How do we do no harm? : exploring adult children of alcoholics’ perspectives on disclosure and support from childhood peers

Erica B. Cormier

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Erica Cormier  
How Do We Do No Harm?  
Exploration of Adult Children of Alcoholics' Perspectives on Disclosure and Support from Childhood Peers  

ABSTRACT  

This qualitative study examines the perspectives of adult children of alcoholics on disclosure and support from childhood peers. Through self-developed, semi-structured interviews, questions were posed to these participants to elicit reflections on their childhoods, specifically on the processes of disclosing caretaker alcoholism and gaining needed support from friends. The study's aim was to gain perspective and examine the experienced effects and the processes of disclosure to and support gained from friends in childhood for adult children of alcoholics. It was in hopes of better providing a foundation for how social work practice can enfold peers into interventions in order to better serve a population that is often under-resourced.  

Major findings of this study include an establishment of different roles childhood friends play in coping with caretaker alcoholism; an overwhelming preference to disclose to friends with like-experiences; benefits, deficits, and challenges in curriculum and interventions in the participants' experiences as well as suggestions for improvement such as attention to destigmatizing alcoholism, including curriculum on alcoholism in the home, and recognition of compounding intersecting identities that pose barriers to gaining support. It has become clear through this study that caretaker alcoholism not only has a profound effect on children, but also that friendships, or the lack thereof, profoundly impact coping, communication, and the provision of support for children of alcoholics. Implications of this study for future research and
social work practice suggest that friendships are an underutilized resource and it is essential that
social work practice promote these relationships and more effective interventions in approaches
for treatment with children of alcoholics.
HOW DO WE DO NO HARM? EXPLORATION OF ADULT CHILDREN OF ALCOHOLICS' PERSPECTIVES ON DISCLOSURE AND SUPPORT FROM CHILDHOOD PEERS

A project based upon an independent investigation, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

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CHAPTER I

Introduction

According to the National Association for Children of Alcoholics ([NACoA], 2011), in the United States alone, 17 million children under the age of 18 live with alcoholism in their homes—one in four children live in an environment where alcoholism is a significant factor in the health and welfare of their development. Undoubtedly, this is a population that the social work field needs to attend to in practice, policy, program development, education, and theory -- as they are a vulnerable population shrouded in conflict and limited resources available to attend to their needs. While there are limited resources for this population, the National Association for Children of Alcoholics website includes pamphlets for parents, clergy, health professionals, teachers, social workers, and early childhood professionals on approaching working with children affected by alcoholism especially through the use of support groups of peers. These pamphlets revolve around a concept formulated by Jerry Moe and Dan Pohlman (1989) called “The 7 C’s”: I didn’t cause it; I can’t cure it; I can’t control it; I can help take care of myself by communicating my feelings, making healthy choices, and celebrating me.”

What this website resource does not account for is the role of the friend or peer in supporting children of alcoholics – there is no pamphlet for peers – though it promotes the use of peers in interventions. The role of the friend is a highlighted topic throughout each stage of child development in how children relate to, socialize with, rank importance of, and use peers during different stages of growth and development (Davies, 2011; Berzoff, Flanagan, & Hertz, 2011).
Social skills and relating to peers can often be found in diagnostic measures as well indicating that these relationships are integral when assessing client functioning (Diagnostic and statistical manual of mental disorders: DSM-5™ (5th ed.), 2013). These diagnostic measures that include social skills and relating to peers often give criteria for assessing how well clients function with peers, whether their interactions are successful or unsuccessful and how these interactions may or may not interfere with their social and personal functioning.

Bernt (2004) examines the span of childhood development research and how the research has included peer relationships in its analysis. He argues that in the last half century, there has been a dramatic increase in knowledge "about children's friendships, their development, and their effects" (p. 219). Bernt also argues that this body of research is lacking in observations regarding friends' interactions, what constitutes positive and negative peer interactions, and how these interactions influence a child's development, coping, behavior, and judgment. Interactions in this sense of the lack of research are conversations or activities with peers that prove to be supportive, unsupportive, needed, unneeded, harmful, or dangerous. In this vein of lack of research, what would be useful to know is how children of alcoholics view specific interactions such as disclosure to and support from peers, whether peers play a role in how children of alcoholics take care of themselves, communicate their feelings, and make healthy choices.

The research question for this study is: What are the perspectives of children affected by alcoholism about disclosure and needed support from peers? With this question in mind, this qualitative research study intends to: explore the experiences of children in families affected by alcoholism; how and if they disclose this to their peers and the decision making processes about disclosure; how they cope; how social work practice can tap into, bolster, and support what interventions do work; and how social work practice can fill the gaps of services for children.
influenced by alcoholism and the peers who may want to support them. If peer support groups are current intervention in working with vulnerable populations such as this, it is integral in the social work profession to consistently evaluate practice interventions as prescribed by the Code of Ethics of the National Association of Social Workers (2008). This research study will attend to that evaluation by looking at peer relationships in the instance of children of alcoholics (COAs) disclosing to peers (both COAs and non-COAs) and needed support outside of specific support groups. Our lens in social work that combines multifarious perspectives such as policy, practice, education, law, and psychology will allow for an ecological view on the relationship that other professions may not be able to support. In order to limit the scope of this research study, I will be exploring the effects of alcoholism in a family on children, excluding those families affected by substance abuse. This is due to the existing vast number of substances with unique and various forms of disclosure, stigma, and policies that require specific attention in further studies.

In order to investigate the meanings for this vulnerable population regarding successful and unsuccessful interactions (conversations, activities, socializations) with peers, I propose a qualitative analysis recruiting adult children of alcoholics to be interviewed on their perspectives, being their opinions and descriptions, on if, how, and why they disclosed family alcoholism as children to peers. Disclosure will be considered as the process of telling -- whether that be directly (e.g., face to face) or indirectly (e.g., through a note), what will be studied is the process of telling a peer and the actual outcomes, both “supportive” and “unsupportive” of that telling. Adult children of alcoholics are defined as adults who identify as children who experienced caretaker alcoholism in their growth and development. Caretaker will be defined as the adult the
participant relied on for the meeting of basic and emotional needs (e.g. father, mother, grandparents, foster parents, adopted parents, older siblings, etc.).

The aim of utilizing retrospective narratives from this vulnerable population is to better understand the role of the childhood peer or friend in the process of disclosure, what interactions work and why, and how social work practice can encourage successful, supportive, needed, and safe interactions and interventions. There will be an exploration of theories and models of interventions for addiction treatment such as self-psychology and object relations in relation to addictions and relationship building with peers and the Transtheoretical Model (DiClemente, Schlundt, & Gemmell, 2004), a theory on stages of change in terms of addictions treatment, will be an applied framework for how others may see children of alcoholics broaching the issue of alcoholism in their families with their peers.

The following literature review examines how alcoholism is impactful on families (mental health of adults and children, dynamics, family roles), theories and models of intervention for addiction treatment, stigma, disclosure, and the role of the friend from theoretical and practical perspectives.
CHAPTER II

Literature Review

This literature review will examine conceptual, empirical, and theoretical sources concerning the subject of children of alcoholics and the role of peers. Theories of what happens internally to a child when confronted with caretaker alcoholism, risk factors for well-being through development, as well as the mental health sector’s response to this issue must be addressed. First, I will explore literature about the experiences of children and families affected by alcoholism. This will include a discussion of not only what qualitative studies have said about this area, but as well, the research on family dynamics, the roles of children in the family, and the influence of these family roles on peer relationships.

Second, there will be an exploration of theories and models of interventions for addiction treatment. This will attend to theories of self-psychology in relation to addictions and relationship building with peers. The Transtheoretical Model (DiClemente, Schlundt, & Gemmell, 2004), a theory on stages of change in terms of addictions treatment, will be an applied framework for how others may see children of alcoholics broaching the issue of alcoholism in their families with their peers. The distress expression paradox (Kennedy-Moore & Watson, 2001) will be applied to the concept of disclosure in terms of the specific risks and benefits that may come of disclosing to peers. The Transtheoretical Model and distress expression paradox will be explored in practicality as well – how these theories play out/look
like in school based interventions, groups, community based interventions, and trainings for professionals working with children of alcoholics.

Third, I will explore stigma, a hypothetical impingement on what, why, and how children disclose alcoholism. The exploration of stigma will attend to what stigma of alcoholism looks like, how it plays out in childhood, and how this may impact children’s decisions to disclose their caretaker alcoholism to peers. This topic moves into the fourth section of the literature review on disclosure itself – if disclosure of alcoholism is similar to other disclosures, what those look like, and how kids decide to disclose to whom, what, when, where, and why. The fifth and final section is an exploration of the role of the friend, interweaving with theoretical perspectives and current studies on how children treat each other (e.g. bullying, social skills) and how children share their personal stories with each other.

I. **Experiences of families affected by alcoholism**

It is important to note that children of alcoholics are not to be pathologized, but the issues that are internalized eventually leading to the risks of psychopathology must be addressed. This section of the literature review explores the experiences of children in families affected by alcoholism utilizing research that considers impacts on mental health and behavior, family dynamics, extended impact of family dynamics on relationships outside the immediate family, and the limitations of the studies completed on this theme. The purpose to surveying experiences of families affected by alcoholism literature in reference to this research study is to give foundation for the argument for social work practice to attend to the needs of these children and those peers who may hope to support them. The literature discussed in this section will highlight the vulnerability of this population and lead to the theoretical perspectives and models of intervention for addiction treatment applied to children affected by alcoholism.
In a search for literature concerning families affected by alcoholism, many studies appear to explore the risk factors and long-term effects on the physical (e.g. children with fetal-alcohol syndrome), mental (cognitive ability), behavioral and emotional characteristics of a child exposed to caretaker alcoholism. The approaches to these findings vary from sampling children of alcoholics (COAs) vs. children of non-alcoholics (non-COAs) (Eiden, Colder, Edwards, & Leonard, 2009; Moore, McArthur, & Noble-Carr, 2011; Sher, Walitzer, Wood, & Brent, 1991) to qualitative studies interviewing children (Kroll, 2003; Tinnfält, Eriksson, & Brunnberg, 2011) to mixed methods sampling mothers (VanDeMark, Russell, O'Keefe, Finkelstein, Noether, & Gampel, 2005). Notable findings in said studies on childhood exposure to alcoholism included increased risk of future substance issues, as well as an impact on mental health such as higher levels of behavioral and emotional distress, depression, anxiety, substance use, and hyperactivity in COAs in relation to their non-COA peers (Eiden, Colder, Edwards, & Leonard, 2009; Moore, McArthur, & Noble-Carr, 2011; Price & Emshoff, 1997; Sher, Walitzer, Wood, & Brent, 1991). Other notable findings include the characteristic effects that exposure to family alcoholism can have on family dynamics and what Kroll (2003), Vernig (2011), and Wegscheider-Cruse (1989) explore: familial roles.

One study that synthesizes many of the themes in the literature on this subject is: Kroll’s *Living with an Elephant: Growing up with Parental Substance Misuse* (2003). In her study, Kroll specifically attends to the experiences of growing up with familial alcoholism by taking accounts from seven sources (a notably small sample) of adults who are recalling their experiences as children. She applies the extensive research that links caretaker substance misuse and children maltreatment to gain insight on the world of these “invisible” children, the implications for practice, and disclosure and confidentiality issues. Sample bias, adult recollection, adult
adjustment and acceptance, as the participants’ status of COA is established are weaknesses Kroll identifies that may be similarly found in this research study utilizing interviews with adults of alcoholism around disclosure and support from peers; this must be taken into consideration in the methodology section.

Kroll (2003) breaks down noted themes of her findings and research into categories: denial, distortion and secrecy; attachment, separation and loss; family functioning, breakdown and conflict; violence, abuse and fear; role reversal, role confusion and the child as carer; what children said they needed; chaos and control; children’s roles; coping strategies; a model for problem solving; implications for friendships; and the risks of having substance misusing parents. An important theme found in this study is what children said they needed: “freeing them from guilt about parents’ substance use, helping them regain some sense of control over their environment, giving them space to be children, if this was hard within the family, and reassuring them that people can ‘get better’” (Brisby et al., 1997; Robinson & Rhoden, 1998 as cited in Kroll, 2003, p. 137).

Kroll (2003) does not give mention of how the role of the friend can play into this “freeing them,” but does note the theme of “conspiracy of silence”: “where shame and fear of consequences effectively cut families off from both wider family and community...[and] children were effectively muzzled and isolated from potential sources of support that might foster resilience” (Kroll, 2003, p. 132). She makes particular mention of this distortion and secrecy, calling for less research around the future risk factors for children affected by alcoholism as in Sher et al.’s (1991) study and more around the interventions around these risk factors. This feeling of loss and isolation can often lead to intense mistrust of others—does this isolation or intense mistrust of others apply to the role of the friend in disclosure and support? Or is the role
of the friend a mitigating factor? This is something that needs to be explored in this research study; perhaps this is a hypothetical theme that may be found in the shared experiences of participants.

Another theme explored by Kroll (2003), defined by Wegscheider-Cruse (1989) and questioned by Vernig (2011) is the idea of familial roles that are adapted when faced with alcoholism. Kroll argues that these roles are maladaptive copings of the feelings of loss in a child-parent relationship. She makes note of the conceptualized roles, first labeled or classified by Wegscheider-Cruse (1989): enabler, hero, lost child, mascot, and scapegoat: the enabler, typically the spouse of the alcohol-dependent parent who colludes with the family to deny adverse consequences of the alcoholic’s behavior, accepting the behavior as the norm, and potentially experiencing/absorbing the consequences themselves while presenting an outwardly appearance of a perfectly functioning family; the family hero, a child who provides the family an exemplar, someone who excels in areas that the family values to provide positive views into the family, however their internal world is typically fraught with self-doubt and inadequacy; the lost child, one whose wants and needs are neglected in favor of the alcohol dependent parent, often disappearing into the background, creating separate worlds from the family though affected in feelings of loneliness and sadness; the mascot, one who is the distracter, the comedian, the entertainer who is often more aware of the family strife than others however with a fear of confrontation, the mascot is often underrated and undervalued; lastly, the scapegoat, the child that draws negative attention through behavioral or social issues that may be considered maladaptive and often leads to the family using the scapegoat’s issues as more problematic than the alcohol-dependent caretaker (Black, 1982; Kroll, 2003; Wegscheider-Cruse, 1989; Vernig, 2011;). A scapegoat child with behavioral or social issues may have difficulty in peer
relationships; a comedian child with a fear of confrontation or separation of the family may fear to the point of non-disclosure with others outside the family; a lost child may need friendships more than family relationships in order to be seen or heard and be prone to disclosure for support; a family hero child or enabler may feel more pressure than others to not disclose to peers in order to seem perfect and exemplary.

Peter Vernig (2011) tries to question these roles against the stand of empirical evidence. Vernig argues that so often these roles are rigidly assigned to a family in the field of substance use counseling and yet the gap in the literature is the lack of empirical science applied to these roles. The roles as discussed in much of the literature reviewed by Vernig include not only the internal and interpersonal role playing, job assignments, or mode of communication, but also that roles protect the family in the status quo of the addiction. The roles maintain a structure in the family that allows the caretaker with alcoholism to continue in the addiction with minimal aversive consequences (Vernig, 2011). Vernig makes note that the roles are not to be pathologized as roles can be found in all family systems.

However, Black (1982) argues that a family affected by alcoholism is strained under normal circumstances as various maladaptive responsibilities and dynamics are created and shift: a child may become parentified, the other caretaker may become sole caregiver, etc. As Kroll (2003) mentions, role confusion and role reversal create blurred boundary lines of responsibility and caring, often leaving children affected in areas mentioned by a study below on self-psychology (Hadley, Holloway, & Mallinckrodt, 1993) such as idealized parent imago and twinship—this will be discussed below. These roles have been used in treatment to educate children of alcoholics in support groups such as Adult Children of Alcoholics (ACOA) and Al-Anon about their role in the family affecting and potentially afflicting interpersonal relationships
(Vernig, 2011). What would be important to explore in relation to these findings for this research study is how these family roles play out in childhood friendships or impact the experience of disclosure to peers. Would the process of disclosure look, be experienced, or be needed the same way for an enabler vs. a scapegoat? Would the role a child may use to cope in the family spill over into their relationships with peers?

As Vernig (2011) argues, there are gaps in the literature around intersectionality (intersections of disenfranchised groups) of risk factors (e.g. co-morbid caretaker diagnoses, trauma, poverty) and intersectionality of identities (racial, socio-economic, religious, etc.) in approaching or dealing with alcoholism itself. For example, though Sher et al. (1991) criticize previous studies’ sampling techniques leaning towards more affluent communities, they sample freshmen in a Midwestern university. Granted, the researchers’ large sample size (253 COAs and 237 non-COAs) gives ample evidence of the increase in risk factors, substance use, and psychopathology for COAs; yet the sample is 87.5% White and is from a privileged university environment. Many of these studies call for the need to attend to the intersectionality of this generalized population of “children of alcoholics” as not all experiences will be the same across the board.

