violence. Therefore, it is necessary for programs to develop cooperative agreements to treat each other's clients and to determine which agency will have the ultimate responsibility to coordinate treatment.

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Perspectives

An AH&RW interview feature

"There is no substitute for thorough and ongoing training in information and referral procedures, assuming the resources are available."

Dorothy B. Hurwitz, M.S.W., is the former director of the Washington Office of the National Conference on Social Welfare, and has been project director of the National Commission on Families and Public Policies. She has a background in education and community social services.

Q.

The contemporary political and social climate in this country is characterized by a growing resistance to societal regulation of, and intervention in, family life. It is obviously necessary to intervene in family interactions to protect children and spouses from physical abuse. How do counselors decide when and how it is appropriate to intervene?

A. Dorothy Hurwitz:

There can be no simple set of responses to this question. Each counselor's decision will be based not only on his or her skills and experience, but also on the nature of the particular community systems involved and the supports available to the counselor - supports such as training, supervision, professional back-up, etc. Just as children and spouses need protection from physical abuse and assistance from community services if they are abused, so too do counselors need assistance and protection in relation to their work with physically abused persons in the form of rules and regulations that spell out not only basic referral procedures but also rules providing protection for themselves. Societal intervention can be *intrusive* or *protective* depending on the values and interpretations of all those concerned. If a broad cross-section of families and individuals is involved in the development and monitoring of such rules and regulations, resistance to societal intervention can be mitigated.

A. Diane Hamlin:

Individual and systematic resistance to intervention in family life is based upon fears regarding the shaping of families and family life in the decades to come. People feel tremendously threatened by the rapid and substantial changes taking place in the nuclear family. If anything has remained a constant, it is the existence of a variety of violent behaviors which take place within the family. What is beginning to change is that these behaviors no longer have societal sanction.

Violence within the family is rarely an isolated violent incident, but more often follows a pattern in which the attacker's behaviors increase in both severity and frequency if allowed to continue unchecked. These family systems are often on a collision course with death. A police study in Kansas City found that in 85 percent of the homicide or aggravated assault cases seen from 1972 to 1973 the police had been called to the home once before. In almost 50 percent of these cases, they had previously been called five times or more. This statistic presents a compelling case for effective interventions at the earliest possible stage in this spiraling violence. It also is illustrative of the reality that in spouse abuse cases, police are often

"There is evidence to suggest that the families in which child abuse and spouse abuse occur are often the same families."

Diane Hamlin is director of the Clearinghouse on Battered Spouses of the Center for Women's Policy Studies in Washington, D.C. The program is funded by the Law Enforcement Assistance Administration of the Department of Justice.

the first ones called. They are, in effect, gatekeepers to the various intervention systems. Comprehensive community efforts coordinating this variety of systems are required to ensure such interventions are both possible and effective.

The other advantage to early interventions may be that these behaviors are less ingrained, and hence, more easily treatable than violence which has been ongoing for many years. Many researchers believe that such violence is socially learned behavior; Murray Straus even refers to the family as "basic training" in violence.

The decision concerning how to intervene should be predicated upon where a family is in the spiral of violence. Good assessment upon intake is crucial to the success of interventions. A primary consideration must be the potential for lethality within the family system. Counselors should make such decisions based on as much information as they can gather. Clinicians working with batterers agree that they have a tremendous capacity for deception and self-deception, and can be both tremendously charming and manipulative. Reliable corroborative information from other family members or neighbors is essential.

The primary goal of intervention must be to stop the violent behavior. There are a number of programs beginning to grapple with creative means of accomplishing this task. These range from in-service treatment at a Veteran's Hospital to an abuse education class with a format analogous to driver education school. The Center for Women Policy Studies is closely watching these programs and should be contacted for more detailed information about their content and outcome.

A. Gisela Spieker:

Our society has a very strong sense of the sanctity of the home and the family. We would not in any way tolerate policies which would permit investigations into homes based on family members' behavior. There are approaches, however, which can work very well in terms of intervention at a very early and appropriate stage. The police department in every city receives calls about crisis situations—family squabbles and beatings. Either a family member calls or neighbors call. In all fairness to the police, they do the best they can but they are not counselors and I don't think any one of us expects police to do social work. In these kinds of situations, counselors should be available for immediate intervention along with the police. In these situations I think we as counselors are missing an opportunity to intervene.

Perhaps one approach would be for the police force to employ professional counselors to handle crisis situations, because crisis situations are really requests for help. Another supplementary approach is

the community education campaign—short media spots about the services available to help people with spouse abuse, child abuse, and alcohol abuse. First, we must educate the public that it is all right to call for help. And then we must be prepared to offer crisis intervention to families at the time they are most receptive to our help—during the crisis.

Alcohol is certainly a contributor to family violence. Alcohol is a stress-releasor. At the same time, aggression seems to have a similar basis, acting as a stress releasor as well. Sometimes, beating somebody, or just having an argument, releases tension. For instance, the news media reported recently that in Wichita Falls, Texas, where one-fourth of the city was destroyed by a tornado, wife abuse has increased 400 percent and we can expect a similar increase in child abuse. People are having to live in cramped quarters and they are releasing tension through aggression.
As important as it is to offer treatment to family violence victims, we must not overlook the question; how do we bring about societal regulations to *prevent* such behavior? Legislation is certainly not the answer. The answer probably lies in allowing people to seek help and—partially through educational programs allowing people to accept help. Many times I have found that when people do seek help—especially with family problems—they will not follow through. They are not able to accept the help.

It was not until the 1930s when AA was founded, and alcohol abuse began to be viewed as a health problem, that it began to be okay to ask for help. The same thing is happening now with family violence. Many people still feel it's not all right to ask for help with these kinds of problems. There is, however, growing community awareness and concern about these matters—partly because of the feminist movement—and communities are doing something about it. This ongoing social reform is the best solution to the problems of family violence.

Q.

Emotional reactions to child beating and spouse abuse often make it difficult, even for trained counselors, to deal with these situations in a constructive way. Alcohol and other counselors not specifically trained to deal with family violence may be not only unaware of resources but also uncomfortable in bringing these problems out into the open. Conversely, knowledge about alcohol abuse and its treatability is often minimal among those who intervene in family abuse situations.
What practical and short-term steps can be taken to deal with these roadblocks to referral?

A. Dorothy Hurwitz:

Roadblocks to referral are similar for many multi-problem situations. To make appropriate referrals, a counselor must be able to do two basic things: (1) make an intake-type of diagnosis which requires a knowledge and skill base in the particular problem area; and (2) have an in-depth knowledge of the resources available in the community. Counselors are frequently lacking in one or the other, or both. Solid knowledge of the availability of good resources to refer to often makes the difference between a counselor's perception of ability or inability, comfort or discomfort, in providing assistance. There is no substitute for thorough and ongoing training in information and referral procedures, assuming the resources are available.

A. Diane Hamlin:

Because very little is known about the relationship of alcohol to family violence, it is extremely difficult to speculate about what would aid alcohol and family violence programs to utilize each other's services effectively. A valuable tool for all these service providers would be to maintain up-to-date directories of other programs and their availability.

It would also be helpful to have alcohol counselors do in-service education programs for the other agencies which provide services, including information about the nature of alcoholism, alcohol abuse, its treatability, and the services that particular alcohol treatment programs provide. Similarly,

"As important as it is to offer treatment to family violence victims, we must not overlook the question; how do we bring about societal regulations to *prevent* such behavior?"

Gisela Spieker, Ph.D., is professor of research at the Graduate School of Social Work, University of Arkansas at Little Rock. She has published research findings on the connection between alcohol abuse and child abuse, family violence, and crime.

shelter staffs and family violence program personnel could provide the same function for local alcohol abuse treatment programs. Also, intake interviews by family violence workers should routinely include inquiries regarding alcohol use.

Finally, communities may establish local task forces comprised of representatives from all these programs as a precursor to an ongoing coordination effort. The primary task of such a coalition of public health, domestic violence, mental health, hospitals, and alcohol programs would be to formulate an intervention, referral, and treatment policy all these agencies can live with. The process of completing this task should do much to increase understanding of the programming and limitations of other agencies, and greatly facilitate effective referrals.

A. Gisela Spieker:

We really do have roadblocks to referral. There are roadblocks to integrating responses to family abusiveness. Over the last two decades, we have trained alcohol counselors to work with alcoholics. When we started doing this we really didn't pay much attention to the family, except to the role the family—especially the wife—might play in causing the male alcoholic's drinking. There was an underlying assumption that if his wife weren't the way she was, the alcoholic husband probably wouldn't be having drinking problems. Seldom did we make the alcoholic really face his behavior within the family, simply because the training we provided for the alcohol counselor was limited to helping the alcoholic specifically.

Family counselors, on the other hand, have received more extensive training—they usually hold degrees as social workers and psychologists—in human behavior skills. But family counselors have been reluctant to deal with alcoholics, because their training led them to treat alcoholism as an emotional problem, an approach to which the alcoholic would very quickly react in a negative way. So there has been little interaction between the two fields.

We have begun to make inroads by providing a more extensive training base to alcohol counselors as well as giving the family counselors a more meaningful involvement with the alcoholic.

Similarly, counselors have tended to view family violence problems with a very narrow focus, rather than looking at family abuse as a comprehensive problem. The Mid-America Institute on Family Violence, at its annual symposium, is making a real effort to train more counselors to recognize and work with alcohol and family violence problems in a comprehensive way. Child abuse, spouse abuse, and alcohol abuse all can and do occur in one family, although perhaps only one area is observable. The counselor

must be able to objectively assess the situation. Training efforts such as the symposium will help, I believe, to enlarge the concept of family violence problems and how alcohol is involved.

Q.

Reports of child abuse and neglect are channeled to protective service agencies while marital abuse is generally handled within the criminal justice system. This is perceived by some as a major barrier to dealing with family violence in a comprehensive manner.
Do you view this as a problem, and, if so, what can be done to improve service delivery to victims of family violence?

A. Dorothy Hurwitz

With the proliferation of public services that has arisen over the past two decades as a result of the many pieces of legislation dealing with special problems, there has been a fragmentation of services to the individual and family. While we need to continue to respond to major crises, we must also respond to this fragmentation by establishing systems of case management with a specified locus of authority in each community. A skilled case manager or case coordinator should be able to see all the actors involved in incidents of family violence, make appropriate referrals, and track those referrals through the service system so that problems can be seen and dealt with within the whole family and the community system, rather than in pieces. While we struggle each year with a "new" crisis in human problems, there are common elements in programming for and dealing with crises. There are, of course, major differences in the knowledge bases of workers in the fields of drug abuse, alcohol abuse, child abuse, spouse abuse, etc. As supports to their work, counselors need this specialized knowledge base; they also need knowledge of community resources, they need to be buttressed by a continuum of care that a workable community case management system offers, and they need workable rules and regulations to protect their clients and themselves. In addition, every community that attempts to deal with family violence must provide a variety of forms of assistance to informal or natural support systems for families. With these approaches we may be able to improve service delivery to victims of family violence.

A. Diane Hamlin:

The differing functions and philosophies in agencies currently handling child abuse and spouse abuse cases is problematic in a variety of ways. This bifurcation in responding to abused children and battered spouses results in a diffusion of skills and resources at a time when program money is difficult to obtain, particularly for human services. In addition, there is often poor or non-existent communication between these agencies because of the stumbling blocks to creating an ongoing and viable coordination system. Agencies may also regard other professionals with a good deal of skepticism and zealously guard what they view as their "turf."

Yet children and adult victims of family violence share at least one need—for the violence and abuse to stop. Criminal justice, health, and social service agencies all have a role to play in achieving this goal. Beyond this, both children and adults are likely to be multi-problem clients who need the resources of a variety of agencies. A child victimized by a parent may have fallen behind in school as a result of the violence and may require tutoring assistance to catch up. Or the child may have withdrawn from peers and need some assistance in reestablishing good relationships within his or her own age group. A battered wife may have no financial resources if she chooses to leave the abuser; she may need some job training or she may need daycare for her children while she works. Victims may require a variety of services, and ongoing communication between the service providers will facilitate access to needed services.

There is evidence to suggest that the families in which

child abuse and spouse abuse occur are often the same families. An ongoing information exchange between agencies would help increase knowledge about this dynamic and aid in formulating more effective interventions and prevention techniques.

The Law Enforcement Assistance Administration (LEAA) currently has a Family Violence Program which requires all its grantees to establish such coordination between agencies. They have experienced a variety of difficulties in establishing this flow between agencies, but those which have done so successfully have been greatly aided once the linkages were in place. A child sexual abuse treatment program at Harborview Medical Center in Seattle, Wash., for example, has established ongoing communication with the prosecutor's office which has greatly increased the effectiveness of their program as well as community understanding of child sexual abuse.

A. Gisela Spieker:

All of the existing services to victims of family violence are very compartmentalized, and they have remained so for two decades. It is difficult to shake a structure which has developed over this time period.

Alcoholism, until the mid 30s, was really considered a criminal offense or sin. Beating a child in the past was considered to be appropriate discipline. And beating one's wife was viewed as a demonstration of the husband's rightful authority. So these three behaviors have, historically, been viewed quite differently from the way we view them today.

The fact that alcoholism is a health problem is fairly well accepted today. But it was not until the 1960's that public attention was focused on child abuse and legislation was enacted to punish the abuser. Social service agencies became active in providing foster homes for abused children and workshops flourished. But the initial actions—removing the child from the home and placing him or her in foster care—really almost had the effect of punishing the victim. Not until the mid-70's did we recognize wife abuse as a public problem. Shelters are just beginning to open in most major cities, and treatment services are still quite limited.

All along, research did indicate some interweaving of these problems. But treatment agencies have been reluctant to integrate services to respond to human behavior problems. This compartmentalization is not a matter of choice, but rather, a matter of development.

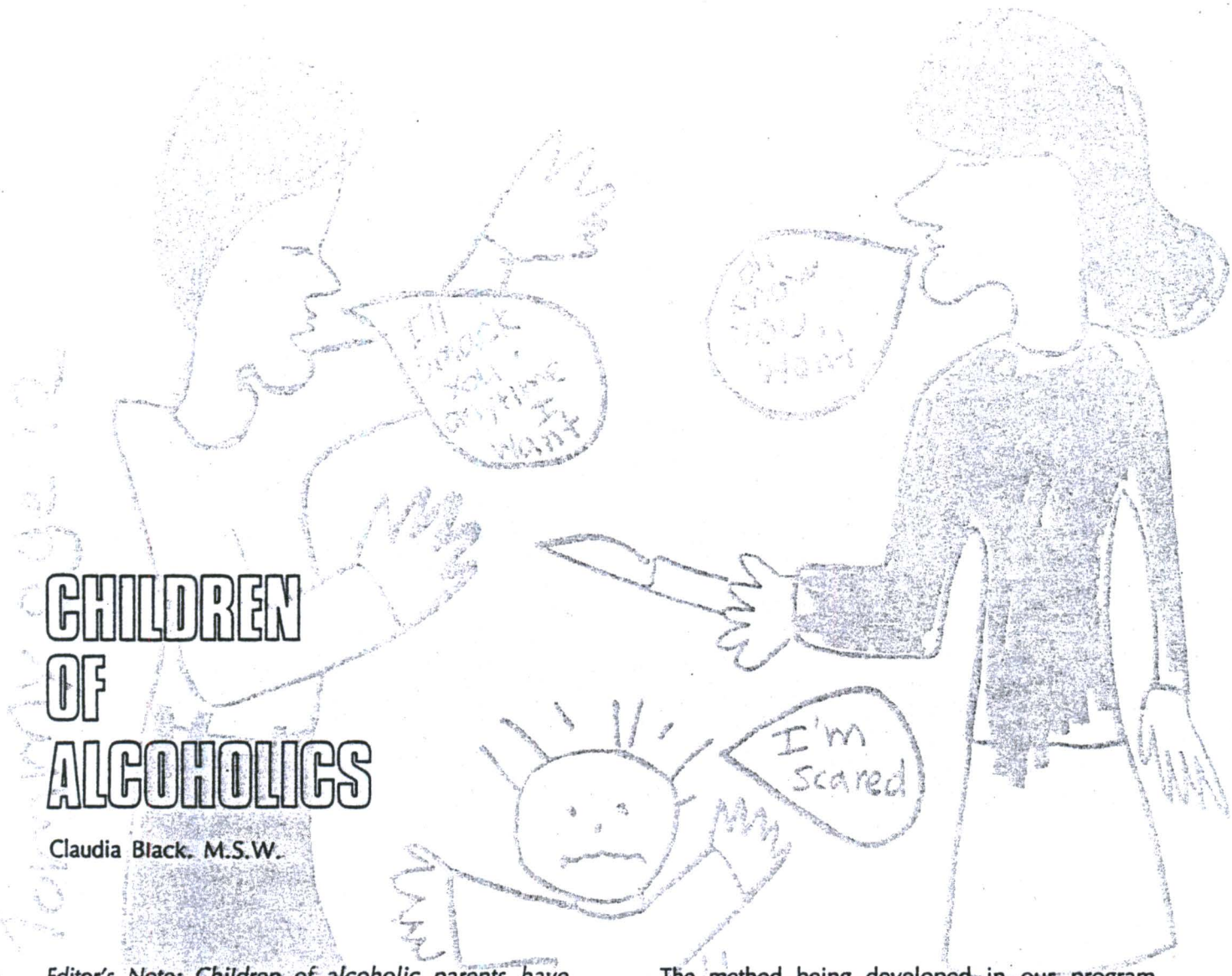
The court system is very reluctant to intervene in homes where violence occurs. We have problems in this community in getting judges to recognize wife abuse as a serious problem and we really don't feel women get protection from the courts. Too often, they are told to get a divorce if they want to end the relationship. But there should be more.

We must take a holistic approach if improvement in service delivery are to be made, and I believe we really are at this point today in the widespread focus on families.

When we provide shelter for the woman who has been abused and protection for children who have been abused, and nothing is done to reach the offender, then we create a situation in which the same behavior is likely to be repeated. The wife can get a divorce, but all too often the abuser—the husband—remarries and the same violence is repeated in the new family.