VanDeMark et al. (2005) in “Children of mothers with histories of substance abuse, mental illness, and trauma” and Marse (2002) in “Depression and perception of maternal rejection in latency-age, African American children of alcoholic mothers” attempt to broach these gaps by studying the variant experiences of children of alcoholics. What could be explored more in this study is the experience of children of alcoholics disclosing to peers, a group that is also non-homogeneous and what it means for children to disclose and gain support from peers who are not “like” them in multiple aspects. These observations leave potential for further
investigation around psychodynamic theories that can be applied to children of alcoholics such as self-psychology as in the study done by Hadley, Holloway, and Mallinckrodt (1993), looking at what exactly it means to gain support in twinship or sameness with friends.

Alcoholism does not exist in a vacuum. Though these studied risk factors and long-term effects are relevant to this research in showing that there are future risks involved in exposure to alcoholism within the family, the studies also name the need for children to gain support from social work practice. Hypothetically, these findings may also name the need for children to gain support from their peers—my research is looking more towards what it looks like for children to disclose, to tell someone about this issue impacting their family, what kind of support they hope to gain and/or gain from telling, and what the role of the friend plays in this disclosure.

II. **Theoretical approaches**

Berzoff, Flanagan, and Hertz (2011) describe psychodynamic theory as the use of theories that give framework to the influence of early experience on thoughts, feelings, and behavior. Psychodynamic theory will be applied to this research study in order to explore the processes and motivations for children affected by alcoholism towards certain thoughts, feelings, and behaviors—specifically the act of disclosure or the act of non-disclosure (purposeful withholding of information) and their ideas of what support would look like in their experience. What are the risks and benefits of disclosing caretaker alcoholism to a peer? Does social work practice support the benefits of disclosure to peers or attend to the risks of disclosure? Can social work practice support the motivation, or lack thereof, to disclose caretaker alcoholism to peers?

Two theoretical frameworks will be explored in this section of the literature review: self-psychology and the distress expression paradox. The models of intervention similar to addictions treatment applied to children of alcoholics that will be explored are the Transtheoretical Model
(DiClemente, Schlundt, & Gemmell, 2004), the use of support groups like Children of Alcoholism and Substance Abuse (COASA) as mentioned above (similar to Alcoholics Anonymous), and the school or community based interventions (e.g. attendance to the topic of caretaker alcoholism and support for children in school curriculum; trainings for staff to be educated on caretaker alcoholism and signs to look for).

Berzoff, Flanagan, and Hertz (2011) discuss the theory of self-psychology as the exploration of shame rather than Freud’s interest in guilt—stressing a person’s conception of the self both unconscious and conscious. Self-psychology is a theory that explores the internalizations of self-object functions—selfobjects defined by Kohut (1971, 1977) as the link between the self and the other. Hadley, Holloway, and Mallinckrodt (1993) describe Patton and Robbins' (1982) depiction of selfobjects as the “intrapsychic representations of persons or things that are experienced as extensions of the self and that perform a function such as maintaining self-esteem and self-cohesion, regulating affect, or promoting expressive trends of the personality” (Hadley, Holloway, & Mallinckrodt, 1993, p. 349). The disruptions or impingements of the selfobject relationship can lead to behavioral and emotional strain, the use of defenses, either adaptive or maladaptive coping skills, in order to compensate for a loss of cohesion. Berzoff, Flanagan, and Hertz (2011) argue that when children experience chaos and stress, an unbalancing of their tri-partite self, there is a process of adaptation towards deficits in self-cohesion and self-structure.

The tri-polar self stands in as the depiction of selfobject functions: the grandiose pole involves ambitions, pleasure, physical and mental attributes, looking for validation, to be seen; the idealized parent imago involves the development of ideals and values, merging with a calming other, containment and joining; and the twinship pole involves finding sameness in an
object. As discussed in the previous studies, when children are faced with disruptions, secrets, a lack in validation, merging, and mirroring (e.g. when their primary caregivers are struggling with alcoholism), there are significant effects on their development of self, self-esteem, self-structure and shame. The internalization of shame can disrupt the organization and balance of these tri-polar selves, causing impingements in how children relate to others.

It is important to note here that relating to others is integral in self-psychology—the twinship pole is one that considers children relating to other children, looking for sameness, looking for validation in their sameness presentation with another. Essentially, a child is raised in an environment with selfobjects (self and other representations) that balance (with optimal frustration or testing) these three parts of the self; there can be a development of healthy narcissism. When there is not cohesion, when there are disruptions, impingements, or chaos, these three parts may become unbalanced, leading towards maladaptive coping skills to compensate for the loss, unbalance, or lack of cohesion.

What does it mean for an unbalancing of the tri-partite self due to caretaker alcoholism and how children may relate to or rely on peers? This theory calls for a recognition of the damaging effects on children’s internal structure while also calling for resources that can validate, educate, and mirror children throughout development. That is not to say that removal from the home is always necessary in the face of these issues—but if it is not, the children deserve resources that can bolster healing and a balancing of their tri-polar selves for greater chance at a healthy development to which social work practice can attend. The role of the friend, in this case, may be considered as a resource to find sameness as with an intervention such as support peer groups. This will be explored more in the Models of Treatment section of the literature review.
Some of the emerging themes from Kroll’s (2003) study such as denial, distortion and secrecy; attachment, separation and loss; role reversal, role confusion and the child as carer; chaos and control; coping strategies; implications for friendships—can be examined through a self-psychology perspective. Hadley, Holloway, and Mallinckrodt (1993) attempt to study the impact of family dysfunction that includes alcoholism, substance use, violence, psychiatric pathology, etc. into one identifying group—adult children of dysfunctional families—arguing that these forms of dysfunction typically are labeled as such due to the incapacity of a parent to meet the emotional needs of their children. They surveyed 97 adults from clinical and community settings self-identified as growing up in dysfunctional families (alcoholism, substance abuse, chronic violence, incest, psychiatric or physical illness—any form of dysfunction that impinged parents meeting emotional needs of their children), looking at the data between adult children of alcoholics and adults with non-substance use dysfunction.

Their findings make note of internalized shame, object relations deficits as well as a negative correlation with two self-psychology constructs (goal instability and superiority), arguing that the use of object relations and self-psychology are superior in treatment. Other correlations – with measures such as the Insecure Attachment Scale, Internalized Shame Scale, Problem History Scale, Self-Expression Inventory, and Bell Object-Relations-Reality Testing Inventory – brought to light the frequent experience of caretaker rejection leading to internalized shame, partner violence, lack of self-expression, grandiosity, and goal instability. These findings call for treatment of developmental deficits utilizing self-psychology interventions around integrating and differentiating in order to achieve self-esteem, worth, and self-cohesion.

Again, what is needed further in this investigation of literature is exploring empirical studies on peer support groups looking at the explicit link between the use of peer groups and
self-psychology interventions. Are some of the benefits of disclosing caretaker alcoholism gaining self-esteem, worth, and cohesion? What are the risks of this kind of disclosure when the themes noted include: denial, distortion and secrecy (Kroll, 2003)? Below is a concept called the “distress expression paradox” defining the benefits, risks, and reactions of disclosing information, a framework that may be used in considering the experiences of children of alcoholics disclosing to peers.

Kennedy-Moore and Watson (2001) explore the paradox of “distress expression,” expressing/disclosing negative feelings as both a form of illness and recovery, a sign of distress and a means to cope. Definitively, this distress expression paradox is disclosure of negative feelings that can be adaptive in “(a) reducing distress about distress, (b) facilitating insight, and (c) affecting interpersonal relationships in a desired way” (Kennedy-Moore & Watson, 2001, p. 187) or maladaptive if it exacerbates distress or causes feelings of guilt or shame. This leads to the wonder of whether disclosure to peers about caretaker alcoholism can be considered adaptive or maladaptive, if they are mutually exclusive at all. How can this distress expression paradox or disclosure of distress paradox be applied to children who disclose their distress to peers? Especially considering what Jacobs (1980) stated as the leading fear for this population being: loss of love of the object.

Black (1982) describes the population of children living with caretaker alcoholism as one that involves chaos, distress, distortion, secrecy, and shame. If shame is involved with the distress itself (Luoma, Kohlenberg, Hayes, Bunting, & Rye, 2008; Mehta & Farina, 1998) perhaps as with alcoholism or there is a fear of loss of love of the object in a disclosure, where do children of alcoholics go for adaptive distress expression? Below there will be a discussion around how stigma plays a part in this distress expression paradox—if there is stigma attached to
alcoholism, how it plays out in childhood (e.g. bullying), and the question of whether disclosure of a potentially stigmatized condition may exacerbate or cause feelings of guilt or shame in peer relationships.

The distress expression paradox can hypothetically be found in the interviews of this research if as a child there was both relieved and stressed in disclosing caretaker alcoholism to a peer. What can also be evaluated in these interviews are the potential successful and unsuccessful distress resolutions in these disclosures to peers. The distress expression paradox, according to Kennedy-Moore and Watson (2001), would be considered adaptive if the disclosure of distress leads to a resolution. Social work practice must attend to this resolution in interventions and models for treatment.

III. Models for treatment

This section of the literature review will explore the models for treatment both for caretakers with alcoholism (if this includes children and how it can be applied to children) and specific interventions for children affected by alcoholism. As mentioned previously, there is a need to understand what the approach to treatment is for these children currently, if there are gaps, and what role the friend plays in this treatment if there is disclosure. Kroll (2003) makes note of what her small sample of children say that they needed, but Contractor, Celedonia, Cruz, Douaihy, Kogan, Marin, and Stein (2010) utilized focus groups with parents and caregivers in a qualitative study to identify needed services for children and barriers to these services.

Contractor et al. (2010) conducted four focus groups: parents with SUD (substance use disorder) with children ages 5-11; parents with SUD with children ages 12-17; family members who are primary caretakers for children ages 5-11 of parents with SUD; and family members who are primary caretakers for children ages 12-17 of parents with SUD. Each group met once,
in a session lasting two hours, and served 22 participants in all (20 African American and two white). Emerging themes about barriers to treatment services from the transcribed focus groups include: 1) children’s ambivalence about treatment, 2) caretaker disagreement with the need for treatment and lack of involvement, 3) inadequacies in mental health services, and 4) attitudes and beliefs about mental health care in general.

Discussions took place in these focus groups around fear of stigma, fear of family displacement, fear of inability to meet the standards of care (e.g., missing appointments and having to wait for months for the next); fear of pharmacologic interventions for children; ambivalence of children reluctant to enter into treatment or receive services, and lack of consistent care from parents. In addressing this fear, Contractor et al. (2010) make note of the Acceptance and Commitment Training (ACT) program that is designed to reduce stigma and fear among individuals and providers around substance treatment, which could potentially be modified and applied to children of parents with SUDs. Some identified needs for services included family therapy, parenting classes, peer support groups, and emotional and behavioral services for the children.

This program is quite congruent with the theoretical model of self-psychology (twinship pole) that can be applied to these emotional and behavioral issues for these children in providing sameness, validation in experiences with peers with similar experiences. The fears described by these focus groups plays into the theoretical framework of the distress expression paradox as well—how do children receive support or treatment if there is fear of stigma or fear of family displacement? If children disclose their distress to their peers, does it provide some relief to these fears or exacerbate them? Again, more of an investigation in peer support groups is needed. Limitations of this study include the sampling size, location, and frequency of testing—a small
sample in comparison to the Shulman, Shapira, and Hirshfield (2000) study described below (22 participants in this vs. 117 in the Shulman et al. research) as well as a lower frequency of testing (four focus groups meeting once vs. Shulman et al.’s three year study).

Regarding the gaps in and barriers to services for children as described by Contractor et al.’s focus groups, Shulman, Shapira, and Hirshfield (2000) attempt to build a model of delivering services for children of alcoholics when their parents are in treatment for addictions. They attempt a model in a 3-year study that involves a multidisciplinary team’s evaluating these children when their parents are admitted for treatment—of the 117 children over the course of three years, 85% completed this evaluation and of these, 72% are receiving services. Evaluations included such spheres as psychology (utilizing Bayley II, Stanford Binet IV, and Wechsler Intelligence Scale for Children III), speech and language, and hearing. Their results show that all of these children have special needs and some co-morbid diagnoses: 69% were diagnosed with cognitive limitations, 68% were diagnosed with speech and language impairments, 16% were found to have with emotional/behavioral disorders, and 83% had medical problems.

The authors acknowledge remaining concerns about the validity of discrepancies in their results due to the lack of compliance with recommended rather than required services and the lack of a control group. They do believe, however, that providing outreach services for children when their parents come to a treatment program can be an effective model for delivery. In looking at disclosure of the caretaker alcoholism, the model would be pertinent for those who have admitted the problem, attempted to get help, and perhaps have discussed the issue of alcoholism with their children, supporting treatment for their family as well.

If the parents are not receiving treatment, however, there may be other possible ways of intervention for children affected by alcoholism such as school involvement with educational
trainings for staff on alcoholism and signs to look for in children and peer support groups or community involvement such as religious communities’ responses to alcoholism. There will be a discussion here around these interventions in hopes to provide a synthesized version of how people respond to disclosure of caretaker alcoholism. What will be important to consider is whether the role of the friend contributes in these interventions or if social work practice may be able to buttress the potential support children affected by alcoholism may receive if they disclose to peers. Perhaps one way to frame how people may view this population, their wants and needs as well as what the disclosure of caretaker alcoholism to peers may look like is the Transtheoretical Model discussed below. This theoretical framework and model of working with addictions is an approach to the want or need to “change,” a scaffolding of stages that provides a potential outline to the process of treatment.

DiClemente, Schlundt, and Gemmell (2004) attempt to synthesize and review their concepts of incorporating readiness for change and stages of change in addiction treatment while addressing measurements and criticisms of their work around the Transtheoretical Model. Arguing that there has been a shift in focus around addiction from “whether addicted individuals change to how they change,” these theorists are adding dimensions to the beginnings of psychological science’s studying of addiction and motivation (DiClemente, Schlundt, & Gemmell, 2004, p. 103). DiClemente et al.’s Transtheoretical Model addresses the multidimensional process of intentional behavior change around addiction and treatment (DiClemente, Schlundt, & Gemmell, 2004). The stages of change include: Precontemplation (little or no interest in change), Contemplation (risk-reward analysis), Preparation (commitment and planning), Action (implementation of plan), and Maintenance (new normative behavior). Criticism of this analysis asserts the difficulty in assessment across differing substances and
addictions and I would argue, across socio-economic, cultural, geographic, and other defining frameworks. The article does not address these identity influencers that would need to be addressed in a process of change, but mentions that the process would be individualized. This theoretical model could potentially be applied to children’s processes of disclosure. If a child discloses caretaker alcoholism to a peer, this hypothetically could be part of an attempt to change their behavior, attitudes, or feelings towards this issue in their family. Do children’s personal motivation to change, to attend to their own needs, rights, and willingness to approach their feelings of shame involve disclosure to peers?

In looking at the literature thus far presented, much of the research views being labeled or "diagnosed" as a COA, there are deficits to be found intrapersonally and interpersonally, in mental and physical health, and in the general well-being (Eiden, Colder, Edwards, & Leonard, 2009; Moore, McArthur, & Noble-Carr, 2011; Price & Emshoff, 1997; Sher, Wailitzer, Wood, & Brent, 1991). Contrastingly, Walker and Lee (1998) attempt to present a strengths based framework that veers from pathologizing COAs towards harboring the “evidence of relational resilience in alcoholic families of origin” (Walker & Lee, 1998, p. 521) built naturally and in treatment with these families. Presented research is criticized (including: Black 1982; Sher, Wailitzer, Wood, & Brent, 1991; Wegscheider, 1981) in the same vein as Vernig (2011) presented: there is a lack of acknowledging intersectional identities and experiences (biological, socio-economical, environment, development) as well as a lack of acknowledging the population of well-adjusted COAs (Walker & Lee, 1998). They present research that shows contrasting views of this population and then question how this occurs—COAs who score high on self-esteem measures; exhibit ability to reframe negative experiences in a positive light; emotional support seeking; have a greater capacity for intimate relationships as compared to non-COAs;
and have lower levels of substance use issues. They call for clinicians to approach alcoholic families as families that “have reservoirs of strengths that the therapists and clients must recognize and tap…assuming that families and/or specific subsystems have the potential to respond to addiction with great diversity by utilizing the collective strengths of their members” (Walker & Lee, 1998, p. 526).

Concerning implications for treatment, Walker and Lee (1998) discuss the hidden strengths of siblings, the protective aspects of parent-child subsystems, and avoiding pathology in favor of context in distinguishing constructive and adaptive traits including parentification. They call for a developmental-contextual approach for treatment of these families, looking at developmental trajectories with a strengths based perspective, case by case basis, in order to appreciate the “complexity of human life” (Walker & Lee, 1998, p. 532). Though Walker and Lee call for a developmental-contextual approach to treatment, building promising stories of resilience and abilities in families affected by alcoholism, they do not attend to supports outside the family systems.

Does this development-contextual intervention occur for children of alcoholics as a population? One of the most common noted treatment interventions for children of alcoholics is through peer treatment groups that highlight adaptive and maladaptive behaviors, educate children of alcoholics on manifestations of alcoholism, and bolster coping skills (Arman & McNair, 2000; Dore, Nelson, & Kaufmann, 1999; NACoA, 2011; Price & Emshoff, 1997). Typically these groups occur in a school setting such as what Arman and McNair (2000) illustrates and Price and Emshoff (1997) emphasize. School interventions are logical settings as children spend much time in school—school employees can easily notice identifying behaviors
and presentations and children may find comfort in attending school for treatment as opposed to a treatment center with stigma attached (Price & Emshoff, 1997).

Dore, Nelson-Zlupko, and Kaufmann (1999) propose and tested a curriculum for groups in schools of latency-aged children with drug-involved children. Their curriculum (similar to what the NACoA recommends and Arman and McNair (2000) illustrates: 30 minutes long, consistent structure of beginning greeting, ground rules review, and 3-5 activities designed to highlight both peer involvement and individual affirmation, alcoholism education, emotion identification, coping skills, alongside discussions. Findings of their two year long study with 206 participants in three Philadelphia inner-city schools involved in eight-week treatment groups include entry levels of social isolation and loneliness and exit levels of improved internal locus of control, social acceptance, and enhanced feelings of self-worth. The overwhelming finding of this study was "that there are so few institutional resources and supports for children with these psychosocial needs is a national tragedy" (Dore, Nelson-Zlupko, & Kaufmann, 1999, p. 188). The researchers also make note of the limitations of this study impacting their data—specifically lacking measures on intersectionality of factors impacting psycho-social functioning (poverty, violence, abandonment, and maltreatment) and the length of treatment being too short and simply not powerful enough.

Though treatment groups may often take place in the school, there is much left to be desired in school curriculum in terms of how to support children of alcoholics. There are models of curriculum out there through such agencies as: ICAP (International Center for Alcohol Policies—a not-for-profit organization supported by alcoholic beverage companies); The Office of Safe and Drug-Free Schools via the U.S. Department of Education; Centers for Disease Control and Prevention; Substance Abuse and Mental Health Services Administration
Curriculum models include: D.A.R.E., Project Northland, Creating Lasting Family Connections and Creating Lasting Connections (in SAMHSA's National Registry of Evidence-based Programs and Practices), Project Alert, Botvin LifeSkills Training, and Too Good, but most of these programs are prevention models as opposed to models that allow space for those dealing with alcoholism in their family to disclose, to receive treatment, teach educators what signs to look for, or educate peers on how to support their friends.

There are not countrywide curriculum standards regarding alcohol education. As an example, Massachusetts's school curriculum based off of the 1999 Comprehensive Health Framework (http://www.doe.mass.edu/frameworks/search/default.aspx) has modules implemented throughout elementary, middle, and secondary schooling regarding effects of drug use and alcohol on the body and how to make informed, healthy decisions in terms of use. Again, these are prevention models. The National Association for Children of Alcoholics provides educator and administrator training modules that can be used in staff trainings on what signs to look for and how to intervene, however, this module is not a country-wide standard requirement.

Kumar, O'Malley, Johnston, and Laetz (2013) identify the prevalence and attempt to examine the effectiveness of state, local, and commercially developed substance use prevention programs surveying 1,206 schools from 2001-2007. Their findings argue that many of the schools create curriculums suited to their students' needs and include multiple programs for prevention and reduction of use (over 200 programs to choose from), however only some of these programs are identified as documented research-based programs. They also discuss the components of evidenced-based prevention programs that are typically included and excluded—most notably excluded are coping and communication skills. These notably excluded elements
are potentially integral skills to learn for those dealing with the themes noted by NACoA (2011), Kroll (2003), Black (1982), and Wegscheider (1981). Though prevention programs discuss peer pressure, making healthy decisions, and effects of drug use on the body and mind, there is little to be desired around how to support children who are surrounded by familial alcoholism.

A community response to children affected by alcoholism is Al-Ateen. Al-Ateen is a family group split from Alcoholics Anonymous that involves sharing personal experiences and stories, taking lessons from members they could potentially apply to their own lives (www.al-anon.alateen.org). The groups are run in tandem structure as Alcoholics Anonymous, Twelve Step program that emphasizes spiritual growth and lessons. Similar to peer treatment groups, Al-Ateen is a place for teenagers to find support and understanding from peers going through similar situations.

Hypothetically, the self-psychology theory may be applied to these treatment groups as emphasizing sameness or twinship, mirroring similarities in selfobjects, bolstering self-esteem and self-cohesion. Finding sameness in a selfobject allows room for validation of self (Berzoff, Flanagan, & Hertz, 2011). Being surrounded by peers that are often in similar situations in an Al-Ateen group may encourage a balancing of the tri-polar self. Being surrounded by others who may also be disclosing personal experiences with alcoholism could also potentially lead to the adaptive form of the distress expression paradox—it may also reduce distress about distress, facilitate insight, and affect interpersonal relationships (Kennedy-Moore & Watson, 2001). It may aid the progression of stages of change, from Precontemplation to Maintenance in the Transtheoretical model (DiClemente, Schlundt, & Gemmell, 2004). Al-Ateen, however, is developed for teens with alcoholism in their family, not those friends who may want to support them. Where do peers outside of these treatment groups lie in terms of providing "sameness" and
twinship; relieving distress about distress; facilitating insight; affecting interpersonal relationships? The next section of the literature review will explore stigma, how it may impact disclosure to peers in non-treatment group settings, and how it relates to alcoholism in general.

IV. Stigma: alcoholism and bullying

In this section of the literature review, there will be an exploration of stigma associated with alcoholism and how this may impact disclosure to peers. There is a need to understand what stigma is, how it relates to alcoholism, and how this plays out in childhood. Stigma of alcoholism may appear differently to latency-aged children vs. adolescent children who may be partaking in alcohol consumption themselves. This examination will include a discussion around how stigma of alcoholism may impact kids and their disclosure around caretaker alcoholism to peers.

Robin Room's (2005) examination of social inequity in relation to alcohol and drug use offers a working definition of stigma paraphrased from a US law: "Stigma' means disqualification from social acceptance, derogation, marginalization and ostracism…as a result of societal negative attitudes, feelings, perceptions, representations and acts of discrimination" (p. 144). Room (2005) argues that alcoholism and drug use occurs in a "highly charged field of moral forces" (p. 152) as our law system outlaws and punishes those who use, defining standards of behavior; alcoholism dependence is also used (confusingly portrayed both positively and negatively in media) as an example of self-control and standards of valued personal qualities; negative consequences of use can be used as evidence of "moral inequity"; seeking treatment and being treated can be seen as evidence of self-management and control failure; and using is a means of both social inclusion (peer pressure and socialization) and exclusion (social marginalization) (Room, 2005, p. 152). Room goes on to state that:
An individual's patterns of psychoactive substance use, in a great many societies, are thus not only a matter of public health interest, but are also subject of social evaluation in terms of approval or disapproval, of honour or stigma, in everyday life….disapproval may be expressed in the form of state sanctions, up to and including being deprived of life, liberty, or property. (p. 146-147)

Williamson (2012) addresses this in a call for ethical and medical destigmatization of alcohol dependence in accord with the 1999 surgeon general who "identified stigma as "the most formidable obstacle" confronting efforts to improve treatment of mental health problems" (Williamson, 2012, p. e5). Despite the advancement of support and efforts in defining alcoholism by the medical model, a disease defined by neurological sciences and mental health sectors, there is still conflict between moral and medical models of alcohol dependence. Children of alcohol dependent caregivers are impacted by this stigma by association compounded by the notion that in this equation they are the least likely to receive services (Contractor et al., 2010; Room, 2005; Shulman, Shapira, & Hirshfield, 2000; Williamson, 2012).

Researchers and theorists have categorized stigma into three general perspectives in order to better understand and measure causes and effects (Glass, Kristjansson, & Bucholz, 2013; Luoma, Kohlenberg, Hayes, Bunting, & Rye, 2008; Mehta & Farina, 1988; Room, 2005). These categories include: perceived stigma or "the awareness of public stigma," experienced stigma or the acts of discrimination in the face of a stigmatized condition (Glass, Kristjansson, & Bucholz, 2013, p. E237); and self-stigma: feelings of shame, evaluative thoughts, and fear of enacted stigma becoming a barrier to an individual’s pursuit of a valued life (Luoma, Kohlenberg, Hayes, Bunting, & Rye, 2008). Arguably and discussed below, children of caretakers struggling with alcoholism may consequently be associated with all three perspectives of stigma.
Luoma, Kohlenberg, Hayes, Bunting, and Rye (2008) designed a study around the self-stigma in individuals in treatment for substance abuse disorder as referred to in the Contractor et al. (2010) study—how does stigma influence the barriers to resources? And more pertinent to this study, does this stigma affect children from disclosing to peers? Luoma et al.’s (2008) study involved 88 participants in a residential treatment program in a six-hour group workshop focusing on mindfulness, acceptance, and values work in relation to self-stigma. As stated above, the study operationalized self-stigma as feelings of shame, evaluative thoughts, and fear of enacted stigma becoming a barrier to an individual’s pursuit of a valued life. The researchers attempt to locate preliminary findings of Acceptance and Commitment Therapy (ACT) as well as mindfulness models as various means to effectively reduce self-stigma in specifically substance abusing clients.

Utilizing a differing model of treatment than DiClemente et al.’s (2004) Transtheoretical Model, ACT focuses on the relationships between thoughts, feelings, and overt behavior rather than modification of thoughts and feelings (Luoma et al., 2008). ACT for self-stigma treatment includes processes of experiential avoidance, cognitive defusion (recognizing thoughts are different from the events to which they refer), value searching, human connection, mutual acceptance, and mindfulness exercises. Preliminary findings from showed a decrease in self-stigma in this population, a first of its kind as a pilot study. It would be interesting to study the effects of this model on a population for children, a population that has complex layers of self-stigma attached to being a part of a family suffering from alcoholism.

What about connections to stigma outside of the self, or perceptions of stigmatized families affecting children from disclosing to peers? Mehta and Farina (1988) explore how others view people who are associated, but not directly marked, with an afflicted or stigmatized
individual by recruiting 120 male and female subjects making judgments in the areas of school, friends, career, and family on a hypothetical roommate whose father has one of five afflictions. These conditions for the associated person were a father “who either is depressed, is an alcoholic, is in jail for tax fraud, is old, or has only one leg” (Mehta & Farina, 1988, p. 195). The study is looking at whether college aged young people carry associative stigma into their college careers, determining whether there is a carryover effect of stigmatization from parent to college-aged child. The results of this study show associative stigma to be occurring and that college-aged children of afflicted parents to have more trouble in various arenas than those with non-stigmatized parents.

Mehta and Farina (1998) hypothesize why this may be true, attributing the notion of “birds of a feather flock together,” implications around social status, heredity, and fear of entanglement. They call for further research to be done in this realm. The limitations of the study, however, include the extent this research can be generalized—the sample was only described in terms of numbers and gender, ignoring the intersecting identities of each student applying associated stigma to the vignettes. Overall, though, this study suggests that stigma affects children throughout development not only in the areas of self-stigma as described by Luoma et al. (2008), but also in areas of associative stigma.

There is a need to explore the potential risks of disclosing to and gaining support from a peer in the face of associative stigma and researched risk factors as described above such as behavioral and emotional distress, conflicted interpersonal and intrapersonal functioning, depression, anxiety, substance use, and hyperactivity (Eiden, Colder, Edwards, & Leonard, 2009; Kroll, 2003; Moore, McArthur, & Noble-Carr, 2011; Price & Emshoff, 1997; Sher, Walitzer, Wood, & Brent, 1991). It is evidenced that stigma impacts an individual's pursuit of a "valued"
life, social acceptance, experiences with marginalization and ostracism. What must be considered are the potential risks of disclosing to and gaining support from a peer including that of physical burden, rejection or loss of love of the object through this associative stigma and the exploitation of vulnerabilities in the acts of bullying and victimization.

In the last decade, bullying has received much media attention about the widespread problem and the advancement of anti-bullying prevention and intervention programs (Harlow & Roberts, 2010). Much of the literature reviewed argues the necessity to understand and recognize bullying as an area that is filled with variance in terms of motivating factors to bully or be bullied as well as the gaps in literature that account for intersectionality of identities, risk and protective factors, etc. Harlow and Roberts (2010) utilize a wide range of "bully" literature to create a working definition: "an ongoing, negative behavior directed toward a victim by an individual or group…including verbal taunting, physical assaults, and exclusion" (p. 16); they make note to mention the recent development of cyber bullying—the action of bullying taking place over internet forums. Four groups are defined within the literature—bullies, victims, victim/bullies or those that both bully and are victimized, and bystanders or those who witness the bullying. Eiden, Ostrov, Colder, Leonard, Edwards, and Orrange-Torchia (2010) examine the association of caretaker alcoholism and peer bullying and victimization, expanding on and contributing to the gap in literature regarding the understanding of factors that may lead to bullying and victimization for this population.

Eiden et al. (2010) sample 162 families, initially assessing toddler-mother attachment at 18 months of child age and then child reports of peer bullying and victimization in 4th grade in attempts to account for "developmental antecedents of bullying" or "bullying in children at risk for maladaptive trajectories" like children of parents who abuse alcohol (Eiden et al., 2010. p.
Their argument stems from literature on risk factors for this population including the potential increased risk for aggression, maladjustment, poor social skills, social isolation, social anxiety, depression, and loneliness, questioning the mediating or moderating factors (parent attachment in this study) that may mitigate this population's noted aggression toward or victimization by peers (Eiden et al., 2010). The results of this study supported hypotheses such as sons with caretaker alcoholism and children with insecure attachment to mothers had a higher risk for peer bullying (being the bully) and externalizing behavior problems; secure relationships with the caretaker struggling with alcoholism also showed association with negative consequences rather than protective mitigating factors in middle childhood.

One notable contradiction in the results of this study, however, was the lack of direct or indirect associations between caretaker alcoholism and peer victimization. That is to say that there was not a clear conclusion made for the developmental antecedents or maladaptive trajectory towards peer victimization (being bullied) for a child with caretaker alcoholism (Eiden et al., 2010). The researchers owe this result to a similar argument by Vernig (2011): the heterogeneity of children who are victimized and the limited generalizability of their sample (families had to be intact with two parents both at 12 months and at middle childhood).

Bystanders, those who witness the bullying, have become an increasingly studied consideration in terms of developing bullying prevention programs. Bystanders are those who witness and do not partake in the bully-victim relationship, but do participate passively or actively in prolonging or stopping the bullying scenario completely; these are peers that may reinforce, assist, defend the victim, or purely witness the action (Cappadocia, Pepler, Cummings, & Craig, 2012; Polanin, Espelage, & Pigott, 2012). Cappadocia, Pepler, Cummings, and Craig (2012) specifically look at the motivations and characteristics of bystanders who actively
participate by intervening in a bullying episode. Polanin, Espelage, and Pigott (2012), however, research the best practices of those bystander interventions as a means of adding to programmatic curriculum on bullying prevention.

Despite the evidence that most children want to help their peers during bullying episodes, there is less evidence of actual interventions taking place. In looking at the motivations of those who do intervene, Cappadocia, Pepler, Cummings, and Craig (2012) utilize 108 participants ranging eight to sixteen years old attending an overnight summer camp that emphasizes bullying education, prevention, awareness, understanding, and empathy (p. 204). Various measures were used including: Promoting Relationships and Eliminating Violence Network Assessment Tool—Child/Adolescent Version (PREVNet—self-report that assesses rates of witnessing bullying and motivation for intervening or not); Empathetic Responsiveness Questionnaire (ERQ—self-report empathy assessment re: bullying and victimization); and Probully and Provictim Scales (self-report of attitudes about bullying and victimization).

The results from this study included naming the "sense of social justice" as the leading motivation for intervening in bullying episodes and a lack of sense of ownership or involvement and fear in those who did not intervene (p. 209). This fear was perhaps due to unwanted attention, fear of becoming targeted for voicing potentially unpopular opinions. A conclusion Cappadocia, Pepler, Cummings, and Craig (2012) make is bullying prevention programs "can encourage bystander intervention by addressing issues of social justice, emphasizing that no one deserves to be bullied and bullying is always wrong and unfair, as well as the importance of helping others when they are in trouble" (p. 210). They also make note of the need of clear-cut best practices of those who are intervening and the need for supportive adults in these situations for the safety of those involved. Convenience sampling and self-reporting limit the
generalizability of this study, however, there is great foundation for future studies on bystander interventions.