We are starting to provide for the victim, but if we don't also provide treatment for the abuser, we are simply going to make more victims. I think it's time, late as it is, that we start paying attention to the offender. It seems we have a reluctance to place restrictions on the offender, stemming from our fear of violating a person's civil rights. But we don't seem to have this same reluctance when we are dealing with the victim.

We are only beginning to deal restrictively with the alcohol abuser who drives when he is drunk, by requiring that he get treatment or lose his right to drive. I believe we must approach the man who beats his wife or the parent who beats a child from a similar perspective—not treating them as criminals, but providing some sort of intervention to insure that the cycle of violence is stopped.



CHILDREN OF ALCOHOLICS

Claudia Black, M.S.W.

Editor's Note: Children of alcoholic parents have been recognized as a group at risk for neglect and even abuse. But parental alcoholism also inflicts emotional damage on the children, damage which is sometimes not visible until later life. Clinical social worker Claudia Black, views her work with children of alcoholic parents as preventing future psychological problems, including the possible predispositon of these children to become alcoholic adults or to marry alcoholics. She works with children in a group setting, relying heavily on the use of art therapy to help them express their feelings.

We know that children of alcoholic parents are at particularly high risk for developing a variety of problems and that few programs treating alcoholics offer counseling directed specifically at these children (see Alcohol Health and Research World, *Winter 1975/76). Ms. Black suggests that all children affected by parental alcoholism—not only those who exhibit behavioral problems—need treatment.*

The method being developed in our program, which stresses prevention as well as intervention, could be implemented in most alcoholism treatment facilities. Before looking at our program, we need to explore the dynamics of the child exposed to alcoholism. Typically, parents and professionals do not acknowledge the need for bringing children into the treatment program, except to treat a behavioral or disciplinary problem or to assist in a confrontation among family members. The tendency is to focus on a problem child who is often stereotyped as a potential future alcoholic; one who exhibits the defined high-risk characteristics of: 1) having a low self-concept; 2) being more likely to perform poorly in school; 3) being more easily frustrated; and 4) having adjustment problems in adolescence and early adulthood (Bosma 1975). I believe, however, that the child with behavioral problems in the alcoholic home is in the minority. Although he or she may receive attention by drawing notice to him

or herself, I believe that all children in alcoholic homes have a high risk of becoming alcoholic and that the majority of the children, those who appear to have adjusted and so are not focused on in the research, are easily overlooked.

We find in our groups that children of alcoholics, like most alcoholics themselves, according to research, are bright and of above average intelligence. People often admire the roles these children have adopted in reaction to their chaotic and inconsistent family setting.

Three role patterns which seem to allow children to survive in alcoholic homes appear regularly. The dynamics discussed here are not revolutionary psychology, but rather are similar to Adler's birth order and the more recent family systems approaches. However, I do not believe these concepts have been generally related in practice to the children of the alcoholic. We have labeled these role patterns as 1) The Responsible One; 2) The Adjuster; and 3) The Placater. A child may adopt one role or any combination of the three. As will be illustrated, these roles create strengths which in turn hide the scars that develop from living in an alcoholic family system. It is important to recognize the deficits in such roles in order to believe in and support the need to address *all* children of alcoholics. Family system theorists view the family as an operational system and believe that "change in the functioning of one family member is automatically followed by a compensatory change in another family member" (Bowen 1973). To each action there is an equal and positive opposite reaction in the family. The roles these children play are compensatory changes or reactions to parental alcoholism, allowing the children to maintain a sense of balance or homeostasis to survive.

The Responsible One

The role most typical for an only child, or the eldest child in a family, is one of being responsible, not only for him or herself, but for other siblings and/or parent(s). This child typically provides structure and stability for him or herself and others in an often inconsistent home setting. An example is the 10-year-old daughter who took it upon herself without telling anyone to complete the household chores daily and to oversee the other two children. Aware of the plans of every member, she attempted to organize the family. She felt this role was necessary because the mother was working 7 days a week, 10- to 14-hour days, and the alcoholic father was not working and was not responsible to anyone in the home for his whereabouts. In this situation where the child assumed the responsible role, one that provided order for her, she carried this sense of responsiblility to other areas of her life. She excelled in school, for she learned to structure good study habits. She learned to manipulate others about her to get done what was necessary, thereby developing leadership qualities. She became goal-oriented on a daily basis. She learned not to project ahead, knowing her alcoholic father could interfere, so her goals became realistic. A self-worth developed as she accomplished these goals.

Claudia Black, M.S.W., is program director of CAREUNIT (an alcoholism recovery treatment program) at Parkwood Community Hospital in Canoga Park, Calif. Prior to entering the alcohol field, she worked with adolescent women in residential treatment settings for 3 years and was a lecturer for the Rape Prevention Forum in Seattle for a year.

The Adjuster

Another role that may be combined with the previous responsible role, or adopted separately, is that of the adjuster. This child easily follows directions, not feeling the great responsibility the elder child feels or to whatever is called for on a particular day. For example, a 28-year-old man, the son of a male alcoholic, describes his childhood as "bouncing from one extreme to the other." He said he fluctuated physically and emotionally—never knowing what to expect from either parent. One day his mother was leaving his father and the next day she was behaving as if the thought of separation could never enter her head. For weeks at a time, the child would sit outside a bar in the car, waiting while his father drank for hours. Other weeks, his dad would not drink at all. Another young woman said she too learned to be flexible in her alcoholic family—she felt she had little choice but to adjust. In the most extreme situation, she could not follow through with her plans because her parents would move without notice. And these were major moves—from the Northeastern States to Florida, to California. Adults who were "adjuster" children say that, as a result, they see themselves as flexible and able to adapt to a variety of social situations.

The Placater

The placating child greatly needs to smooth over conflicts. This child, often very sociable, develops the admired quality of *helping* others adjust and feel comfortable. This child often adopts his role to alleviate a sense of guilt that he caused the alcohol

problem. An example is the 22-year-old daughter of a male alcoholic who talked of being aware since age 6 of tension in her family, especially great sadness in both parents. So she spent years trying to help both parents feel good. Everytime her dad said, "Hey, let's go for a ride," she'd go, now reflecting that the ride always resulted in a series of stops at local taverns. She combined the placating and responsible roles, additionally doing a great amount of housework to please the mother who worked because dad did not work. For hours at a time, she would wait on and listen to dad's buddies as they drank and talked. She said she did not understand what was happening in the home, but she knew people hurt, and she would do whatever she could to please them, thinking it would take away the pain. Strengths developed out of this role. She felt she was popular and got many strokes for helping others, being sensitive to their feelings and listening well.

Survival is Key

I have found that children in alcoholic homes are busy surviving. We admire the way they assume the role(s) that make(s) the most sense to them—roles that will help bring peace to the chaotic, denying family in which they live. Displaying behavioral problems is not a role that helps attain peace. We do see some—but not most—children from alcoholic homes in the acting out role.

Unfortunately, it is easy to overlook the children who are responsible, adapting, sociable, and bright. But they are possibly being set up to be 50 to 60 percent of society's future alcoholics. Whatever the role these children adopted in the family, there will be some negative consequences for them.

As these children reach their late teens and early twenties, they are often busy leaving the primary family. They make decisions on education, employment, marriage, and childbirth. Focusing on their futures, these children usually are unaware of the negative effects of their alcoholic upbringing. They often recognize their strengths because they have been rewarded for being so healthy. As adults, they say they often heard from others and/or told themselves, "You've really done well in spite of your home life." Again the scars are unseen, even by those who are close.

But these children whose roles have allowed them to survive do not change roles just because they leave the alcoholic environment; these roles become patterns carried into adulthood. It is after the children have begun to lead settled lives as adults that they begin to realize that old methods of coping are no longer working to provide a sense of meaningfulness to life. It is at this time the effects of living in the alcoholic home begin to show. These adults often find themselves depressed, and they do not understand why; life seems to lack meaning. They feel a loneliness, though many are not alone. Many find great difficulty in maintaining intimate relationships. And many become alcoholic and/or marry alcoholics.

In additon to the strengths developed through adopting these roles, there are some equally powerful deficits. Many of these children learned it was not all right to experience certain feelings like anger or sadness. It did not help to feel. When they showed their sadness, their fear, no one was there to comfort them. When they became angry, they found themselves punished. Or when they wanted to talk about anything important, they simply found themselves ignored. It did not take long for these children to learn first, not to express their feelings, and second, not to feel.

The 25-year-old daughter of a male alcoholic gave a good example of how her fear of anger has had a major effect on her adult life already. She talked of learning to please others, always avoiding conflict because she feared anger. She said her alcoholic father was extremely violent when he drank. She generalized her fear of his anger to anyone's potential anger. Thus, she negated her own anger, and possible satisfaction of her wants, by continuing to placate. She was unaware of this dynamic until she walked out of a marriage of 5 years; a marriage in which she never argued and only felt depressed. Several months in therapy helped her acknowledge her fear of anger and her own anger and to begin working on acceptance of that feeling in herself and others. But all of this was too late to save this first marriage.

Children who ascribed to the responsible role

often found their leadership and self reliance led them to being "too alone," unable to depend on another person, to trust that another person would be there for them when they needed someone. This can carry over to adulthood.

Many of these "responsible" children have talked about their "need to be in control" which has led to difficulty in relationships at work and socially. These children,too,end up often working alone and not having meaningful relationships.

A classic example was the 31-year-old daughter of a male alcoholic. She was bright and a successful lawyer. But she worked alone, had no close friends. Her third marriage was failing. I definitely believe her fear of trusting others as well as her fear of her own feelings, which she learned in her alcoholic family, were responsible for her confusing, lonely life.

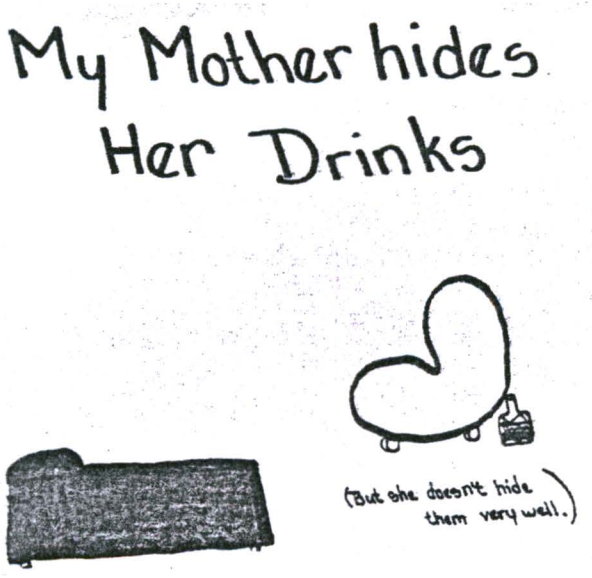
"Adjuster" children become "adjuster" adults, unless there has been some direct intervention as a result of their own insight for a need to change. They continue to allow themselves to be manipulated by others, thereby losing self-esteem and power over their own lives. Their option is to invite someone into their lives, often an alcoholic, who has problems or creates problems. This allows them to continue their reacting role..

Adult placaters will try to continue the childhood habit of taking care of and trying to please others. Both adjusters and placaters will often not respond to or even be aware of their own failings and desires. As one woman said, "After I raised my kids and only had my husband to please, it seemed life had little meaning, and before long, I was here in the hospital for alcoholism."

The examples given have been those of adults who were raised in alcoholic families. I used adult examples because most of the children still at home appear to be doing well; not until adulthood are negative consequences apparent. But the pattern begins at a very young age. I see denial systems starting to develop in 5-, 6-, and 7-year-olds. Nine-year-old Melody was in group for more than two months before she responded to a question with anything other than "I don't know." A breakthrough came when she was able to say, "Sometimes I pretend that my Mom is not drinking...when she really is. I never even talk about it." The denial is usually not apparent to family members and seldom, if ever, apparent to outsiders. I see these young children learning to find the role that helps them feel better, either taking care of others and the environment (being "responsible"), adjusting, not questioning, or busy trying to please others and trying to take away others' hurt. Melody summed up the roles in her family clearly when she said, "My younger brother worries—I don't know—my Dad takes care—my Mom drinks." As Melody says, she "doesn't know," she simply asks no questions, makes no statements, does what she has to to get through the day. As her dad said, she "adjusts" very well.

Preventing the "Alcoholic Personality"

These children may be physiologically predisposed to be alcoholic, but we, the professionals in the alcoholism field, can help them to not have the emotional and psychological "alcoholic personality" that may feed the physiological predispositon. Recognizing this, I began to see the young children of our patients individually. I found the children were attentive, listened, asked a few questions, but sel-



dom mentioned their feelings. Finding the interaction was more meaningful when I saw three to four siblings versus an only child or two siblings, I decided to start a group. The group began in April 1978 with a brother and sister; it took 3 to 4 months before a core group developed. Since then the group has grown from the core of 4 or 5 to 15 to 20 children each week.

The group is open to any child being affected by alcoholism. This includes biologically natural children who live with the alcoholic, those who no longer live with the alcoholic, stepchildren of the alcoholic, and "common law" children related to the alcoholic. We have two sets of grandchildren. One set lived with their alcoholic grandmother and alcoholic grandfather. The other set seldom saw their alcoholic grandmother, but were being affected by their own mother's reactions to the alcoholism.

During the early sessions of the group, the leaders and the children discuss alcoholism and read stories about it. Sometimes the children who have been in the group longer explain alcoholism to new members. When children first join the group, we try to give them a basic understanding of alcoholism and build their trust in us. When we later focus on the children's feelings, they are acclimated to the group and have heard other children with whom they can identify talk about their feelings. Typically, the children prefer to talk about what the alcoholic and non-alcoholic parents do and say to each other rather than to share their own feelings.

Films, games, and puppets help elicit feelings. The children continue to express these feelings of their perception of the illness when they draw pictures or write stories.

Art therapy has been the group's most valuable tool. When the children are not able to verbalize their feelings, they are often willing to illustrate them on paper. After thoughts and feelings are on paper, they then find it easier to verbalize. The pictures the children draw are not shown to their parents. The children let the group leaders know from the inception of the group that they would be more honest with their pictures if their parents were not going to see them.

In their drawings, the youngsters deal with such parental behavior as hiding bottles, arguments, and violence. Approximately 50 percent of the children we see witness or experience violence related to drinking in the home. They usually do not openly talk about it or how they feel. But being scared is the feeling the kids identify with most. Another theme we see in drawings is guilt; many children feel they have caused the drinking.

These children, if they have already begun denying feelings, will continue to do so when the alcoholic person recovers. I believe, as Margaret Cork found in her study of children of alcoholics, that family life does not become significantly better when the drinking stops (Cork, 1969). For the alcoholic, recovery is a process that only *begins* with abstinence. There is a period of years before the parents may be healthy role models. We cannot rely on parents to undo the emotional damage to their children. They are not apt to recognize any problems when the children outwardly appear fine. Yet the children have developed and are using a very sophisticated denial system and certainly need an ongoing recovery program—as much as the parent—to get well.

The group is a safe place for them to learn to trust and express thoughts and feelings. It is a place in which they do not have to be Responsible, Adjust, or Placate others. It is a place where they can rely on others and better understand what is happening in their own home. Treatment professionals need to evaluate their concept of the family illness and, I hope, to incorporate children's groups. As treatment professionals we can do prevention work; this is our responsibility.

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The Addiction Syndrome – A Model Training Program for Counselors

Robert A. Holzhauer, A.C.S.W.

Although research has consistently demonstrated a close relationship between alcohol and other drug abuse or addiction and incidents of child abuse and neglect, there is little coordination between relevant service providers.

State laws which require professionals in a variety of fields to report suspected or actual child abuse and neglect have led to an increase in reporting over the past several years. However, little attention has been paid to substance abuse among child abusers.

Until quite recently, there appeared to be a conflict between mandatory reporting legislation and federal regulations which prohibit the disclosure of client records from alcohol and other drug (AOD) agencies without client consent. This has recently been resolved through development of a federal policy which sets forth guidelines for such reporting (see pg. 31).

The problem of reporting is complicated still further by the dual "stigma" of drug or alcohol abuse/ addiction, as well as child abuse or neglect. It is difficult for a counselor and a parent to work through both problems at one time. Also, a greater stigma is placed upon women who are abusers of alcohol, pills or drugs and who are already guilty about the effect this has upon their children. The shame and guilt make it difficult for such patients to be successful in recovery from one "stigma" much less two.

It has been frequently stated in the alcoholism and drug treatment fields, and in child abuse and neglect (CAN) services that we now need more information for both the public and for professionals on how these related abuse situations develop, how they can be identified, and how we can help to improve them—without necessarily involving the courts (Coltoff and Luks 1978).

The clients feel that mandatory child abuse reporting would cause them to lose custody of their children, at least temporarily, and the families of clients are reluctant to expose spouses for the same reason.

Exposing the child abuser might create more

problems in the family during the period of recovery from alcohol or drug abuse, they believe, and they have a negative view of the "services" which may be suggested. Also, we must bear in mind that alcohol- and drug-using parents are often considered de facto negligent or abusive because they admit to addiction. Some departments of public welfare or social service agencies insist, for instance, that known drug users who are parents, (particularly mothers) must accept treatment in childrearing, parenting, and family violence, before they can receive additional services. This type of rule may raise a legal question, but it does mean that certain agencies do require their clients to become involved in child protective services or allied services in order to protect the family and to insure some treatment.

Self-Referrals Encouraged

Because of the regulatory and social difficulties involved, an emphasis should be placed on encouraging self-referrals, both for child abuse or neglect and alcohol problems.

There are three general ways of handling referrals to child protective services:

1. Clients who discuss child abuse and neglect in the home agree to report themselves voluntarily to child protective services or, with the assistance of the counselor, have such a report made. This would, therefore, include a client's written consent and not violate confidentiality rules. 2. Clients, as indicated above, report themselves without being identified as a client of an agency. 3. The alcoholism and drug agency enters into a "Qualified Service Agreement" with the child protective agency (see pg. 31 for a detailed procedure), making it possible for an alcoholism and drug agency counselor to refer a client without written consent to a child protective service.

The Federal Standards for Child Abuse and Neglect Prevention and Treatment Programs and Projects (NCCAN 1978) noted in the standards for the mental health system in regard to child abuse and neglect that confidentiality has long been an extremely important aspect of mental health. "Confidentiality is a controversial topic, with some mental health practitioners believing that absolute confidentiality is a prerequisite for effective therapy."