Polanin, Espelage, and Pigott (2012) conduct a meta-analysis on the literature of bullying and victimization, focusing specifically on bystander intervention constructs and best practices. Their method included cross referencing international research spanning 30 years on bullying and victimization through five databases, totaling to 360 total articles—all but 11 were deemed irrelevant and/or did not meet the criteria of the analysis. These 11 studies included a sampling of 12,874 children from the United States and Europe. The results of the meta-analysis included revealing that "bullying prevention programs might be effective at encouraging prosocial bystander intervention when the frameworks, programs, and/or curriculum explicitly target bystander attitudes and behaviors" (p. 61); that is to say that the analysis included results that supported similar findings of Cappadocia, Pepler, Cummings, and Craig (2012): there needs to be an increase of supportive interventions with a consistent message about intervening for the betterment of social justice with "ample support from adults and administrators" (p. 62).

These studies highlight the need of including all those involved in situations of bullying, stigma, and in a way, marginalization. Even those who are not actively participating, but are mere witnesses to pain and suffering, can participate in the prevention, the promotion of helping others, the addressing of issues that are wrong and unfair. What can social work practice offer to peers who want to support their friends who may be struggling with their caretakers' alcoholism? Children of alcohol dependent caregivers are impacted by stigma—through experience and self-stigma especially as they are the least likely to receive services though most likely to experiences feelings of shame, loneliness, and guilt (Black, 1982; Contractor et al., 2010; Kroll, 2003; Room, 2005; Shulman, Shapira, & Hirshfield, 2000; Williamson, 2012). The literature examined
accounts for experiences with peer bullying though does not definitively say if children of caretaker alcoholism are peer victimized due to their experience or association specifically. What would be interesting to explore in this research study is the response of peers if and when children disclosed their experiences of potential unfair shame, loneliness, and guilt to a peer. What must be understood and explored first, however, is the act of disclosure.

V. Disclosure

This section of the literature review will explore the very act of disclosure in general—what it does and does not look like, if disclosure of alcoholism in a family is similar to other disclosures such as achievement or emotional self-disclosure. This section will attempt to make an investigation of the process of disclosure in terms of answering who, what, when, where, why, and how disclosure plays out in childhood. Kroll (2003) argues that “Because of children’s innate sense of loyalty, their awareness of people’s opinions of drinkers and ‘druggies’ and fears about professional intervention, they were often trapped in a position where they could not ask for help or acknowledge their fears to outsiders, remaining weighed down by ‘silent knowledge” (p. 136). This section will explore this idea in terms of what may happen if this trapped position is influenced by the role of the peer in COAs’ lives.

An important element of the Mehta and Farina (1988) study of associative stigma is the notion that those case vignettes called for a form of disclosure about the roommate—disclosure about what type of family they come from. What happens if this roommate keeps the type of family they come from a "secret"? What happens to children who hold the family "secret"? Jacobs (1980) explores clients’ relationships with family secrets and the impact of secrets or secretive alliances within a family on clients’ psychology by using clinical examples and ego psychology references derived from the clinical material he amassed as an analyst. In his
discussion of clinical cases, Jacobs makes such arguments as the secret holding a great “intensity on the patient's awareness and claim(s) an inordinate amount of his attention. This intensity, although it may reflect the hidden presence within the secret of drive derivatives pressing for discharge, also has a defensive, protective function” (Jacobs, 1980, p. 28). He notes the role of parents in the shaping of a secret and the emergence of memories in analysis, especially those secrets that are only allowed to emerge if given permission in childhood for their emergence -- affecting the shape of memory in adulthood. He goes on to say, “…the function of memory was…significantly affected by the existence of secrets and collusions within the families…[playing] an important role in the problem as it touches on the child’s most basic fears of object loss and of loss of love” (Jacobs, 1980, p. 33).

This can be extended to children who may disclose a “secret” to peers about caretaker alcoholism—there could potentially be a fear of loss of love of the object both in parent objects and peer objects. If they disclose this “secret” to peers, children may fear the loss of love of the parent they disclose about, the enabling parent, or even siblings whom are also holding this “secret” in. Children may also fear the loss of love of the peer due to stigma and judgment. Though the analysis Jacobs offers from two clinical examples provides a good foundation in what a family secret can mean, there are many limitations in this theoretical piece including small sample, and personal bias. However, it offers some rudimentary views on what a family secret can do to children’s development.

Looking into the alliance piece between loved ones, one must look at the factors that allow for “secrets” to be talked about, confronted, and accepted in the family dynamic. Afifi, Olson, and Armstrong (2005) look at the “chilling effect” as it relates to family secrets, continued concealment. The chilling effect is “a partner’s power [that] can suppress relationships
complaints, influence attempts, or adverse information” (Afifi, Olson, & Armstrong, 2005, p. 564). Afifi, Olson, and Armstrong (2005) argue that it is important to not only look at the psychological chilling effects between partners, but also with family members, especially when parents hold a secret from children. The major result from this study that is relevant to my research topic is the need for protection mediating the connection between family members’ and individuals’ continued concealment of secrets from them. This study offers insight into the idea of children knowing secrets of their parents -- but also about the struggle and courage it may take to confront them, or in disclosing this secret to a peer; however, there are limitations in the study and its findings’ generalizability. Most of the families were white with adult children in their 20s and 30s, limiting insight for both families of color and families with adolescents (who may find concealment more salient in working towards autonomy) or older children.

This analysis of holding secrets led to an exploration of bodily effects of internalization of shame and the potential disruption of the organization and balance of tri-polar selves in children affected by alcoholism as described by Berzoff, Flanagan, and Hertz (2011). Slepian, Masicampo, Toosi, and Ambady (2012) examined whether there are physical burdens associated with secrecy, influencing perception of the secret and action. In application to this research study, if family alcoholism is a “secret,” how may this secret cause physical burdens that may be relieved if the “secret” is disclosed to a friend? Considering the metaphorical language of “being weighed down” or “being burdened” with a secret, Slepian et al. used four studies to examine “whether secrets would lead to perceptions, judgments, and actions consistent with those that occur when people carry physical weight” (Slepian, Masicampo, Toosi, & Ambady, 2012, p. 619). The first study examined whether carrying a secret would influence the perceived steepness of a hill; the second study examined perceived distance; the third study examined the frequency
of thoughts predicting perceived effort in physical tasks; the fourth study examined the suppression of a secret influencing helping behavior for physical tasks.

Results showed that “secrets affected judgments as physical burdens do: The larger the secret, the steeper the hill seemed…[and] distances to seem farther away” (Slepian et al., 2012, p. 620-621); Results suggested: “the more burdensome their secrets were, the more participants perceived everyday behaviors as if they were carrying a physical burden” and “suppressing a secret seemed to physically weigh participants down, leading to less prosocial behavior regarding physical tasks” (Slepian et al., 2012, p. 621-622). All of these studies suggest that there are health implications with concealment or suppression of a secret. This has implications for COAs as Kroll (2003), Wegscheider-Cruse (1989), Sher, Walitzer, Wood, and Brent, (1991) suggest in the theme of secrecy and distortion found in their studies on families affected by alcoholism; children who hold this information may have similar physical feelings of burden or relief in disclosing the information to their peers. This plays into the distress expression paradox as well as disclosure of negative feelings or a potential “secret” can be both distressing and healing at the same time (Kennedy-Moore & Watson, 2001).

There is much literature on the subject of children's disclosure of physical and sexual abuse as well as disclosure of mental illness and sexuality. Though this literature review will not equate the disclosure of abuse, mental illness, and sexuality with the disclosure of caretaker alcoholism and aim for support, the processes of telling may be similar. Corrigan and Rao (2012) discuss the implications of disclosing mental illness for reducing self-stigma and changing societal stigma of mental illness. Despite the lack of algorithmic strategies and the lack of attention to risks experienced in disclosure, Corrigan and Rao argue that coming out is one way for someone to "promote antistigma and counter the shame" that may prove to beneficial results.
They describe a hierarchy of disclosure strategies: *social avoidance* is staying away from others so there is no opportunity for stigmatization; *secrecy* is participating in the worldly experiences, but not telling anyone about this personal experience; *selective disclosure* is telling those who seem like they may understand such as in treatment groups; *indiscriminate disclosure* or hiding it from no one; and *broadcasting* meaning being proud and letting people know.

Social avoidance, secrecy, and selective disclosure (in such things as peer treatment groups) are well-known and documented processes to the COA population as with those with mental illness, but "broadcasting" one's experience "means educating people," seeking others to share and support similar experiences, and fostering "their sense of power over the experience of mental illness and stigma"—this is not something that can be found in the literature regarding a COA status (Corrigan & Rao, 2012, p. 466-467). Corrigan and Rao set up a blanketed ideal response to a stigmatized situation, a strategy and hierarchy of disclosure in a vacuum without discussing the potential risks involved in exposing specific mental illnesses or exploring specific stigma related to experiences. However, the hierarchy of disclosure may be applicable to the findings of this research—it may be useful to identify different points of disclosure that children of alcoholics may go through. It would also be interesting to know in these interviews what the outcomes of disclosure or nondisclosure brought for children of alcoholics, the risks and the benefits, the strategies for telling or not-telling and why.

One of the main points of inquiry for this research study is the social support processes for children of (the mental health sector's label) "dysfunctional" families or families that struggle with specific issues. How do children reach out to their peers for support and what does that process look like? Altermatt and Ivers (2011) examine the process of receiving social support in the face of positive events by interviewing 116 fourth to sixth graders before and after a focal
child outperformed their friend on an achievement-related task. The research they present argues that when there is sharing of a positive event with positive reactions from peers, both share positive emotions, strengthening the relationship. Altermatt and Ivers (2011), however, expand upon the research by looking at the context of the disclosure by including an examination of when competition is present between the focal child and friend.

Though this study may not be relatable to the act of disclosure and receiving support from peers in this research topic's context exactly, the reaction of the peer in the competitive context may provide a theoretical view of what themes may become present in the interviews. The reactions of the peers in this study were split into two forms: help-seeking or requesting assistance and acknowledging the importance of the event and abilities of the person who experienced the event; and off-task statements or those that were deconstructive, passive, and unrelated to the event, turning attention away from the achievement or event. In this study, friend reactions to the achievement related event were found to be an important predictor of how children feel about their accomplishments and themselves. What may be interesting to look at is how the peers, potentially help-seeking or passive in reaction to the disclosure, impact the views and experiences of the children of caretaker alcoholism.

Rotenberg (1995) sums up the literature regarding relationships between children often as 1) how friendships develop and change and 2) the impact of friendships on social and cognitive functioning. In the study, Rotenberg (1995) specifically looks at how children develop friends and whether "restrictive disclosure" played a part in the intimacy or significance of the friendship. Restrictive disclosure is defined as "children's particular willingness to disclose personal information to their friends rather than to nonfriends" (Rotenberg, 1995, p. 280). This study is less about how children disclose and more about when—when do children disclose
highly personal things to friends? In the sample of 180 preschool aged children (focal children, their friends, and the nonfriends), he found that restrictive disclosure to friends developed across the preschool age span, more evidently in older preschool children (four to five year-olds) than younger preschool children (two to three year olds). Analysis of this result included the idea that formulation of friendships at this age is parallel to adult friendships, initially starting with low personal disclosures and progressing to high personal disclosures as the friendships develop across time.

In a similar analysis though with a sample of 174 12-15 year olds, Papini, Farmer, Clark, Micka, and Barnett (1990) look into patterns of emotional self-disclosure to parents and friends in early adolescent stage. Their results revealed that not only do females demonstrate greater levels of self-disclosure arguing that disclosure among males may be stigmatized as "emotional" and "feminine," but also that older adolescents had a greater level of disclosure to friends than younger adolescents who may have chosen emotionally disclosing parents over friends. The analysis of adolescents who disclosed to parents throughout this developmental age held a noticeable association to positive family communication, cohesion, and satisfaction of family relationships. Added to this is the developmental research presented in this study that suggests "adolescent psychological well-being is facilitated by satisfaction with emotional support from both peers and parents" linking to the sense of self-esteem, self-image, ego development, and identity development (Papini et al., 1990).

Arguably, disclosing "secrets" or emotional express plays a role in development in many aspects—thus far discussed, disclosure may release the physical burden of "secret keeping," disclosure may improve self-empowerment and self-image in finding supports, may decrease self-stigma and strengthen relationships. However risks include the fears presented by Kroll
(2003) and Jacobs (1980) in fear of losing love of the object—parents, siblings, and even friends if their reactions are passive and deconstructive. Below will be a discussion of the role of the friend in development including that of theoretical perspectives and how social skills may be impacted by caretaker alcoholism.

VI. **Role of the friend**

Analysis of interactions with friends in childhood is known as integral for understanding treatment and support in the social work field. In the Diagnostic and Statistical Manual of Mental Disorders: DSM-5™ (5th ed.) utilizes analysis of how children (and adults) interact with others as a diagnostic measure in mental health. Specifically, the DSM-5 uses the "World Health Organization Disability Assessment Schedule" in order to better understand difficulties that people encounter due to their health conditions—and in this assessment, there are scaled questions concerning the difficulties encountered in friendships and community activities with other people. How people interact, why, when, and what these interactions look like are all important to understand in working with those whom we treat. With children, it is important to understand what children's friendships look like, how they may develop, what is considered healthy or unhealthy in friendship, how these friendships impact the psychosocial functioning of children in their world and their futures.

Much of the literature on friendships reveals the positive or negative impacts on children's functioning and success in the social world (Berndt, 2004; Newcomb & Bagwell, 1995). An examination of when friendships became a popular topic, Berndt (1995) looks at perspectives of childhood friendships across half a century, emphasizing the work done by Harry Stack Sullivan's in the 1940s and 1950s. Sullivan's work was an impetus for researchers to look
at the importance, effects, and development of childhood friendships. Berndt references Sullivan's work (1953) where he stated:

…look very closely at one of your children when he finally finds a chum—somewhere between eight-and-a-half and ten—you will discover something very different in the relation—namely, that your child begins to develop a real sensitivity to what matters to another person. And this is not in the sense of "what should I do to get what I want," but instead "what should I do to contribute to the happiness or to support the prestige and feeling of worth-whileness of my chum." (p. 208).

Some argue that close friendships affect social skills with others—meaning having a supportive friendship may help with having positive interactions with other peers (Bagwell, Newcomb, & Bukowski, 1998; Berndt, 2004; Hodges, Boivin, Vitaro, & Bukowski, 1999). Others argue that close friendships are universally good though marked with conflict (Newcomb & Bagwell, 1995). Friendship could be considered as a condition that mitigates the negative effects of bullying as well as contribute to the potential etiology of the victimization (Hodges, Boivin, Vitaro, & Bukowski, 1999). Some argue that both the absence friendship and peer rejection "predict trouble with the law across adolescence and adulthood" (Bagwell, Newcomb, & Bukowski, 1998, p. 150).

However, a notable theme found in the literature reviewed is the concept that friendships are not something that can be described as homogeneous—not all are the same especially considering the intersectionality of persons involved, environments, and other impacting factors. Friendships are hard to study in childhood as a researcher relies on both self-disclosure and looking into concepts that are in development, not fully realized such as self-esteem and identity formation (Berndt, 2004). Most also argue that friends themselves are an understudied and
underutilized population—this is a population that social work practice and other realms of mental health need to attend to (Bagwell, Newcomb, & Bukowski, 1998; Berndt, 2004; Rose, Schwartz-Mette, Smith, Swenson, Asher, Carlson, & Waller, 2012; Schwartz, Stutz, & Ledermann, 2012; Swenson & Rose, 1999).

Swenson and Rose (2009) attempt to look at friends' knowledge of children's adjustment issues or struggles—looking into accuracy of knowledge, bias, and how friends can play an important role in prevention efforts. They utilized a sample of 208 youth (104 friend dyads) in 5th, 8th, and 11th grades. Their results, utilizing measures such as self-reported internalizing and externalizing adjustment, friend-reported internalizing and externalizing adjustment, friendship quality questionnaire from the Network of Relationships Inventory, and self-disclosure questionnaire, indicated that on average, friends do understand or have knowledge of their friends' adjustments. However, the results also indicated that this understanding also came from personal bias over accuracy. That is to say that the friend was influenced by their personal experiences rather than the accuracy of the knowledge of their friends' adjustment.

Swenson and Rose (2009) discuss two integral notions for application to this research study: 1) "friends who are aware of youths' adjustment problems could increase the support they give, which could reduce the youths' symptomatology" and 2) "knowledge of a youth's psychiatric symptoms could lead friends to terminate the relationships, possibly exacerbating youths' adjustment problem" (Swenson & Rose, 2009, p. 899). This leads to Swenson and Rose arguing that friends may play an important role in prevention and intervention as many children receive services due to being identified by others as needing such—typically by adults. What may be needed to promote children's well-being are "programs that teach youth strategies for
encouraging friends to seek help and teach youth about warning signs (e.g. suicidal ideation) that should not be kept secret” (Swenson & Rose, 2009, p. 899).