It goes on to say that sometimes fear of the harmful or insufficient services that the child protective services or a probation service may give would impel the mental health practitioners not to make referrals. This does raise the issue that the primary concern of a counseling facility is the client and reinforces the traditional reluctance to turn over a case to another agency that cannot deliver the necessary services.

One report, dealing with child protective services, asked, "What was the most central problem in the way child abuse and neglect is handled?" The answer was that there were "limitations in interagency cooperation" (Nagi 1975). Also, the report noted that counseling was the service most frequently lacking in terms of the agencies' ability to handle the cases and deliver necessary services.

On the other hand, many alcohol treatment projects do not offer programs which incorporate services to children and emphasize family involvement in the alcoholism treatment setting (Hindman 1977).

A familiar comment is: "This knowledge of the active alcohol misuse in families does not seem to be matched with the existence and ready availability of family services. The point being made is that historically the alcoholic user (or alcoholic rather than the family) has been a primary concern of treatment agencies. An equal concern for both alcoholic misuser and the family is urgently needed" (Filstead 1977). In addition, "Professional groups often misdiagnose or do not diagnose alcohol misuse; professional service providers lack flexibility in providing a range of treatment alternatives for alcohol misuse; and most professional service providers tend to ignore or reject alcoholism in the family." The author goes on to say that the stress created by alcohol misuse often causes medical problems not only to the user, but to the rest of the family; physicians do not see this connection or identify it. Professional people in general do not see the need for family treatment to be coordinated with the recovery program of the alcoholic or drug user.

Other studies indicate that the community social services involved in both child abuse and substance abuse are inadequate and rarely well-organized or coordinated.

Perhaps a lack of knowledge is at the root of the problem. There is a need for alcohol and drug professionals to know more about the disclosures and reporting laws, as well as about CAN proceedings; to learn how to enlist their own agencies and their clients in recognizing the potential for family violence; and lastly, how to bring needed services for prevention and treatment to the caretakers and their children.

In turn, the CAN staffs need to know more about

Robert A. Holzhauer, A.C.S.W., is assistant professor, School of Social Welfare, University of Wisconsin at Milwaukee and alcoholism-/drug specialist for the Region V Child Abuse and Neglect Resource Center at the university. The training program he has developed is funded by the Child Abuse and Neglect Resource Center.

alcohol and drug abuse so that they are able to refer to and consult with AOD agencies, to help agencies in the community identify potential neglect and abuse in AOD situations, to utilize services, and to coordinate community services for the families in need.

Training is Essential

Before CAN and AOD staffs can truly work in concert with each other, both must be familiar with the issues involved and services offered. This education for staff is essential to ensure agency cooperation in helping children and their families. Our training program has been developed through funding from the Region V Child Abuse and Neglect Resource Center and is directed towards staff members of child protective services and alcohol and drug services. In addition, we involve supervisors and administrators, interested State agency representatives and agency board members and community councils and boards.

The 1-day training session is intended to accomplish two primary objectives: (1) to bring together staffs of child protective services and alcohol and drug agencies, encouraging ongoing interactions between these two professional groups, and, (2) to share knowledge about referral and treatment resources.

The training is not intended to develop investigative skills or legal and medical expertise. By bringing these two groups of service providers together we expect to heighten awareness of the relationship between parental alcoholism and child abuse and to encourage cooperation in developing better responses to the problems.

Because of the highly demanding work of both groups, the training is very short-term. The day-long session begins with an introduction of the problem, outlining the compelling evidence linking alcohol abuse with child abuse and the need for cooperative arrangements between those who provide services to alcoholics and child abusers.

The protective service workers spend several hours learning about alcohol and other drug problems—how to recognize the symptoms of alcohol abuse and identify referral resources. At the same time, the alcohol and drug workers participate in discussions about the child protective services network—learning how to identify child abuse problems, referral resources, and the legal issues involved in making referrals.

The alcohol and drug counselors are helped to analyze their personal attitudes toward child abusers and to recognize that these situations can be successfully treated. Conversely, the child protective workers look at their own beliefs about and attitudes toward addiction and learn that alcohol and drug problems can and must be treated if the family violence problems are to be successfully resolved.

The afternoon is spent in joint discussion of service needs, community resources, and identification of problems in the referral process. A plan of action to ensure future cooperation between the two groups is mapped out—generally including plans for further training, either separately or jointly, as well as development of coordinating mechanisms. The emphasis is on developing cooperative service delivery networks, sensitive to the range of needs in the community, that will strengthen family life and prevent abuse and neglect.

Materials have been developed for use in the training program covering such areas as legislation pertaining to child abuse and neglect, federal regulations governing alcohol and other drug services, confidentiality regulations, and privileged communication and mandatory reporting. In addition, materials outline ways to assess the potential for family violence among clients in treatment for alcohol and other drug problems, assessment of alcohol and other drug problems in parents who are child abusers, and techniques for early intervention.

While it is too soon to assess the effectiveness of the training sessions, we expect them to produce:

- increased reporting of child abuse and neglect by alcohol and other drug agencies
- increased referrals of clients by child abuse and neglect agencies for alcohol and other drug treatment and education
- development of ongoing training systems for counselors in both systems
- increased community awareness of the relationship between alcoholism and child abuse
- broadening of the network of community services that respond to child abuse and neglect problems, including self-help groups, courts, schools, mental health, and physical health services
- increased community awareness of the need to identify and treat alcohol and other drug problems when dealing with child abuse and neglect cases

References

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Confidentiality of Alcohol and Drug Abuse Patient Records and Child Abuse and Neglect Reporting

Editor's note: In a joint policy statement finalized recently, the director of the NIAAA, National Institute on Drug Abuse, and National Center on Child Abuse and Neglect have outlined procedures for reporting child abuse and neglect by alcohol and drug agency clients without violating federal confidentiality requirements regarding patient records.

In view of questions which have been raised concerning the apparent conflict between federal statutes and regulations protecting the confidentiality of alcohol and drug abuse patient records and state laws regarding child abuse and neglect reporting, the National Center on Child Abuse and Neglect (NCCAN) and the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), organizational components of the Department of Health, Education, and Welfare, have developed guidelines which will assist states and organizations in promoting child abuse and neglect reporting consistent with the federal requirements for patient record confidentiality.

The Child Abuse Prevention and Treatment Act, as amended (42 U.S.C. 5101, et seq.)[1] encourages the reporting of child abuse and neglect by providing for federal grant assistance to states which enact statutes requiring such reporting. Section 333 of the Comprehensive Alcohol Abuse and Alcoholism, Prevention, Treatment, and Rehabilitation Act of 1970, as amended (42 U.S.C. 4582),[2] section 408 of the Drug Abuse Office and Treatment Act of 1972, as amended (21 U.S.C. 1175),[3] and implementing regulations[4] restrict disclosure of information concerning patients maintained in connection with the provision of drug and alcohol abuse diagnosis and treatment (or referral for treatment) services which are federally assisted, either directly or indirectly. It is the view of the National Center on Child Abuse and Neglect and the Alcohol, Drug Abuse, and Mental Health Administration that the purposes of the federal and state statutes pertaining to child abuse and neglect reporting and the federal confidentiality requirements can be accommodated as set forth in this guidance.

In response to increasing awareness of the nationwide prevalence of alcohol and drug abuse, and its health, social, and economic consequences, the Congress enacted legislation which provided for federal assistance (both through formula and project grants) to states for the treatment and rehabilitation of alcohol and drug abusers. Early in the history of these programs, it became apparent that the social and economic stigma attached to persons identified as alcohol or drug abusers discouraged many persons from seeking treatment. In an attempt to encourage participation in treatment programs, the Congress mandated in the alcohol and drug abuse treatment acts that the records of alcohol and drug

[1]Enacted by Public Law 93-247 and amended by Public Law 93-644.

[2]Enacted by Public Law 91-616 and amended by sec. 122(a) of Public Law 93-282.

[3]Enacted by Public Law 92-255 and amended by sec. 303 of Public Law 93-282.

[4]42 CFR Part 2.

abuse patients be kept confidential, except that the law permits limited disclosures where written consent is obtained from the patient or without written consent in the case of medical emergencies, scientific research, management audits, financial audits, program evaluation, and pursuant to an authorizing court order.

The Congress responded to an increasing awareness of child abuse and neglect problems by encouraging states (through the enactment of a statute authorizing federal grant assistance), to adopt effective child abuse and neglect reporting laws. These comprehensive reporting laws are part of a broader effort directed toward strengthening the social services made available to abused or neglected children and their families.

The federal statutes pertaining to child abuse and neglect and to the confidentiality of alcohol and drug abuse patient records were enacted to serve valid purposes. There is no indication of a congressional intent that the confidentiality statutes should absolutely preclude alcohol or drug abuse service providers from reporting child abuse, or that the receipt of drug or alcohol treatment should give rise to any presumption that a patient neglects or abuses his or her children. In order to construe both the confidentiality and child abuse and neglect laws in their proper frame of reference, the NCCAN and the ADAMHA recommend that the following procedures be used where it is suspected that there has been child abuse or neglect by a patient receiving federally assisted alcohol or drug abuse diagnostic and treatment (or referral for treatment) services.

If an alcohol or drug abuse service provider subject to the confidentiality regulations[5] believes that cases of child abuse or neglect by its patients may come to its attention, and desires to comply with a state requirement that such cases be reported, the service provider is encouraged to enter into a qualified service organization agreement[6] with the appropriate child abuse protective agency. While this agreement would bind the child abuse protective agency to maintain confidentiality in accordance with the federal regulations, it would enable the service provider to comply with both the federal confidentiality requirements and the state child abuse and neglect reporting requirements.

[5]See 42 CFR § 2.12.

[6]See 42 CFR § 2.11(m) and (n).

Under the qualified service organization agreement the child abuse protective agency would agree to provide services aimed at preventing or treating child abuse such as day care, nutritional and child rearing training, individual and group therapy, and other such services to drug and alcohol abuse patients suspected of child abuse. In order to meet the pertinent requirements of the confidentiality regulations (42 CFR § 2.11(n)), the child abuse protective agency would, in the written agreement, (1) acknowledge that it is fully bound by the provisions of the confidentiality regulations in the handling of any alcohol or drug abuse patient information received from the service provider, (2) agree to institute appropriate procedures for safeguarding the information, and (3) agree to resist in judicial proceedings any efforts to obtain access to patient information except as expressly provided in the confidentiality regulations.

Because § 2.11(p)(3) of the regulations provides that a communication of information including neither patient identifying information nor identifying numbers assigned to a patient does not constitute a disclosure of records, a child abuse protective agency which has entered into a qualified service organization agreement would be subject to the regulatory restrictions on disclosure only to the extent that any communication of patient information by it to third parties discloses patient identifying information or identifying numbers assigned to patients. If a communication of information contains such information or numbers the child abuse protective agency is, under the qualified service organization agreement, subject to the restrictions in the regulations to the same extent as is the provider of alcohol or drug abuse treatment services from which the information is obtained under the agreement. These restrictions apply regardless of the requirements of state law because, as provided in 42 CFR § 2.23, no state law may either authorize or compel any disclosure prohibited by the confidentiality regulations.

Because the child abuse protective agency would, under the agreement, be bound by the restrictions of the confidentiality regulations with respect to the patient information obtained from the service provider, it may disclose information identifying an individual as a drug or alcohol abuse patient only with the patient's consent in accordance with the provisions of Subpart C of the confidentiality regulations (42 CFR §§ 2.31 - 2.40-1), without patient consent in the

limited circumstances set forth in Subpart D of the regulations (42 CFR §§ 2.51-2.56-1), or where disclosure would not be permitted under either of those subparts, in accordance with an authorizing court order entered in accordance with Subpart E of the regulations (42 CFR §§ 2.61 - 2.67-1). If a child abuse protective agency wants to use the information obtained under the qualified services organization agreement for the purpose of initiating or substantiating any criminal child abuse or neglect charges against the parent/patient it must obtain an authorizing court order under 42 CFR § 2.65. A crime involving child abuse or neglect could reasonably be found by a court to be one causing or directly threatening loss of life or serious bodily injury under § 2.65(c)(1) of the regulations. Thus, if a court made that finding and the other findings set forth in § 2.65(c) and the requirements of 2.65 are otherwise met, the court would be permitted under the regulations to enter an order authorizing a disclosure for the purpose of investigating or prosecuting that crime.

Under a qualified service organization agreement, employees of an alcohol or drug abuse service provider who know or suspect that a child of one of their patients is being abused or neglected (whether because of a home visit, something occurring at the program site, or because of statements from the client), would report this concern to the appropriate local child abuse protective agency. The local child abuse protective agency (a social service agency which is usually funded under Title XX of the federal Social Security Act) would accept the report as a *referral for services*. The protective agency would then contact the parent or parents involved, usually making a home visit. At time, it would offer the family, for its acceptance or refusal, such social services as would appear necessary to deal with the alleged abuse or neglect or to assist the parents with any other personal or family problems. In approximately 80% of child abuse protective cases the parents accept the services of the child abuse protective agency when they are offered.

Ordinarily, if the parents refuse to accept the services and the child abuse protective agency believes that the child has been neglected or abused, the child abuse protective agency will either seek more information or petition a court to obtain an order authorizing certain actions for the protection of the child. A court order authorizing use of alcohol or drug abuse patient records to investigate a patient for a crime would not be necessary to permit the pursuit of the former alternative, since in that case the patient records obtained from the provider of drug or alcohol abuse services would not be used to conduct a criminal investigation of a patient within the meaning of 21 U.S.C. 1175(c), 42 U.S.C. 4582(c), and 42 CFR § 2.65. However, if the information obtained in an investigation conducted by the child abuse protective agency for the purpose of determining whether child abuse protective services are necessary is subsequently sought to be used to criminally investigate or prosecute the parent/patient, an authorizing court order would have to be obtained at that time under 42 CFR § 2.65.

If a court order authorizing actions for the protection of the child is sought after the refusal of a parent or parents to accept the child abuse protective services, any disclosure of information identifying a parent as an alcohol or drug abuser in connection with that proceeding would be permissible under the confidentiality regulations only if authorized by a court order entered in accordance with 42 CFR §§ 2.61 - 2.64. A request for this court order which is required under the confidentiality regulations may be made concurrently with the petition for an order authorizing actions for the protection of the child. Attached is an outline of a court order which meets the requirements of 42 CFR §§ 2.61 - 2.64.

There are many advantages to be derived from qualified service organization agreements. For example, they would increase the protection afforded to endangered children without recourse to artificial and stigmatizing presumptions, and they would expand services available to the clients in drug and alcohol treatment programs to include such additional services as homemakers, daycare, nutritional and child rearing training, as well as individual and group therapy. Additionally, they would afford new opportunities for discussion between child protective, child welfare, and public social service agencies to provide training on the identification, management, and referral of child abuse and neglect situations. Further information is available upon request from the following persons:

Frank Ferro
Acting Director
National Center on Child Abuse and Neglect
(202) 755-7418

John R. DeLuca
Director
National Institute on Alcohol Abuse and Alcoholism
(301) 443-3885

William Pollin, M.D.
Director
National Institute on Drug Abuse
(301) 443-6480

OUTLINE OF COURT ORDER AUTHORIZING DISCLOSURE OF ALCOHOL OR DRUG ABUSE PATIENT RECORDS UNDER 42 CFR §§ 2.61-2.64.

I. In accordance with [U.S. code citation to the drug or alcohol confidentiality statute, as appropriate][1] and [the pertinent sections of the regulations, e.g., Subpart E of 42 CFR Part 2], this court finds:

(a) That the record shows *good cause* [as required in § 2.64(d)] for the disclosure of certain *objective data* [limitations set forth in § 2.63(a)] specified below, pertaining to *John Doe* [pseudonym used in accordance with the intent of § 2.64(a) and (g)(3)] for the purpose of_____.

(b) [The specific facts necessitating disclosure] outweigh the possible injury to the patient, etc. [follow the language set forth in § 2.64(d) and in subsection (b)(2)(C) of the authorizing statute] and outweigh the following adverse effects upon the successful treatment or rehabilitation of the patient, etc. [follow the language set forth in § 2.64(f)].

(c) (Optional) Further, that disclosure will benefit the patient as follows:_____;

or that disclosure will benefit the effectiveness of the treatment program or other programs similarly situated as follows: _____.

II. It is therefore ordered that [*the program and/or name(s) of responsible program staff*] is (are) authorized, in accordance with 42 CFR §§ 2.61 - 2.64 and [the appropriate U.S. Code citation] to disclose to this court and/or to the following named parties who have a need to know this information: _____;

the following limited information: _____

which is essential to fulfill the above-described objective(s). These persons [may not redisclose the information, or may redisclose the information only as follows:_____.]

To the extent the disclosed information is to be retained by the court, in accordance with § 2.64(g)(3), it will be kept in a sealed record.

(Optional) Except pursuant to an authorizing court order issued in accordance with § 2.65, no information disclosed pursuant to this order may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

[1] 42 U.S.C. 4582 for disclosures of alcohol abuse patient records. 21 U.S.C. 1175 for disclosures of drug abuse patient records.

The following agencies and organizations provide funding, information, and training in the area of family violence services. This is a partial listing and includes primarily those resources available at the national level.