As the previous studies mention the intimacy and impact of friendships on children, one important theme to understand is how children talk to their friends, how they come to rely on their friends with information, what formulates that intimacy. Rose, Schwartz-Mette, Smith, Swenson, Asher, Carlson, and Waller (2012) explore the expectations of feelings when children disclose problems to a friend. Four studies ranging from middle childhood to mid-adolescence looked at the differences in how children expect talking to a friend may make them feel. Their major findings included that of girls promoting positive expectations or that they expected that they would feel understood or cared for whereas boys expected to feel "weird" or as if they were wasting time in talking to a friend about their problems. Their rationale for this sex difference has often been labeled as a societal construction of gender roles, that disclosure is more normative for girls than boys (Rose et al., 2012). The negative expectations, however, did not have the same sex differences—that is to say that boys and girls did not differ in feeling worried or embarrassed, ridiculed or not cared for. Rose et al. call for more research regarding the examination of social cognitions or social constructions of gender norms in order to understand the sex differences in disclosure—especially considering the need for social work practice to promote positive outcomes when disclosing.

Friendship is an integral part of development both in construction and promotion of social skills (Davies, 2011); it is important in the learning of intimacy, sameness, and sensitivity (Berndt, 2004; Berzoff, Flanagan, & Hertz, 2011); it is also a means of both healing and conflict with rivalry and competition (Newcomb & Bagwell, 1995). Friendship between children plays many roles—it is as complex as children themselves. However, this complexity is noted to have
potential positive influence over the well-being of children, playing the roles of listener and encourager for support. Social work practice needs to attend to this role in child development, encourage positive and beneficial outcomes to disclosing and looking to peers for support when dealing with caretaker alcoholism.

Summary and motivation for the study

The literature reviewed for this paper gives insight on various subjects related to children affected by alcoholism: risk factors to exposure; psychopathology; physical burdens; themes to inform social work such as stigma; theoretical perspectives such as self-psychology and distress expression paradox; delivery models and theories of change such as the Transtheoretical Model and peer support groups; disclosure; current interventions in schools and communities; and the role of the friend in childhood. This evaluation of the literature has drawn attention to specific gaps in the research literature to date, what it means to children of alcoholics to disclose and search for support in peer relationships.

In considering the future of work with children of alcoholics, the potential supportive relationships between children of alcoholics and the peers they may rely on can only be more specifically understood from the perspective of adult children of alcoholics (ACOAs). Learning how ACOAs view their experience with peer relationships will serve to improve current practice and policy in work with children of alcoholics. Below is the methodology utilized in this study to give voice to the experiences and perspectives of adult children of alcoholics in growing up with caretaker alcoholism and the potential use of support and disclosure in peer relationships.
CHAPTER III

Methodology

Research purpose

The major research question for this qualitative thesis is: What are the perspectives of adult children affected by alcoholism about disclosure and needed support from peers in their childhood? As the literature review suggests, the intersecting experiences of children of alcoholics has implications with the various degrees of support children may need, how the supports are received, and how social work practice can take part of these supports. To better serve this population and those who may want to help them such as their peers, learning about how adult children of alcoholics view disclosure of caretaker's alcoholism and needed support from peers may influence and inform practice and program designs.

While this study may contribute to the literature in this field of work, adding rich narratives of experiences and opinions, closing gaps in research presented, it is also an attempt or effort to better service children affected by alcoholism. The overarching purpose of this research is in asking the question of: how do we do no harm? This is a social work ethical code that asks for the players in the field to traverse the systems we work in, we live in, we exist in with great reflexivity and grace, insight and compassion, with the goal to do no harm in systems unknown and known. That is to say, children of alcoholics, as presented in the literature, are faced with stigma, shame, guilt, and secrecy. A potential finding of this research includes the notion of: how we provide resources to children without breaking secrecy, bonds, and family rules of "Don't
talk; don't trust; don't feel" (Black, 1982). Perhaps through the channels of peer support, either through groups like Children of Alcoholics or through psychoeducational support of peers around them, this population can receive services without harming. How does social work practice directly or indirectly participate in servicing children affected by alcoholism or addiction? This study and its qualitative approach are envisioned as another initial step of a larger goal that will eventually provide resources for children affected by alcoholism in multiple forms as required through policy, program considerations, and agency outreach. The following chapter describes the design, sample, data collection, and data analysis used in this study to locate these narratives of experience and opinions as well as a discussion of biases.

I. Study design and sample

The qualitative exploratory/descriptive study employed semi-structured interviews with a sampling of adult children of alcoholics. The population was composed of adults who have a history of primary caretaker alcoholism defined as the person that the adult participant self-identifies as having relied upon for the meeting of basic and emotional needs (e.g. father, mother, grandparents, foster caretakers, adopted caretakers, older siblings, etc.), who are 21 years of age or older, proficient English speaker (in order to mitigate any translation issues such as bringing a third person into communication), and primarily schooled in the United States (in order to examine U.S. school curriculum). Adults who were in active, current treatment at a facility or hospital for alcoholism or substance abuse were excluded; asking about family dynamics and past history may have presented as an interference with treatment.

This population was chosen because it could be assumed that their experience with caretaker alcoholism throughout childhood led to situations in dealing with the alcoholism with peers who surrounded them. Upon suggestions of my research advisor, I changed my initial age
limit from 18 to 21 and older, the drinking age in the United States, so as to mitigate any ethical conflicts of participants' disclosure of their own alcohol use. The limited scope with language and schooling qualifications were put in place for this researcher's feasibility—it was in no way to presume that other adult children of alcoholics who do not fit the criteria do not have a narrative that would illuminate and add to the research. In the recruitment process as discussed in the next section, the inclusionary and exclusionary criteria were presented in the recruitment emails and during the interviews so as to be certain of the qualifications.

With non-probability sampling, a total number of 12 participants of the 17 who expressed interest in participating in the study fit the criteria, completed the informed consent process, and completed the interviews. The five participants left over expressed interest, but did not complete the informed consent process in order to continue with the interview portion. The sample's self-identified demographics include: eight women, four men; ages ranging from 25-70; ten Caucasian, two Hispanic. Due to the reflective nature of the interviews, I found it important to allow room for the participants to pick from three descriptive phrases (poor, somewhere in the middle, and well-off) to describe their childhood socioeconomic status especially considering the changes in these views throughout time (so as to not put a 21st century perspective on some mid 20th century childhoods): two chose poor backgrounds, nine chose somewhere in the middle, and one chose well off; ten attended public schools, two attended religious schools; four grew up in urban areas, six in suburban, and two in rural. The sample recruited came from people living in various areas across the country from Washington, D.C. to California. Through the interviews, it was learned that six participants grew up in the New England/Tri-State area and six participants grew up in the south with the highest concentration of participants being from Texas (four).
II. Recruitment

Approval of my proposal for this research from the Smith College School for Social Work Human Subjects Review (HSR) Committee, ensuring ethical standards were met and merit of subject matter was acquired prior to the recruitment process (Appendix A). The accepted proposal for this research study approved the use of snowball, availability/convenience sampling utilizing the participation of those persons available, those who fit the criteria, and those who consent to the interview. This recruitment process included asking colleagues at my internships and people in my school, friend, family networks to pass along recruitment emails and flyers as well as emailing leaders of Adult Children of Alcoholics meetings whose contact details were found from the Adult Children of Alcoholics World Service Organization resource (Appendix B). These efforts brought about 17 responses of interest, 12 of which continued with participation after receiving, reviewing, signing, and sending back the informed consent document to my person (Appendix C).

III. Data collection

After the informed consent was received with a wet signature, the participants were contacted to set up a mutually convenient and safe location and time to conduct the in person (three of which occurred in person), phone, or Skype interviews. Before the interviews began, the informed consent document was reviewed with the participants to explicitly describe participant confidentiality, protection of their identities, how to withdraw from the study ten days following the interview, and how the interview was to be structured. The 30-45 minute interviews were scheduled between the dates of February 28, 2014 and March 24, 2014 utilizing an HSR approved interview guide (Appendix D). They were recorded using the AudioMemos and iTalk apps on password protected iPhone and MacBook Pro; these memos were then
uploaded into the application Transcribe, one that offers dictation, playback, and speed controls, aiding the transcription process. These transcriptions were done by myself only, stored on my password protected computer, with names and locations redacted and separated from the informed consent documents.

My research advisor will have access to the data collected from the interview, but only after names have been replaced with pseudonyms. Likewise, in publications or presentations, if illustrative quotes or vignettes are included, they will be thoroughly disguised. All data collected from the interview will be kept in a secure location for three years as mandated by federal guidelines. Should data be needed beyond this three year period, they will continue to be kept securely and will be destroyed when no longer needed.

During the interview, I utilized the interview guide (Appendix D) that included focused and follow up questions regarding: experiences living with caregivers with alcoholism and how it has affected various life areas; what helped to build capacity to cope and survive; current struggles with this family history; whether disclosure of family history to a peer influenced coping; what kind of support was gained from disclosing; how the process of telling took place including the choice of person. These questions were formulated through a combination of my experiences in the field, a review of the literature, consultation with my research advisor, and suggestions from the HSR committee. Knowing that the interview material might be potentially emotionally evocative, each participant received a list of resources to contact in case of upset or potential distress. The risk of potential distress was low.

IV. Data analysis

The demographic information collected at the beginning of each interview was analyzed utilizing descriptive statistics on age, ethnicity and racial identity, sex and gender identity,
socioeconomic status of families in childhood, and types of schools allowing for inferences to be drawn in the discussion section. The narratives as extracted through open-ended questions were open coded for conceptual methods, exploring recurrent, salient, and odd or rarely occurring data for this population, to shed light on the experiences of support gained from peers and through disclosure. Transcripts of the 12 interviews were closely read multiple times, drawing an initial list of codes, a secondary list of codes during a second reading for categorization, and a final assignment of heading codes for analytic reflection that are depicted in the findings chapter, a method that draws out themes in the discussion section for analysis (Saldaña, 2013). Saldaña (2013) describes this coding process as one that requires thinking of a category as a word or phrase that is explicit whereas the themes are outcomes, they are subtle, tacit, and analytical. I did not use any qualitative data analysis program or utilize a second or third reader to provide decreased bias in coding—these supports could have been useful upon further reflection.

V. Potential biases of the researcher

As the research progressed, I became more aware of the assumptions, biases, and inexperience I may have coming into researching this topic. I want to acknowledge here that my position as a student researcher is one that has potential for impacting the accuracy and richness of the data and ability to fully employ the methodology without biases. As someone who has been disclosed to as a child, someone who supports children who disclose, and someone who intends to work with children in social work practice, my experience came of use during the interviews, however this also colors my perspective on this topic of study. I found that there was a lot to learn in simply asking the questions being mindful of bias and without leading. Part of the process involved challenging my own assumptions and this became evident during data collection.
For example, much of my work with children has been around the assumption that the alcoholism in their families at one point was a “secret” that they must have had to hold, to keep for fear of upsetting the family equilibrium. This became particularly evident when I used the word "disclose" during the interviews. In my assumption, the process of holding a secret and telling someone involves disclosing—it holds power, holds potential for chaos, holds potential for release as found in the distress paradox—and yet it can also hold no power at all. It can be a norm. To even use the word "disclose" was making an assumption that something needed to be said aloud, however there was power in the unsaid disclosures as well. This will be further analyzed in the discussion section of the research study. As discussed in the literature review, the themes of distortion and secrecy make evidence of this power disclosure may hold, but they also must account for the multifarious experiences and families influenced by alcoholism. I will attempt to continue to be conscientious of this in future study.

To increase trustworthiness of the data, the following findings section presents the data in quotation form under categories and sub-categories for feasibility of researcher analysis. There will be multiple examples quoted from the narratives to provide the reader with as much direct access to the data as possible in the following chapter.
Chapter IV

Findings

The following chapter presents the findings of qualitative data accumulated through 12 interviews with participants who define themselves as adult children of alcoholics (ACOA). The aim of this research study was to gather narratives on the perspectives of adult children on how and if, in their childhood, they disclosed to their peers and the decision-making processes about disclosure; the role of the friend in their experience; and the perspectives of what services were offered and are needed for children influenced by alcoholism and the peers who may want to support them.

The major findings were that adults children of alcoholics do perceive to be profoundly affected by caretaker alcoholism. There were three major findings from this research. The first was that defining themselves as ACOA is a label that is telling, but also complex in the intersectionality of experiences and identities. Secondly, peers and friends played specific roles in disclosure and non-disclosure of alcoholism. Lastly, resources for children of alcoholics are sparse and conflicted as depicted by 100% of the participants. This chapter will explore these major findings as they emerged through conceptual methods, exploring recurrent, salient, and odd or rarely occurring data for this population. It is important to note here that though there are direct quotes used to present this data, not all could be included.

The data have been organized into five categories (with subcategories) beginning with a review of the Demographics. Next presented is the Experienced effects of caretaker alcoholism
as a child and adult. Third is the category: *(In)Direct (Non)Disclosure* on direct disclosure, indirect disclosure, and non-disclosure. Fourth, there is the section titled *Have You Got a Friend?* exploring the presented roles of friends. Finally, *How Do We Do No Harm?* presenting participants reflections on what supports were available, should of and could have been there, and their conflict of gaining these supports.

I. **Demographics**

The participants answered five questions about their demographics—this was to better identify the sample for the researcher as well as to give a context to certain questions such as type of school attended in terms of looking at resources for schools, and generational experiences of alcoholism stigma. The demographics are presented in this aggregate way and pseudonyms are used throughout the presented findings so as to protect participant confidentiality.

Eight women and four men completed the 30-45-minute interviews between February 28, 2014 and March 24, 2014; all but one participant agreed to be audio-recorded and recorded interviews were transcribed. Notes and memos were used to collect data for the one participant who did not consent to audio recording. The age range of the participants at the time of the interviews was 25-70 years old (three participants in their 20s; three participants in their 30s; three in their 40s; two in their 50s; one in their 70s). The majority of the sample identified as Caucasian or White (10 out of 12); one participant identified as White Spanish decent and one participant identified as Latina, Mexican American. As discussed above in the methodology section, the participants were offered phrases to describe their childhood socioeconomic status: two reported being from poor backgrounds, nine reported being somewhere in the middle, and one reported being well off as children. Ten participants attended public school as children and two attended religious schools. In terms of geographic description, four participants grew up in
urban areas, six in suburban, and two in rural areas; six participants grew up in New England/Tri-State area, and six grew up in the South with the highest concentration of participants being from Texas (four).

II. Experienced effects

Participants were asked about their experiences including: the extent and quality of their relationships with their caretakers, their perspective about how they felt about alcohol, school curriculum addressing alcoholism, and peer pressure in childhood; and relationships in their childhood that were significant. The last question in the interview also provided space for the participant to think over the interview, address what they think could be useful to know, and address the effects that they may not have addressed before. As the literature review suggests, studies have shown that children of alcoholics experience physical (e.g., children with fetal-alcohol syndrome), mental (cognitive ability), behavioral and emotional effects of caretaker alcoholism. All participants discussed the effects they experienced, none admitted to being unaffected, discussing at least some of the following topics about their experiences, which are the subcategories of this section: violence, fear, and intergenerational alcoholism; roles; relationships; and denial, secrecy, normalization. Below are these findings.

i. Violence, fear, and intergenerational alcoholism As the literature review suggests, effects of caretaker alcoholism can take on various forms, influencing the physical, mental, behavioral, emotional, and characteristic structures of a child—however to repeat what is brought to light in the literature—not all children of alcoholics experience all of these forms. Six participants in this study discussed the violence directly linked to alcoholism in their families. Out of these six, two participants disclosed sexual violence. When asked if he ever had explicit conversations with his caretakers about their alcoholism, Cade stated: "It would mean that there
would have to be some admission on their part on having neglect and/or having abused me." For Gayle: "He was just relentless….my father could get violent." And Anthony:

My father could become physically violent at times and what was interesting was he was kind of more relaxed and personable when he was drunk but the next day there would be really intense hangovers. When I was a teenager we would get into really intense shouting matches and sometimes those would turn physical and I think, well I know that, he would start hitting me, slapping me, and beating me—I know at one point my mother said "you know how your father is, why do you always make him so angry." In retrospect I look back and have some resentment about that because I feel like whatever I was going through as a teenager, it did not justify any physical violence towards turned towards kids. And then there was one point when I was 17 when my father threatened to punch me. I told him that if he did I would call the police, that I hoped that he did because I would like to see him arrested and he backed off after that.

Aly "colored" her discussions of her family with stories she had heard about previous generations struggling with alcoholism including the murder of her grandmother at her grandfather's hands. Below is an experience she and her sister went through:

I don't know if this is ridiculous to say that—part of his reaction was disproportionate to what was happening and he was drunk. She barricaded us in this bedroom—started in a big bedroom and walk in closet and he's like "I need my daughters" and they start fighting through the door. And like she's just threatening him. She puts a dresser in front of the door and "you're not taking them"…he was like "Fuck you! I'm taking them." He like breaks down this door, [my sister] was with me and losing it, and I'm kind of like I'm super scared and really upset, but I'm trying not to be hysterical. He breaks the door down
and rips it apart like "the shining" style and the lady is like (pause) I don't even know this, but my family they are kind of like into guns. So she's got this handgun drawn at home—he was like "Jesus Christ, like what the fuck are you doing?" She's like "Get the fuck away, I will SHOOT you!" I laugh about it because it's so dramatic. I don't know. Nothing ever happened—obviously he didn't get shot. But it was this sensational experience that changed me. In many ways.