Resource Listing

ACTION
806 Connecticut Avenue, N.W.
Washington, D.C. 20525
- VISTA national grants available to multi-regional organizations involving the use of fulltime volunteers in poverty-related projects

Child Welfare League of America
67 Irving Place
New York, N.Y. 10003
- "Finding Federal Money for Children's Services: Title XX and Other Programs", booklet

The Children's Defense Fund
1520 New Hampshire Avenue, N.W.
Washington, D.C. 20036
- "Title XX: Social Services in Your State, A Child Advocate's Handbook for Action", booklet

Center for Women's Policy Studies
2000 P Street, N.W. Suite 508
Washington, D.C. 20036
- "Response", a newsletter on intrafamily violence
- Clearinghouse publications list of available articles, bibliographies, booklets on child abuse and spouse abuse; listing of emergency shelters nationwide

Department of Housing and Urban Development
Women's Policy and Programs Divison
Room 3234
451 7th Street, S.W.
Washington, D.C. 20410
- Fact sheet on funding for battered women's shelters through community development block grants

Department of Justice
LEAA, Special Programs Divison
633 Indiana Avenue, N.W.
Washington, D.C. 20531

- Family Violence Program funds grants for direct services to domestic violence victims, focused on improving the response of the criminal justice system
- National Criminal Justice Reference Service offers literature searches, publications including "Guide for Discretionary Grant Programs". Write NCJRS, P.O. Box 6000, Rockville, Md. 20850

Department of Labor
Women's Bureau
200 Constitution Avenue, N.W.
Washington, D.C. 20210

- Information about CETA (Comprehensive Employment and Training Act) funding guidelines and programs which have used these funds to assist battered women
- Battered Women Kit

Legal Services Corporation
733 15th Street, N.W. Suite 700
Washington, D.C. 20005

- Information about local legal services programs

Mid-America Institute on Violence in Families
University of Arkansas at Little Rock
33rd and University
Little Rock, Arkansas 72204

- Training, research, technical assistance and information dissemination services

National Institute on Alcohol Abuse and Alcoholism
5600 Fishers Lane
Rockville, Maryland 20857

- Funding for information and referral services for victims of domestic violence as well as alcohol abuse; contact Division of Special Treatment and Rehabilitation
- National Clearinghouse on Alcohol Information provides literature searches, article reprints, other publications. Write NCALI, P.O. Box 2345, Rockville, Md. 20852

National Center on Child Abuse and Neglect
P.O. Box 1182
Washington, D.C. 20013

- "Children Today", newsletter
- Clearinghouse provides literature searches, bibliographies, publications on child abuse
- Funds demonstration treatment projects

National Center for Health Services Research
3700 East West Highway
Hyattsville, Md. 20782

- Funds for research on performance measurements of medical systems for behavioral emergencies

National Center of Volunteers Against Violence
Domestic Violence Project, Inc.
202 East Huron, Suite 101
Ann Arbor, Mich. 48104

- Listing of 10 regional volunteer centers involved in training for family violence projects
- Publications available:
  "How to Develop a Wife Assault Task Force and Project"
  "Counselor Training Manuals No. 1 and and No. 2"
  "The Bucks Start Here: How to Fund Social Service Projects"
  "The Effective Coordination of Volunteers"
- Technical assistance available upon request

National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20857

- Funds research and training grants in the area of domestic violence through the Center for Studies of Crime and Delinquency.
- Clearinghouse offers literature searches; annotated bibliography "Violence at Home"

New York City Affiliate, National Council on Alcoholism
133 East 62nd Street
New York, N.Y. 10021

- "Preventing Child Maltreatment: Begin with the Parent," booklet available at $2.25 per copy

Department of Health, Education, and Welfare
Office on Domestic Violence
P.O. Box 1182
Washington, D.C. 20013

- Information Clearinghouse and interagency coordination
- Technical assistance to public and private nonprofit local service providers
- Coordinates HEW programs
- Coordinates interagency activities through the Interdepartmental Committee on Domestic Violence

University of New Hampshire
Department of Sociology, Family Violence Program
Durham, N.H. 03824

- Post-doctoral fellowships in the Family Violence Research Program; period of study from 9 months to 2 years; stipends depending on experience.
- Pre-doctoral fellowships in the Ph.D. program in sociology; $3,900 stipend for one calendar year. For information contact Dr. Murray A. Straus

U.S. Commission on Civil Rights
Publications Management Division
Room 700
1121 Vermont Avenue, N.W.
Washington, D.C. 20425

- Proceedings of a national consultation on domestic violence, "Battered Women: Issues of Public Policy"

Local Resources
The following local resources should be explored in seeking funding for and information about services for victims of family violence:

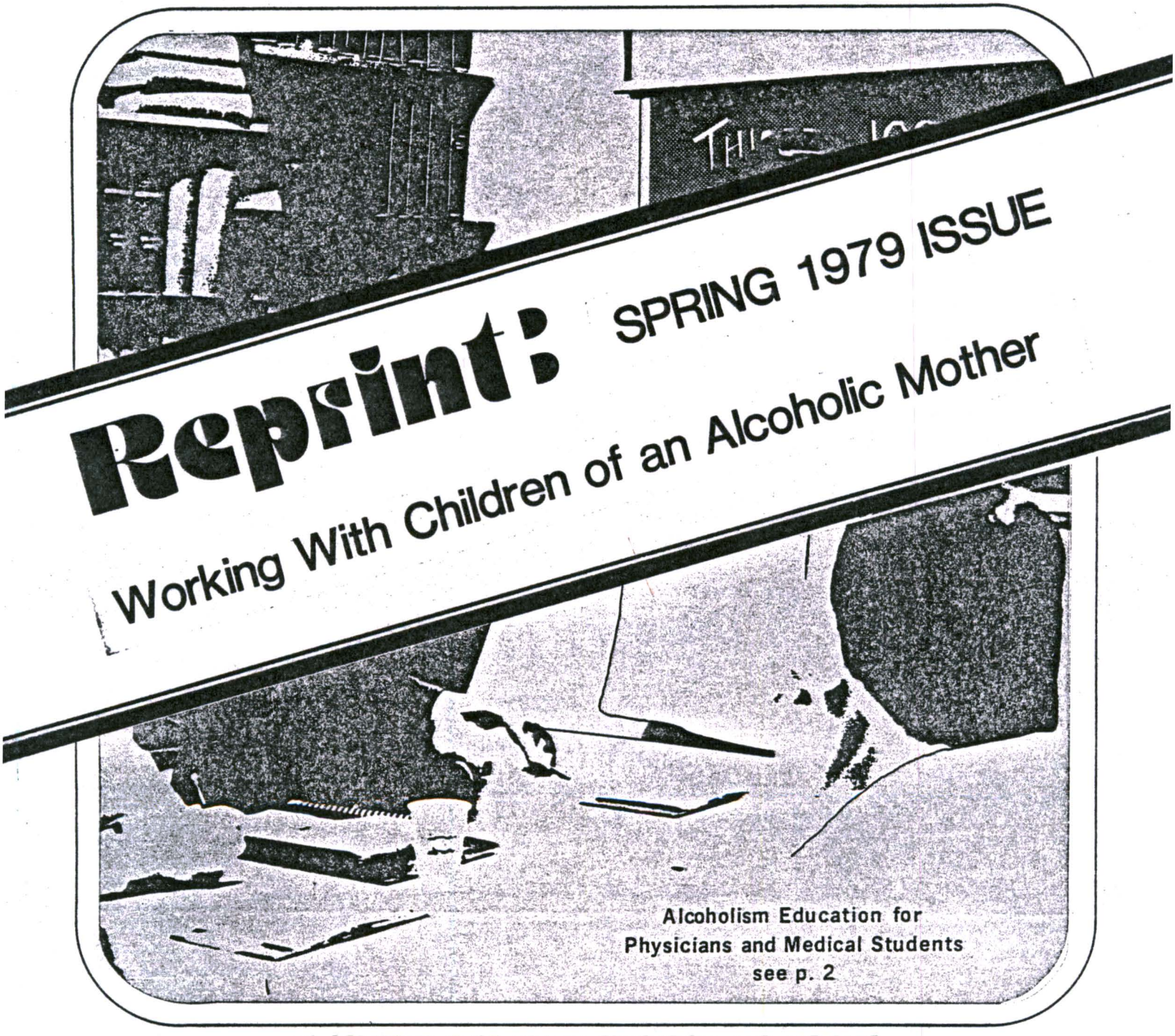
- State ACTION Office
- Community Action Agencies
- General revenue sharing funds received by local governments
- Community Development Agencies
- State Departments of Human Services
- State Criminal Justice Planning Agencies
- Lawyer Referral Program of local bar associations

Compiled by Erica Adams, NCALI Staff

RP0247

ALCOHOL HEALTH AND RESEARCH WORLD

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM



Reprint: SPRING 1979 ISSUE

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readers' exchange

The Readers' Exchange is designed to enable people working in alcoholism or related fields to share with each other stimulating ideas or descriptions of program initiatives in the form of short articles. Readers are invited to submit articles of up to 1,000 words for this page.

Working with Children of an Alcoholic Mother

Tarpley M. Richards, M.S.W.

Children who live with parental alcoholism are a population at risk in terms of increased incidence of psychosocial problems and the development of alcoholism in later life (Aronson and Gilbert 1963; Cork 1969; Fine et al 1975; others—see reference list). Usually, literature on children of alcoholic parents concerns the effects of paternal alcoholism; however, there are writers who have indicated that maternal rather than paternal alcoholism has more serious consequences for the children.

One author has found that an alcoholic mother exposes her children more to the effects of alcoholism (Hecht 1973); another reported that these effects were not only potentially more devastating but perhaps were irreversible (Fox 1968). In a recent report on a 20-year longitudinal study of the impact of parental alcoholism on children, Miller and Jang (1977) concluded that the negative impact of an alcoholic mother was greater than that of an alcoholic father. Especially damaging was the presence of alcoholism in the mother during the child's prepubertal years.

Children of an alcoholic mother may find themselves in one of the following circumstances:

- Care of the child has been left completely to the mother, either because the mother is the only parent in the home, or because the father—although present—ignores the child-rearing function for a host of reasons.
- Care of the child is left for the most part to the mother, but the father assumes the mothering role after work and on weekends.
- Care of the child is delegated to a "nurse," in the form of an adult female relative such as a grandmother or an aunt.

In all of these family living arrangements, the alcoholic mother is not hidden from the child; she is, in fact, quite visible. Having another person in the home acting as mother does not resolve for the child the fact that mother—an important team player—is injured and sitting on the sidelines.

Impairment of the mothering role clearly has an impact on the child whether the impairment is due to alcoholism or not. But when the mother is unable to properly nurture her child because of alcoholism, until some active steps are taken to stop the drinking, the child may be left to grow up under the influence of an unpredictable primary caretaker.

The purpose of this paper is to delineate the clinical experience of working with children of al-

Tarpley M. Richards, M.S.W., is a psychiatric social worker and director of the Family Alcoholism Program at Kolmac Clinic of Silver Spring in Silver Spring, Md.

coholic mothers and to identify several serious difficulties experienced by children who have lived in a home environment with an alcoholic mother for a prolonged period, including the prepubertal years. We hope, also, to point out some specific problems the therapist may encounter in working with these children.

Children of Alcoholic Mothers Problem-Ridden

Children who experience parental alcoholism also may experience several other types of problems. Social dysfunction—such as difficulty in school, truancy, and trouble with the police—have been discussed by Haberman (1966), Sloboda (1974), Fine et al (1975), Nylander (1963), Weir (1967), Kammeier (1971), and Aronson and Gilbert (1963). Impairments in self concept and in emotional maturity and interpersonal relationships have been addressed by Cork (1969), Hecht (1973), McKay (1963), Mayer and Black (1976), and Mueller (1972).

Many of these problems occur irrespective of the sex of the alcoholic parent. However, the following problems have been identified by the author as pronounced in young children whose mothers are alcoholic.

The most common affliction is a high degree of impaired reality testing. An explicit example of the way children perceive the world is demonstrated in the story of "The Emperor's New Clothes." The normal child believes what is seen. For the adult family member who watches the alcoholic hide liquor, who listens to denials of alcohol consumption, and who witnesses disturbing events which occur during an alcoholic blackout that are later denied, the response is rage and indignation that the alcoholic would expect an adult to be such a fool as to believe outrageous "lies."

For the young child, however, whose instinct is to believe what is seen, to be told by the mother that what was seen is not real produces an enormous conflict. The inevitability of the mother's denial—not only of drinking but of the occurrence of events—shakes the child's sense of reality. This may be compounded when some fathers deny, also, to the child that what he or she sees is really happening. Thus the mismatch between the child's observations of events and reality is not corrected.

Prolonged exposure to such a bewildering situation usually results in an intense dependency upon the mother. Since the child cannot trust what he or she sees, the mother is needed even more, not less, as the child grows.

The child stands a greater chance for healthy growth if there is another adult in the home environment who can assure the child that what he or she sees is real. Too often, however, the child lives only with the mother in the home and suffers the same degree of isolation that she does. Hence the faulty reality testing of the alcoholic mother has a greater chance of being contagious to the child.

A second difficulty observed in the young child who lives with an alcoholic mother is retardation in the development of mature ego functions in the area of object relations. That parents are not always consistent is common in homes of nonalcoholic parents—but in homes where the mother is an alcoholic, inconsistency is extreme.

The inebriated mother may deliver sudden and harsh punishment followed by overindulgence. This behavior is regulated by the quantity and frequency of alcohol intake and the alcohol level in the blood rather than by appropriate responses to events in the environment. A young child cannot make this sophisticated distinction.

The prepubertal child's most available defense against such inconsistency and unpredictability is—in its mind—to "split" the mother in half and experience her as two people: good (sober) and bad (drunk). Since the child is so dependent upon mother to confirm its sense of reality, it has to "bury" the bad mother and deny rage lest the good mother be also destroyed and the child abandoned.

The negative feelings about the bad mother then become expressed in the form of anger at other people, in school problems, and, later, in antisocial behavior.

A third problem apparent primarily in children of alcoholic mothers is pseudomaturity. This seems to result from the child's having to act as a mother to him or herself as well as to the mother

when the latter is drunk, sick, or otherwise unable to care for the child. Pseudomaturity grows out of a raw necessity to survive.

The casually observing adult may view the grownup and overly responsible child as a real prize. It is hardly advisable, however, to ask a child to shoulder the burden of acting as a parent to its own mother. The rage, resentment, and feelings of deprivation are evident if one manages to get to know children who have been forced to function at a level far beyond their years.

It is believed, then, that prepubertal children of an alcoholic mother suffer impairment in reality testing; primitivity in object relations; and pseudomaturity; or any combination of these three difficulties.

Therapist Must Make Choice

The therapist who works with the child who lives with an alcoholic mother will be faced first with making a decision as to the appropriateness of treatment for the child. Children are the property of the parent(s) in a legal sense; hence, the therapist must evaluate what support will be present in the family for the child to be able to continue treatment. In any event, a clinical determination should be made that the child is not likely to be abruptly withdrawn from therapy, thus making the treatment approach essentially more harmful than helpful to the child.

There are no rules in this area, but it appears that the best prospect for positive outcome in treatment is greatly enhanced when:

- In the case of the single mother, she is sober and already active in AA or psychotherapy at the time that she requests help for her child.
- In the case of couples, that both the mother and father are in AA and Al-Anon or psychotherapy, and agree to attend family sessions with the child.

Family situations which experience has shown to be nonsupportive and, in fact, serve to undermine the child's therapy are those in which: the mother is actively drinking, is not in treatment, nor wants to be in treatment; the parents are "forced" by a social system (e.g. the courts) to get help for their child and they refuse to be involved; or the child's parents are not interested in treatment and are experiencing severe marital discord or divorce proceedings.

The home environment of the child with an alcoholic mother is not always clearly classifiable as supportive or nonsupportive; an array of complex circumstances often becloud the situation. It is suggested that as much information as possible about the child and the child's family be reviewed by several mental health professionals before a decision concerning particular treatment modalities is made. At the very least, a determination should be made that the child would more than likely be able to remain in treatment for the needed period of therapy, before treatment is begun.

A hazard in the therapist/child dyad is the temptation to the therapist to jump in and try to supplant the mother. Needy children often provoke this response in adults, therapists included. The therapist will be wise to fight this impulse to the greatest extent possible. Not only will it alienate the mother (who has to continually manage her jealous feelings toward the therapist), jeopardize her cooperation and thus the course of treatment, it may eventually interfere with the child's ability to focus on having to establish some sort of relationship with the mother, which the child needs in order to grow.

Therapist Must Use Caution

The therapist's role is difficult. The therapist has to cultivate a bond with the child while avoiding "mothering." This may best be done by the therapist's acting as a reality tester and a receptacle for the child's anger. The therapist can initially make use of the child's splitting of mother into "good" and "bad" and assume the role of the "bad" mother for awhile.

As the child becomes able to express anger to the therapist and becomes aware that his or her anger is tolerated by the therapist, he or she can eventually learn to experience anger at mother, the object for whom it was originally intended. This process occurs in stages and takes many months. The progression seems to be as follows:

(1) For a time, the child refuses

to acknowledge that he or she is angry about anything.

(2) The child expresses anger toward friends, siblings, and the nonalcoholic parent.

(3) There is a sudden increase in acting out.

(4) The child expresses anger at the therapist during therapy sessions.

(5) The child expresses anger at mother to the therapist.

(6) The child expresses anger at mother to mother directly.

(7) There is an increase in acting out.

(8) Family sessions are increased to work with both the mother and the child in managing the expression of the child's negative feelings in a way which is tolerable to the parent.

This pattern presupposes that the therapy is of at least 1 year's duration and that the mother is concomitantly in treatment and is remaining sober. With any break in the treatment or prolonged return to drinking on the part of the mother, the process may revert to stage one.

Another problem that needs to be addressed is the therapist's management of his or her own angry and hostile feelings which will inevitably be stirred up in working with children of an alcoholic mother. It is recommended that the therapist, no matter how skilled, have supervision during therapeutic work with these children. It is easy for the therapist to become furious with the child's mother and to see her as neglectful and abusive rather than as a woman struggling with an illness.

Furthermore, the double-barreled attack of having the child peg the therapist early in treatment as the "bad mother" and having the mother subtly reinforce this split (because of jealousy of the therapist's role) may cause narcissistic injuries to the therapist. Without supervision, this can limit the therapist's effectiveness and may result in premature termination on the part of the patient or in the therapist's dismissing the patient as "untreatable."

In summary, therapeutic work with the child who lives with an alcoholic mother presents some problems for the therapist. As much as possible, these problems must be faced and resolved if treatment is to be effective over the long run. Such difficulties include appropriateness of treatment for the child, which may not always be easy to determine; and establishing a working alliance with the child's mother, which also may not be easy. In addition—and most importantly—the therapist should have access to ongoing supervision during the work with the child to prevent the occurrence of a negative countertransference toward the mother that could limit the therapist's effectiveness or result in premature termination of the patient.

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