Eight participants recognized fear as an experienced effect—fear in the household when alcoholism was present and fear in their characteristic make-up as an adult. Darla discussed her experience with her father's alcoholism—a traveling salesman that would be away from home Monday through Friday, how the three days he was home would be "hellish" defined by "disaster and chaos" that they would all anticipate and fear during the week. Gayle voiced:

One night, I wouldn't back down, that was the other thing, he put his fists through the wall and then he went for a walk I guess to get away from me, my mother said to me "If anything happens to him it's your fault. Bothersome right? I'm anywhere from 8-12 years old when that's being said to me. Well HOLY SHIT now I'm responsible if this guy has a heart attack, it's my fault.

Dee described her experience with emotional and verbal abuse:

Emotional – yes. Verbal – yes. But for the most part I was safe. There was nothing really going on that needed intervention. I think my dad needed help. And if my dad would have gotten the help, things would have gotten better. (pause) I think I used to take a lot of my dad's abuse because it was like he provided a house, he bought me a car, he put clothes on my back, he paid for... (pause) I kind of just had to take it because what else could I do? That's an awful feeling.
Kerry was sexually abused by her uncle and party-goers at her caretakers' house and discussed that she was afraid to tell anyone about the abuse: "I think what could have helped if I had been able to not be afraid to tell somebody." She described the horrors of sexual abuse and motions that led her to calling the police many times:

My uncle wasn't the only one that touched me. There were all kinds of those people in and out of the house a lot. I don't remember who they were; I just remember that every time she had a party, I needed to lock my door. And that was part of the sneaking the phone in the bedroom (laughs) calling the police: "You gotta shut this down, we're tired." There was a lot of people there that were just drunk. There were a lot of people there that weren't just drunk.

For Aly, one facet of fear that was brought about was through discussions in curriculum equating alcoholism with sexual violence and other drugs like meth and heroin: "They always grouped it in these big places. "If your parents are alcoholic and they sexually abuse you." They lumped them in this like (pause) I would always get so scared that this was part of the bigger issue."

Brian, Marianne, and Anthony discussed the fear that spread through their adult lives despite being away from the alcoholic home. Brian stated: "But I don't fundamentally think that there's security or stability in the world and therefore I better provide it. I think a lot of that has to do with how I was growing up." Marianne described the act of leaving for college: "I wasn't afraid of going to college but I was scared of walking away. But I knew I had to."

Anthony addressed the influence on his career path:

I also think that being a product of a generation of which my father was brought up in and what was expected in men then—or his experience of growing up with an alcoholic father who did not know how to nurture him—he tended to be highly critical and had very
negative messages. I think that I have internalized those messages. And I think that in professional situations, I sometimes have been afraid to take risks say for promotions or going for bigger jobs because I have really strong voices in the back of my head that repeats many of the same messages that he gave me like: "You're not really talented; the only reason you succeed is because you're in the right place at the right time, you don't have anything special to bring to the table."

Ten participants voiced the intergenerational alcoholism as a factor in their growing up—eight of these participants disclosed their journey towards sobriety themselves. Marianne expressed:

I became an alcoholic before. I think I got sober after 10 really bad years of drinking and using drugs. I don't think that would have happened if my mother hadn't been the role model for the disease. I am very fortunate to be in recovery for over 40 years.

As expressed by the participants, it appears that violence, fear, and intergenerational alcoholism are experienced effects that are long-lasting, influencing childhood and adulthood.

ii. Roles and dynamics Eight participants voiced various experiences in their family with members participating in what some called "roles" and others described as family dynamics. The first described is the child in the role of caregiver. Aly alluded to the notion that in any family there are certain roles that siblings and caretakers play in any family: "And I'm sure there is a dynamic in every family: the elder sibling protecting the younger or one sibling protecting everybody. I definitely felt like I needed to play an active role to protect her because she was taking these things so hard." Marianne discussed: "I was a maybe when I was in the 3rd or 4th grade I started caregiving because of my mother's drinking. She was having babies and so I had a
job by then. I was helpful from that time on. It was a helper of my father taking care of the situation."

Aly described her caregiving role and savior dynamic as one that has extended throughout her childhood and adult life:

Yeah, when I was really young and remember, it was kind of (pause) it was like I was going to save my parents. Starting when I was like 6, my aunt she was like "your dad has to quit smoking!!" so she gave me like $100 in cash and I was really young and she was like "give this to him and have him go get patches or something. Promise him that you'll pay him $100 if he quits." So I did this intervention at age 6 that was super weird and kind of was like "What the fuck?" Nothing became of it and I was devastated…(in a later section) I've been that person who would sacrifice themselves which is something I'm dealing with now. Hey, you gotta take care of yourself first. Because taking care of my dad for six years was really hard. Because a lot of what he was dealing with was based upon his addiction. He died of smoking basically which is one of them and then wasn't healthy at all because of all the Oxy and alcohol and bad stuff…(pause) I look at it as I have to grow from it, I'm not going to let this happen to me, I'm going to be bigger than it.

Another role described is that of the enabler—specifically, the role that a caretaker may have played in enabling the other caretaker's alcoholism. Jake described his family: "My mom, I had an older brother, younger sister, we all lived together in what I would have described as a very strong nuclear family most of upbringing. I would classify my mom as a true classic enabler."

Nina, however, discussed that in her process of forming relationships, she herself has taken on an enabler role:
I feel like I tend to be an enabler in a lot of my relationships. Sometimes I get myself in bad situations because I'm so concerned about making sure other people have what they need and their needs are met and the outcomes they want…it's just a lot of like things that we individually talk about the connection a lot of those traits that [ACOAs] tend to have when they start getting older. Things that they may not have realized were going on?

The third role or dynamic brought to light is *scapegoat*. Gayle ascribed this specific word to her role in her family:

I was the scapegoat. So everything that happened got blamed on me. (pause) Part of the issue where the family dynamic plays out is that I am the scapegoat and people want to shut down and now I always want to communicate. Even as a kid I wanted to talk about it but didn't feel like I could let the secret out.

Similarly to experienced effects, the discussion of roles and dynamics could be considered to be long-lasting as well. Jake, Gayle, Maureen, and Nina who used specific language (e.g. scapegoat, caregiver/partentified, and enabler) as presented in the literature review also made note of their participation in groups such as Alcoholics Anonymous and Adult Children of Alcoholics, two support groups using frameworks that utilize this specific language when processing experiences.

**iii. Relationships** All of the participants were asked: what were relationships like growing up—including family and friends? What relationships were significant and why? They were asked to comment if alcoholism in the family affected these relationships. All twelve participants confirmed that they believe it has affected their relationships. Marianne, Cade, and Darla mention the isolation that alcoholism brings and how that has impacted their relationship skills. Marianne states: "I didn't develop skills. I developed management skills, but I didn't develop social skills or a lot of ways that I needed to. I had some friends. I had some friends that
I had to keep at a distance so they didn't know." Darla stated that she did not know how to have relationships as she was forced by her parents to keep isolated from extended family and friends; she had to relearn every single thing because what was modeled was "wrong, inappropriate, and backwards." Cade mentioned that:

I would say [alcoholism] prevented me from having my own family. All of my relationships that I have had have been unhealthy—and they've been few and far between and for very brief periods. And so as I approach you know the, or moved past the middle of my life, you know, I fully recognize the impact that alcoholism being a child of an alcoholic and becoming an adult of an alcoholic has had. The negative impact that it has had on not only my relationships with the opposite sex. Negative impact on my ability to have my own family and negative impact on ability to develop intimate, close, friend relationships.

Some participants discussed their realization of their attraction towards amorous partners who struggle with addiction. Laura voiced: "I think the most profound effect of my childhood experiences with alcoholism has had on me is in forming relationships. I noticed, again it took me far too long to realize that, I kept getting romantically involved with addicts and alcoholics. I didn't see the pattern or connection for far too long."

Jake stated:

It's shocking when I look back, I think the interesting thing about it is when you get into the relationship you don't have an understanding of the person's issues or how strong those issues are. You're seeing the good sides of things, but I think is kind of interesting about it is whatever the consequences of their addictions to alcohol or otherwise, the personality they exhibit from the things that they have are probably the things I was
drawn to, but only later that I realize the reasons they had those characteristics was a function of their alcoholism and addiction. Blindfolds are off, "oh right, I'm back in this pattern again."

Anthony discussed a similar realization:

I think that my father was checked out with his addiction, I needed nurturing and constant affirmation that I was not getting from my father—and I thought that trying to get that validation and nurturing sometimes through having sex with older guys when I was a teenager. I think that what I've noticed in my life is that if I am strongly attracted to someone, sometimes they are an alcoholic or an addict, sometimes and active addiction, and I think that is a kind of devotional pattern from me—trying to get some of my needs met from childhood that I didn't get met by pursuing unavailable romantic partners. I think I have a hard time with intimacy, don't let people in romantic situations because I had really negative messages from my father.

Dee and Brian described the quality of their relationships as being affected by their childhood experiences with caretaker alcoholism. Dee stated:

I find relationships overwhelming. Relationships in general. I kind of keep them, even with my family, I couldn't find a way to keep them back without being (pause) they engulf you and I feel like I lose myself. I like being alone a lot. So I can gain my composure because I feel like I'm going to get lost in whatever. And I can get sucked into drama. So quickly. And it's not even my drama, but boy do I get sucked into.

And for Brian:

I also feel like I owe a great deal of loving support to the important people in my life, but that I should not expect anything back except for love from them. So in my adult life and
in my relationships, I have a very difficult time asking anyone for anything concrete or if they are doing something, a friend, a spouse, in my life, if they're doing something I don't like, I'm very quick to just swallow it. They're not going to change and I just have to love them for who they are. And sometimes I screw myself there because it wouldn't be that big of a deal to stop doing something or to change something. But I never asked my mother to change anything, I never brought up the drinking, I never brought up any of the insanity. And that's how I got by there and I think I still act like that in my important relationships as an adult.

Describing the experienced effects of caretaker alcoholism on relationships did not just apply to people outside of the family; participants were asked to describe the quality of their relationships with the caretaker, to which many expressed being influenced by the alcoholism, among other things such as immigration issues, co-morbidity of mental health conflicts, and fundamental differences over such things as sexual orientation. The data of intersectionality will be described in the section *How do we do no harm?*

iv. Denial, secrecy, and normalization

Participants were asked if alcoholism was ever explicitly spoken about in the home—this question brought about narratives around denial, secrecy, and normalization. Ten participants specifically referenced denial as a form of dealing with impacts; denial meaning that it was never spoken about, never admitted to being a major influence in the family's lives. Anthony and Laura discussed denial in relation to their cultural upbringing. Anthony stated: "I would say that we were the classic southern family and if you didn't talk a problem, it wasn't there." Laura stated: "It was very much a situation where alcoholism was never spoken about, it's was not allowed to be said in my family. I think that's
true for first generation immigrants." Participant Brian speaks to how his mother denied any influence:

She had never told me that she is an alcoholic. She had mentioned that she was grateful that she doesn't have more of a problem with alcohol in light of the process that I've gone through as an adult in confronting my own alcoholism. Which is sort of difficult and in a way humorous to hear my mother say because she has a major drinking problem.

Cade discussed how denial of the alcoholism played into his own journey towards sobriety:

What I've learned about the alcoholic family or alcoholism is that the most powerful symptom is that of denial. You don't start getting better until you start removing the denial and that usually happens in layers. So if everyone in an alcoholic family in which they are, enmeshed with one another in sickness. That could be all alcoholism, some alcoholism, some codependency. Everyone was been in denial that the family is sick or any individual in the family is sick. Now, not in all cases, but I think in most of what I've learned and in a lot of cases that's the way it is and that's the way it was in my family…It's certainly, the biggest factor in allowing me or enabling me to stabilize and become sober, was facing this family alcohol disease and being in the center of being an adult child who was raised as a child of an alcoholic and I was only able to start doing that until, I wasn't able to do that until I started peeling off the labels of denial.

Going hand in hand with denial is the act of secrecy—secrecy meaning that in addition to active denial both inside the family and internally with participants' realizations that it was alcoholism affecting them, there was a certain expectation that the participants would keep the alcoholism secret from the outside world. Eight participants voiced secrecy as being a player in how the alcoholism affected their relating to the outside world. Marianne simply stated: "We had
to be quiet about it. We couldn't tell anybody." Cade similarly stated: "That's the whole complexity of the alcoholic family, you see is that the secret has to stay within the family. That's the secret, you see (pause) what goes on inside these walls stays inside these walls. So that was understood." Gayle noted:

> I don't think I thought about my own emotions about it, I think those got tucked away, under it, even sealed from me. I just remember thinking "Okay, you just can't let the secret out." I just remember thinking the importance of the SHOW, we have to put the show on, your house can be in chaos but when the phone rings and someone answers it everyone just shuts down and shuts up.

In the face of a teacher intervening when he made note to ask Dee if everything was alright at home after she described her father being drunk, she stated: "I thought it was strange and a little weird. I realized I should be more cautious on what I say. Because he asked me, "Do you feel like you're safe at home?" and I was like "yeah, I feel fine at home." So I think I became more cautious after that." Aly also voiced:

> I think I immediately thought this was very bad, don't tell anyone, we live in a place where people would be judged. I didn't want to make people think that my family was bad or my dad was a bad guy—I really wanted to defend and protect him. I wanted to protect the illusion. I bought into that bullshit. I bought into the Stepford wives thing—it mattered how you looked. A lot of that is from my mom. It mattered more to me that people thought everything was fine and good.

In tandem with the experience of denial and secrecy, 10 participants responded to the question about realizing when it was alcohol affecting their family with the experience of normalization. Participants discussed how alcoholism was normalized in their family, extended
family, and social situation because they did not know any different; in a way, it was family
culture. Nina stated: "I had other friends whose dads drank as well. I think to me being a father
figure with a beer when other people aren't drinking was really normal, it came across as
normal." And Brian: "I don't think I recognized my mother's drinking as a outlier from the world.
It seemed normal to me." Jake stated how the city he grew up in has an alcoholism culture:

When I was a kid, I grew up in ________, which is a very alcohol heavy town, it's part
of the culture. And to me, drinking was fun and it was a good thing and my father's
drinking was just as it was—just that he had a problem. It wasn't that it was the alcohol in
general that was a problem. It [alcohol] was cool. Gambling addiction, checking into
rehab was not cool, but drinking and getting drunk and passing out drunk (pause) there
was even a weird [city] culture around drinking and driving. Alright, how much can I
drink and still get away with driving home? Constantly pushing the edge. Horrible.

Similarly, Laura discussed the normalization of alcoholism within her family culture:

There is a lot of stigma in even calling it that. It's something that's normal within my
culture. She sort of excused his behavior. He would have his…I remember he had his
license taken away for a DUI and it was sort of just "oh well…wrong place wrong
time"…it was kind of normalized and de-emphasized.

For Gayle, the normalization had to do with the generation she was growing up in: "Back when I
was growing up people had liquid lunches—you know martini lunches. And that MADD
Mothers wasn't even in existence. Alcohol, there was a different connotation back that." Whereas
Anthony learned what was and wasn't normal in discussions with a friend:

What was really interesting is, when you grow up with something and you never lived
outside your home, everything's the norm. I remember when I was 11 or 12 years old and
I was talking to my best friend—she was precocious, a bit more worldly than I was—I was describing how my father would drink I think 2-3 six packs of beer a night. She made the remark "that's not normal, not everyone's parents drink like that"…that was new information for me. That was something I had to ponder on.

Darla voiced her experience about how she came to realize what was and wasn't normal, expressing how isolating this realization became:

I had to learn how to be a human being because what I witnessed was inhuman behavior. That's what I thought was normal—shocking that that was not what everybody does behind closed doors. We were exception, not the norm. People are not going to accept that. You aren't going to have anyone if you keep doing that. That is why you don't have anybody around.

The development of denial, secrecy, and normalization in this dataset seemed to be important messages throughout the interviews.

**III. (In)Direct (Non)Disclosure**

The next questions asked were surrounding the topic of disclosure. Beginning first with inquiring about the significant relationships, specifically friendships, in their childhoods, it was posed if the caretaker alcoholism was known in those significant relationships. If so, it was asked how they disclosed, why they disclosed it, and what the outcomes were. If not, it was asked why and what they thought the hypothetical outcomes of not disclosing brought. Participant answers were separated into three sub-categories: direct disclosure, indirect disclosure, and non-disclosure. Disclosure is considered as the process of telling -- whether that be directly (e.g., face to face) or indirectly (e.g., through a note; through observation) – and non-disclosure or the purposeful not-telling or keeping the caretaker alcoholism unknown. However, it should be
known that these categories are not mutually exclusive—some participants discussed directly disclosing, indirect disclosing, and non-disclosure, making a point to bring distinguishing reasons as to why. Below are these findings.

i. Direct disclosure Five participants recalled disclosing directly to friends. Direct disclosure is defined as the act of telling person to person rather than through exposure. Nina stated that she remembers talking to one friend in middle school in particular, a friend that she continues to have to this day, and a friend in high school that she directly disclosed her caretaker alcoholism to. When asked why, she stated: "Both of their dads were also alcoholics. Now that I'm thinking about it, I know that middle school friend's dad was barely around. My high school friend's dad was always at home just constantly fighting with her mom. So I definitely saw differences." Jake shared with his high school partner: "I certainly talked about it with my high school girlfriend, we were together when in his gambling phase. She was aware of the issue that we had. I'm sure with her I would say what I certainly wouldn't share with my guidance counselors."

For Darla, two of her friends were privy to everything that went on in her home. She discussed being able to be vulnerable and honest with them, that she could unload "horrible secrets" to them. Similarly, Aly participated in a therapeutic group in high school that would mentor middle school aged children, bringing theatrical psycho-educational demonstrations to younger children:

Well I was in [that group] and everyone talks about everything. We all disclosed everything. I told people about what was happening—it was an open forum. I just felt like kind of liberated, but I also felt like I could be part of a group because other people had the same problem that they were dealing with. We were a group that helped kids with
addiction and dealing with that kind of stuff. So, it was "Hey guys! I'm getting some street cred here. I know this first hand!" Yeah, so at that point I did start telling one friend and I would tell him like "Hey, all this shit is happening, I'm gonna have to crash at your place." And he was like whatever, but we didn't talk about it. It was kind of like "oh that sucks." But I had already told him because of [the group]. But he only knew because I told everybody.

**ii. Indirect disclosure** Eight participants stated that their friends and significant relationships discovered what was occurring in their household via indirect disclosure or observation/deduction. Aly described a situation where her friend found out via indirect disclosure: "Yeah, well, one time he got really drunk at a friend's house and her parents got drunk too, it was kind of a horrible experience because then like I was stuck. He left and he was drinking and driving." An outcome of this indirect disclosure was that she and her friend: "We kind of immediately grew very much closer. And I think to this day, we kind of have that like—we shared this experience, which was terrible. I think her dad punched a hole in the wall. It was like we were at a frat party with children."

Similarly for Dee: "Because she was over my house when my dad sort of had *(pause)* my dad was hungry and drunk. And he wanted me to cook this thing that I didn't know how to cook. So I went to ask him a question and he sort of blew up at me. Which happens. I had to drive her home. " And the outcome of this:

I didn’t expect anything to happen. I just felt like I had to explain it to her because it was very very awkward. And you could tell she was kind of scared…It was more like one of those situations where like, I have to explain to her what just went down. ...We never
really talked about it again. It was just….I didn't really want to talk about it. "Sorry! My dad was drunk and got angry. It happens."

Gayle had a similar experience. When asked what hypothetically would have happened if she would talk about that indirect disclosure, Gayle voiced: "I just think that I would have felt a lot of shame." For Marianne, people who surrounded her found out, but Marianne stated that they never discussed it together:

She would go out when she was drunk. We were always afraid of that. She couldn't drive, we wouldn't let her. We would let her walk. It was really sad. She looked like a drunken lady walking down the street...(in a later section) Kids found out. They found out. But they didn't embarrass us by talking about it with us.

Brian discussed how there was indirect disclosure of his caretaker's alcoholism due to their interactions when visiting his home:

So we spent a lot of time at my mother's house. My friends and I. Despite anything currently going on there with the adults, my mother wanted to have my friends over, wanted to know them. We would be upstairs watching TV and sleeping over at the house—so before I would have needed to tell anyone or talk with anyone about my mom and step mom's drinking, they all knew. They saw it. They heard it. It was just—everyone was very aware.

In terms of outcomes for his friends knowing, Brian stated:

I didn't have hardly any conversation with my friends about it. It would come up sort of unspokenly and maybe we'd get out of the house for a little while because it was getting crazy downstairs, but I definitely didn't need to have any introductory conversations.
For Laura, her guidance counselor noticed her absenteeism because she was usually showing up to classes and getting good grades. The outcome of her guidance counselor knowing was: "Uhm she tried to steer me into Al-anon and groups, like Al-Ateen," but could not get to these groups due to her father being too drunk to drive and mother not having a license. Laura discussed that some of her friends learned of her caretaker's alcoholism through the same indirect disclosure, but never had discussed it: "I just wish we had known that it was something we should bond with each other about. And that we could have peer support around. I felt like, I don't know, it wasn't worth it."

iii. Non-disclosure Ten participants spoke of non-disclosure, the active not-telling or not-discussing caretaker alcoholism with others. Non-disclosure is not to be mistaken as a phenomenon—it is a non-act that all persons participate in. People make decisions every day as to whom they want to tell anything. As Gayle put it: "But yeah, that's the whole thing about vulnerability, you can only go so far with it with certain people. Maybe with all people, some people maybe hold back 1% and others hold back 99%." Some of these participants when asked why they did not disclose parental alcoholism responded by describing a sense of denial that kept them from even thinking about disclosing. For Brian: "I don't think I knew how to acknowledge that to a peer. I don't know if I would have known to be the first person to put words to that problem." For Cade:

And that goes back to denial—I'm in denial that there is a problem and denial is developed when you know that the operating system within the unit is that everything that happens is the family secret and stays inside. And that's the stuff that makes you sick, too....So you simply answer your question, no—not only did I not tell anyone what was happening, the idea of telling one or anyone what was happening never entered my mind.
Other participants described fear of the outcomes of telling peers or others. Some described a fear of being taken away by a child welfare agency or misunderstood; Dee described this as:

As far as telling, I think there's a misunderstanding sometimes about what alcoholism is. I definitely hold the idea that you can be struggling with addiction and still be a good parent. Could you be a better parent? Yes. But I don't think that if a parent is struggling with addiction that it warrants that the child should be removed. I don't believe that.

Whereas for Anthony:

[The guidance counselor] sort of started asking if [dad] was physically abusive—I think that it caused me some anxiety realizing that, I don't think I could have articulated this, she might have had a responsibility to report something like that about it and that legal authorities would have to get involved. So I sort of backed off and sort of downplayed that.

There were also narratives about fear of the outcome bringing about feelings of shame and embarrassment. Laura stated: "I think I didn't want people to know if they didn't have to because it was really embarrassing as a kid to know that like your dad be home, might be behaving a certain way because he was drunk or because he had that DUI that was also embarrassing." For Gayle, she described the "suit of armor" she had to wear:

I don't think I thought about my own emotions about it, I think those got tucked away, under it, even sealed from me. I just remember thinking "Okay, you just can't let the secret out." (pause) It's weird to grow up and think that you don't quite fit in. Afraid to say something because someone might make fun of it.

Jake hypothesized what disclosure may have brought as:
Embarrassment would be the first emotional reaction. I went to a...my high school was a private school attended by mostly affluent people white people, I'm white, and I would have classified our family as middle class and so it was a very strong urge to fit in, I had to fight scrap to fit into that class. SO. Something like sharing about my father, well, sharing the intervention and the details of that would have been embarrassing.

The processes of telling, disclosing directly, indirectly, and non-disclosure play into the experience of friendships for many of the participants as described below.

IV. Have you got a friend?

Friendships and friends play different roles in children's lives—for the purpose of this study, friendships were viewed through the lens of what "support" participants gained in friendship when experiencing a form of dysfunction in the family. This section formulates the responses to the combination of relationship and disclosure questions in relation to friendships in childhood for the participants. When asked about friendship support, many participants answered illustrating roles these friends played, acting as subcategories of this section: escape from home; friend as the distraction; comrade in shared experiences; threat. Below are these findings.

i. Escape from home Four participants described their understanding of how their friends supported them as an escape from home—both physically and emotionally. Anthony described it as getting out of the house:

What would sometimes happen was my close friend Ann Elizabeth and her family seemed to be the opposite of mine. Here parents were always happy and always welcoming; I spent a lot of time in her house. I think that I just wanted to be out of my parents' house; they were very smart.
For Brian, his friends would take him out of the house without directly speaking as to why: "My friends really did that for me without me having to ask for anything because they knew if I got into it with my mother I was going to devolve, get agitated, and get into it with my mother." Aly described her getting out of the house with friends in extra-curricular activities as a means to cope with the home-life:

There's a family; a meritocracy. That kids getting out of school and home-life. If my home-life sucks, it's harder to be good at school. But it's not hard to be good at soccer or basketball because you show up. There's no homework. You see it in other populations especially urban populations. Nobody's suffering in the NBA because of home-life—they excelled for some reason. It gave me a sense of self, of purpose, of control. Positive feedback group.

ii. Friend as the distraction In a similar way, some participants described that the support they gained from having and disclosing to friends was a means to becoming a support for their friends, finding a distraction from their own home life. Taking care of friends brought about a distraction, "a sense of purpose," from the participants' own home-life. Kerry described her relationship with one friend who was going through an abusive situation:

She got married when she was 16. I'm sorry, 15. And uh, had four kids with a very abusive man. So we used to, used to help her try to hide and stuff...I don't know. I mean I think in ways that maybe she didn't know she was [a support] and maybe I didn't know. Maybe I thought that she needed more help than I did because she was getting the shit kicked out of her...It gave me a little bit of purpose. That I was doing something good.

iii. Comrade in like experiences For nine participants, the question of significant friendships and why they were able to disclose to peers, they answered that specific friends were
able to "understand" and "relate" to their own experiences with caretaker alcoholism. Marianne described the unsaid connection she had with one of her friends: "I think her father was and alcoholic and neither one of us talked about it. But we were good friends—consoling to each other without even talking about it. My mother drank, her father drank." Kerry stated:

I think it was just she was somebody I could talk to and say "this is fucked up" cause when I was 11 I wasn't allowed to say fuck…and I could say to her "this is really fucked up" and I could talk to her and I could say it the way I really wanted to say it. And she talked to me about her crazy mother…who didn't drink but she was really crazy. So we both came from dysfunction. Just different kinds.

For Jake, talking about alcoholism wasn't a means of "gaining support," but was something that he and his friends could relate to: "Other kids, other parents, it was just part of the culture":

The fact that my father drank was that was just actually part of the culture. That was a stigma. I mean everybody's dad drank in high school. High school kids drank and that was pretty well understood. Drinking was actually kind of a joke. People liked to joke about their parents…(pause) things are coming up now. Like we used to, it was almost a lot of pride of how much you could drink in [our hometown]. We used to tell this joke, a fucking story about how my dad had this way of sitting on the couch and passing out and still not spilling his drink. It was this hilarious joke that we would always tell. It was like another addiction.

Similarly, Laura described:

I mean I had pretty strong friendships in high school—I was myself a teetotaler, I actually avoided substances straight through college I think partly because of my experiences as a
child, being around that environment. So I gravitated to peers who were also non-substance users, or very, very light and occasional substance users. I just didn't feel comfortable hanging out with kids that were using…

*Did these friends know about your father's alcoholism?*

Some of them did, some didn't, some of them were in a similar situation as me in that they were also first generation or immigrants themselves and culturally you would never call it alcoholism. I think that I wouldn't even have done it at the time looking back and in retrospect. You know? They kind of knew, oh my dad drinks—my dad too!

**iv. Threat** Three participants discussed the threat that having friends posed. Darla voiced that she was discouraged from having friends, labeling the disease of alcoholism as isolating. Her immediate family "cut off" their extended family. She found that it was hard to keep friends not only because she was discouraged to do so, but also the fear that her friends would be exposed to something humiliating and embarrassing in her caretaker's alcoholism. Similarly, Dee described her experience of being "protected" from the outside world, encouraged to keep friends at bay and not bring them home. She stated: "If I could make it through the day without being noticed, I figured it was a good day." Cade described his lack of intimate friendships as:

> I think that it was a matter of not developing because it meant that [friends] would be exposed to my alcoholic family. And so I guess, I think that was more of a subconscious thing as opposed to—I know it was. I never thought consciously that I want to keep these people at bay so they're not exposed to my family. But looking back I believe that there was a certain subconscious dynamic on my part to keep them at bay so that they would not come in contact with my alcoholic family. Or at least that contact would be minimized as much as possible…(*pause*) There's probably even something more
profound than just that—which was that you don't want to have to happen to them what happens to you. The solution to that problem is to simply not come around.

The various responses show the wide range of influence that alcoholism, stigma, and policy (in terms of child removal) can have on children's development of friendships. This will be further expanded upon in the discussion chapter.

V. **How do we do no harm?**

One of the last questions posed to the participants asked about hypothetical needs—what they think they could have used as support in their experiences. Participants both added onto what they had already given freely, discussed if groups were offered to them as a support, and were posed with the hypothetical treatment of COA groups. All participants addressed this hypothetical needs question, speaking to at least some of these sub-categories: curriculum past and improvement; need for validation; experiences of intersectionality; groups offered and potential benefits; conflict of gaining support. Below are the findings.

i. **Deficits of past curriculum and suggestions for improvement**

All participants answered the question "What are your thoughts on peer pressure, school curriculum/classes on alcoholism?" when reflecting about how they felt or knew about alcoholism in childhood. Some participants stated that they never experienced classes on addiction or alcoholism. Maureen stated: "There wasn't any health class. No nothing. No health class, they never talked about it. They didn't do anything. There was never any communication about it at all." Others stated that their curriculum in school was more around avoiding drugs and alcohol. Jake voiced: "Yeah, our school was really good about that, I remember two specific classes, one that was on "Skills for Living" 6th grade so I guess about age 12. It was really around peer pressure and the effects of
alcohol, drugs, smoking all those things; there was definitely one class on that." Brian similarly put:

I do remember, uhm, health classes, the classes that involved drinking or substance abuse—middle school classes—most that I remember is that we weren't supposed to use chewing tobacco. I thought that class was really pointless. Then in high school there was a health class that had to do with alcohol and drugs.

Nina, Laura, and Aly discussed their experience with the program D.A.R.E. (Drug Abuse Resistance Education) aiming to prevent drug abuse, gang involvement, and violence. Laura stated:

Oh my gosh yes, I remember taking a D.A.R.E. class. And I remember it was kind of goofy. Taught by a cop what age...I was in seventh grade, I'm pretty sure. 11 years old. They didn't really talk about having the experience of having alcoholics in your family or being related to alcoholics—they just really really focused on keeping the kids away from drugs and alcohol. Using scare tactics, the authority of the PO. Overall at the age of 11, I thought it was sort of a goofy experience. I'm not sure I got a lot out of it.

As mentioned in the Experienced effects section, Aly was the only participant to describe her experience with school curriculum as something that instilled fear for a reason other than avoiding drugs and alcohol. Specifically in her experience in the D.A.R.E. class where alcoholism was lumped in with multiple other things such as sexual abuse and heroin use, she described being "honed" in on that dialogue and fearful.

Participants Aly and Jake described programs that were in their school that involved peer support. Aly described the program "Journey" as one that involves high school students making

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presentations to middle school aged students: "We were a group that helped kids with addiction and dealing with that kind of stuff." Jake discussed the class called "Peer Support":

And then in 8th grade we had something called Peer Support where seniors in high school would spend one lunch day a week with a group of eighth graders to get some visibility on what peer pressure was about and things like…You know at the time it was very hard to, you're just learning how to deal with things as they come, but I do believe looking back that having more information probably allowed me to make smarter decisions. I don't really know if I would have made different decisions. I can only imagine that I felt more informed and able to make better decisions.

In being asked about hypothetical needs as a COA, some participants made note to mention improvements on curriculum. Jake described his suggestion for improvement as: "If there was some way to get some perspective to say this isn't normal, on what's normal, to be able to say "oh wow, this isn't normal" that would have been awesome." Brian argued how his classes could have addressed what was going on inside the home rather than in avoiding drug and alcohol use:

In terms of school or health classes, I don't remember any class talking about if there's drinking in your home, if there's drug use in your home. I remember health classes and those sorts of things were entirely why YOU the child shouldn't smoke cigarettes and why YOU the child shouldn't do drugs. I don't remember any class asking me to consider are you in a home where there's drinking or drug problems and (pause) I was even getting into some trouble growing up as a kid. And counselors and teachers had lots of opportunities to have long conversations with me. And I don't remember that really coming up.

For Aly, the improvement on curriculum could be to inform children in a different way:
I think the challenge is always that people want to stay impartial. And there's either the people that are just being a therapist, I'm just here to listen. And then there are people who like kind of get dramatic about it. And they give you stories that are a little foreign like—we hear about crack. They've probably changed this a lot, but when we were younger it was about these violent criminals, extreme cases and it was fear mongering and effective with me because I never did anything as a result because I was so afraid of it, but there was also this like "White people trauma" or "white collar" addiction that isn't as easy to understand and I wonder if there had been a bit more, if I had had more information like fact based evidence, evidence based, but then also had something to do…

Though some participants stated that alcoholism was never talked about in school, some participants make note to mention what was missing in the classes they did have—specifically about alcoholism in the home.

ii. Need for validation When asked what participants could have hypothetically needed to support them in childhood, six participants discussed the need to be noticed and validated. Gayle described it as: "Emotional support. To be listened to. To be heard." Dee made note to say: "I think compassion goes a long way. Remembering that they're not kids in the same way that other kids are kids. They've seen things, done things; they've taken responsibility for things that some adults don't even take responsibility for. I used to meet people and they would describe me as an old soul. I don't think I am. I just think I adapted to the situation.

Similarly, Darla discussed how she was good at "putting out a great front" by staying under the radar. She accomplished many things. She stated: "I think it's hard to look at a kid like someone
like me and think they have to reach out to me." She went on to say that she needed someone to really notice, to pay attention to her type of sadness, one where a kid is not acting out, but is quiet. For Cade, he stated that he needed the school to notice and for him to be removed completely, but to start with recognition:

But I think that's a start that the school could recognize that there is alcoholism in the family and then I don't know what the law is—and that may vary from state to state as to what options the school and state agency or two together has.

Many discussed validation and "being seen" as what has helped them process their childhood experiences in adulthood and these six participants made note to say that it would have been helpful to have that experience in childhood as well.

iii. Attention to intersectionality Some participants answered questions around hypothetical needs and other questions about their childhood by describing different forms of intersectionality that perhaps had caused conflict and confusion in addition to the alcoholism. Eight participants mentioned some co-occurring experiences—it is important to note here that no question addressed intersectionality, so these responses may not account for the experiences of participants fully. The findings are presented as what was brought up by the participants that they discussed as influential, conflictual and /or confusing. Brian and Nina mentioned being raised by single mothers by way of divorce and what that meant for them to also have alcoholism in the family. For Dee and Laura, they discussed their experiences with first generation immigrant parents and the confusion over facing the alcoholism. Dee voiced: "But it's hard to say whether it was the drinking or the fact that he was being faced with deportation. That was really hard. That's when I kind of realized "oh, this isn't the norm." Both in that I became aware that I was actually really Mexican and that my friend's fathers weren't the same."
Laura discussed how calling her father's drinking "alcoholism" was problematic in her culture as it was the norm. Discussing the alcoholism with a family member posed a problem:

It was very much a situation where alcoholism was never spoken about, it was not allowed to be said in my family. I think that's true for first generation immigrants. There is a lot of stigma in even calling it that. It's something that's normal within my culture.

Participants discussed a wide variety of factors aside from caretaker alcoholism that were formative in their development including caretakers' co-morbid addictions to opiates and suicidal ideation, sexual abuse, living with a disability, sexual identity marginalization, and struggles with personal mental health issues. For Aly, the alcoholism coincided with her caretaker's co-morbid addiction to opiates and suicidal ideation. He attempted to end his life twice, once when she was an adolescent and once when she had assumed the role of caretaker in her adulthood. Kerry discussed being a sexual molestation survivor in addition to being disabled. Gayle expanded upon her own struggle with depression as something that has influenced her processing her childhood experiences:

Being treated for depression (crying) I did two outpatient things, sorry, at ---- this [year].
I lost my job in September, I just hit rock bottom for three or four weeks. I think that even hearing people's stories there and some people do have substance abuse and all that stuff in the program, there's still this sense of support and I feel that same way with the group that I meet with on Thursday nights.

For Anthony, his identity as a gay male greatly affected his experience with his caretaker:

When I was like 11 or 12, he told me "Son, the lowest thing you can be in the world is a queer." I remember not saying to him, but knowing, "Well I think I'm gay so if I am the lowest thing you can be in the world, what does that mean?"
Intersectionality of both the caretakers and participants seemed important to note for these participants in describing their experiences. Much of the literature reviewed for this study made note of the limitations in their studies in representing the full experiences of families affected by alcoholism. Some future implications for research included the need for research to dive deeper, become more specific in looking at intersections of identity as compounded influencing factors in development. It begs the question: how can social work practice can account for the intersectionality in providing specific supports without doing harm? This will be later addressed in the discussion section.

iv. Groups offered and potential benefits Very few participants mentioned groups offered in their childhood. Participant Dee's sister attended Al-Ateen. Brian stated: "So I don't know where those were, I don't know if they existed." Jake and Darla discussed taking part in their caretakers' rehab programs by going to family week and family groups. Darla stated that the participation was a great experience learning about the disease concept. She described it as a good foundation for what she would go through in her adulthood struggle with her own addiction. Jake described:

My dad, when I was 17 and he was in rehab, and they had sort of support groups like that—that felt really awkward. Especially because I didn't want to be there. I had denial around that. Hey. I'm embarrassed about this whole thing the last thing I want to do is engage and be part of this being different thing.

However, when Marianne's mother was brought to programs such as these, she experienced something different: "When she was in the hospital, they didn't do anything with her, really. They just gave her medication. There was never any involvement. Never went to AA. Never any Al-Ateen or anything. There was nothing."
When posed with the question: "What do you think about peer or friend groups such as Children of Alcoholics or Adult Children of Alcoholics and Al-Anon in dealing or supporting children with caretaker alcoholism?" there was a wide variety of responses. The conflicts of gaining support through these groups and through other means will be brought to light in the next section. In terms of benefits of these groups, Gayle stated:

So I think kids should be taught how to meditate, go for massages, learn how to talk about how they feel about things. Maybe Al-Ateen, I think that would have been very helpful, I'm in this adult thing ACOA and it's hugely helpful. But had it presented itself or come to fruition, I think I would have benefited from it...I don't feel like there's anything bad about it. Like giving someone a hug that you don't know well because the bond is already established. Telling their truths.

Laura described the benefits of a group, offering insight on what could be needed:

And I think maybe at that age doing very, very, very, very early work to just tell kids about alcoholism—not in a sort of D.A.R.E. way of stay away from drugs—but just in a sesame street way. Yes this is an issue that happens in families, and it's not his fault, and if you want to talk about it to someone, you can go to the guidance counselor and we'll have groups with other kids that are dealing with this issue...everything there is confidential, you don't have to worry about your family getting angry with you about airing your dirty laundry (pause) and offering these kids maybe coping mechanisms to kinda distress and find...I don't know; I want to say like a peaceful place within their home that they can go to. Not even physically. Just you know some sort of de-stressing methods they can use when your parents are fighting when your parents are drunk or
some boundaries you can use about relatives that are drunk, but what happens when they start verbally or physically abusing you.

Aly and Nina stated that they could have used a group such as COA or Al-Ateen in order to begin the work they have started in adulthood earlier. For Aly, groups would partly be useful to make a support system: "I also think the participating in therapeutic activities and making sure they have support systems and have all the activities to do so they don't just go home at the end of the day—they get support systems they need." For Nina, groups would have been beneficial to give a support system early:

   And then I feel like, bringing it out in the open and getting me into some kind of program like Al-Ateen, might have been beneficial. I feel like it all came up…I've always been putting people first and seeking other's approval but it never meant anything to me. It was just kind of like my character and like now, being an adult and experiencing that in adult relationships. Ends up being so much more. I think I could have started working on this stuff a lot sooner.

   Succinctly, Marianne put it as: "That would have made all the difference in the world—I wouldn't have been alone."

   Jake stated a consideration in making it accessible and beneficial for kids—bringing college kids into a room with adolescents to discuss drinking, parties, and college in a way that will help adolescents talk about their families similar to the Peer Support group he participated in. He would then add a sort of "shocker effect":

   …but then almost turn that around at the end of the sessions and turn it into some cold hard facts. Maybe even some sobering stories. Which is a little bit of a shocker, shocker effect, but it might be a good way to get kids in a group environment talking about
drinking because they think it's cool and fun and then more willing to open up about it, but then, they've developed a respect for these college kids who are also cool and fun and outgoing, but because they're older they have an opportunity to be teachers and mentors. Turn it around and be like, have you guys ever had to come across this or deal with this, to be there for support. I could see that being, that would have been helpful for me.

Anthony made his "mission" to begin groups in his area for the adult children in his Alcoholics Anonymous group because he found benefit in processing not just their own sobriety, but the experiences they had in growing up around alcoholism:

So many people [in Alcoholics Anonymous] talk about alcoholism in their families when they were children and so many of those people aren't in ACOA recovery. But it's obvious that their childhood experiences have really had a profound and significant impact on them. And to know I guess my…take is that there are a lot of Adult Children out there who grew up in alcoholic homes that scarred them and left them debilitated and people aren't willing to talk about it. And so I basically started a meeting at this clubhouse, been over three years from 10 to 50 people wow I kind of feel like it's my mission to talk about this because a lot people aren't and I also want to see that the people who come to ACA and do the work and it gets really painful and a lot of times people back out because it's just too overwhelming. So I sort of feel like I need to be in that community and be strong and encourage people and let them know that things will get better.

The perspectives of these participants include support for groups such as COA and ACOA, however there were also instances of challenges that were brought to light in talking about these groups and gaining support in general.
v. Challenges of gaining support All twelve participants stated that there were challenges including internal conflict to disclose, lack of available and prepared adults, and availability to attend support groups etc. in gaining support. Darla described a challenge to gaining support as an internal conflict, finding issue with discussing or divulging the family secret in order to get support. She described how her caretakers didn't like secrets getting out, didn't like Darla being in therapy. Dee succinctly put her challenge of attending groups as being compounded by having to define the alcoholism as a problem in the face of normalization and her family's struggles with immigration:

My dad is also a non-documented immigrant…So remembering that you're classifying this as a problem. The kid doesn't know any better. To them it's my family. I love them, they love me, this is how we function. I didn't think it was a problem when I was a kid. Granted, now I can look back and realize that was real shit.

Brian also described this struggle to define the alcoholism or acknowledge it as a problem without other adults stating it as so:

Maybe they could have helped me some, but somebody would have needed, some adult would have needed to talk to me. Because I was only sort of grasping that there was a drinking problem, that alcohol was the cause of a lot of this sort of chaos and screaming and fighting and needing to leave the house. So I was not going to make the leap to like find an Al-Ateen group.

Anthony described the challenge of acknowledging the problem as one of generational differences:

My mother was a highly educated woman who was employed full time with her own job and why at a certain point did she not say to my father "you need to stop hitting your
child and drinking or I'm leaving you." She didn't do that. And there are several things: my therapist who is about as old as my mother has told me that women were not supposed to rock the boat, they were just supposed to have a home and make it work 40s-60s when I was growing up.

In terms of the challenges faced in disclosing to a support group, Jake and Nina described that clinical groups facilitated by adults or professionals can bring about a guardedness about divulging family issues. Jake stated:

It's almost like you have to have a, I don't know, a teacher, or someone between high school kid and a professional that can be in that room and almost be a fly on the wall and then like bring the kids aside later and kind of bring it up. A) you can hear each other talk about things. It just has to feel safe and that's the hard part. As soon as you have an adult facilitating that, the people start feeling guarded about what they share.

Nina brought it back to disclosing to peer friends versus professionals:

And they definitely don't want to talk about it with anyone in the professional area. It's so hard to talk to a professional, but when they have the comfort of knowing it in a therapeutic group. I see it at work all the time. I mean, more so that they would rather confide in one of their peers. Like who is their roommate in residential. Someone like that. Rather them and their friend when they're out in the community than trying to get help from a professional who may not understand.

Anthony brought up a similar fear about the preparedness of a professional leading the group—including attention to trauma and development:

I guess I also worry—I'm not sure what you were envisioning if the group would be facilitated by a therapist or a 12 step model, which it's a group giving, sharing experience,
strength and hope. I did think that if there were a group of younger people sharing experience strength and hope, is there going to be somebody there who has the knowledge with how to deal with trauma and people coming into their own development as they grow up and all those factors that can play into how someone responds to living in an alcoholic home.

Other participants described the difficulty in actually physically getting to support groups. Darla didn't know how she would have gotten to any type of support as there was no support for her getting there. She stated she could have used something that contradicted the negativity and made sense of the things in the home. Laura similarly stated:

I think it would have been great if I could have gone to a sort of event or group in my school that I didn't need to travel to. It's really annoying that we expect kids to get these sorts of interactions or resources, but we kind of expect their parents to take them there when often times it's their parents that are part of their issue. So if my guidance counselor told me that we're starting a small group here in the school Wednesday afternoons for other students who might have similar issues for you to talk about that. The school may not have been large enough to have that many students, but that would have still just been phenomenal.

Similarly, Aly stated that it would have been difficult for her to approach her family to bring her to a group:

I feel like the schools are so big, why not have a group for kids like Al-Anon at the school. I remember looking for Al-Anon meetings and it would be at a police station on a Tuesday night so I'm going to have to ask my mom to go and she'd be like "what the
fuck?!” That creates some kind of conflict but as soon as I sat down at the Journey groups and people talked about their families, I was like "oh, okay. This is good."

In a similar way, Kerry put the challenge of attending a support group in terms of facing her parents with her own feelings:

If you're talking to the kids, are the parents going to let them go to something like that? Or would they be able to put it into the school system somehow, I don't know. I know when I was a kid my mother wasn't going to let me go to a place that was going to talk about her. Even though it wasn't talking about her, it was talking about or would have been talking about how I felt.

The challenges in gaining support pose as barriers for children of alcoholics and the peers who may want to support them. The challenges are internal, entrenched in family culture, and situational in terms of access to resources. For peers who may want to support the children, there may be a similar attention to such barriers, which may provide an implication for future research as explored in the discussion section.

Summary

Results from findings provide evidence that children affected by alcoholism have a wide variety of experiences when it comes to disclosing to peers and gaining support. Some relevant expected findings include the normalization of alcoholism in a family due to outside factors such as intergenerational alcoholism, denial, and cultural factors. Key findings in this chapter include participants' overwhelming response to the support they gained from disclosing the caretaker alcoholism and home-life to peers with similar experiences, the support they could have gained from COA groups, and the multifarious challenges in gaining such support.
There were also unexpected findings that were not observed in the literature reviewed. The notion of normalization being extended outside the family was unexpected—Jake illustrated that the normalization was extended into his geographical region. Aly's experience with her school's curriculum "fear mongering" tactic played a part in developing her fear of alcoholism, her role as the caregiver and savior was also unexpected. Some of the participants also had a visceral reaction to when narratives led to a discussion of alcoholism as a "problem" or that they had something to "disclose," some making note of how stigma can affect the depiction of families of alcoholism. Using the word disclose carried weight for some of the participants, enlightening the researcher to the notion of how limiting, influential, and assumptive this word can be—it is perhaps making an assumption that children of alcoholics cannot cope without disclosing.

Further discussion of the data and literature review comparisons, implications for social work practice, and the conclusion of this research study is developed in Chapter V.
CHAPTER V

Discussion

It is well recognized in the literature reviewed on this topic that a caretaker's alcoholism can impact a child's mental health including behavioral and emotional distress, depression, anxiety, substance use, and hyperactivity as compared to their unaffected peers as well as impact family dynamics and roles (Eiden, Colder, Edwards, & Leonard, 2009; Kroll, 2003; Moore, McArthur, & Noble-Carr, 2011; Price & Emshoff, 1997; Sher, Walitzer, Wood, & Brent, 1991; Wegscheider-Cruse, 1989). This qualitative study aimed to address specific gaps in literature such as 1) how children of alcoholics (COAs) mitigate the impact of alcoholism including family dysfunction by utilizing peers and friendships and 2) how social work practice can or does contribute (if at all) to these relationships. In order to fill these gaps, the study was undertaken to gain perspectives from adult children of alcoholics (ACOAs) on disclosure and needed support from peers in childhood.

The findings from these interviews provide data that compare well to the findings in the literature review. Eliciting various ACOA perspectives, rich narratives were evoked on the challenges and barriers to gaining support through peers and outside sources. While doing so, the data also established different roles that friends played in supporting the participants and revealed the very influential determination of like-experiences as a factor for disclosing and feeling supported. These findings can be greatly useful for social workers, psychologists, guidance counselors, school curriculum developers, and other helping professionals to expand
the current practices of interventions for this often poorly attended to population and broaden the understanding of what a child of an alcoholic needs in order to feel supported. Key findings of this data are discussed below considering the literature reviewed, applying theoretical frameworks, addressing limitations, biases, and strengths of the study, implications of the findings for future research and social work practice, and a summary that will conclude this chapter and study.

I. **Key findings and connections to established literature**

Responding to the questions about if and how caretaker alcoholism impacted their childhoods, all participants substantiated the presented literature in some shape or form. All supported the notion of detrimental effects of experiencing caretaker alcoholism on relationships. There was an establishment of different roles childhood friends played in coping and an overwhelming preference to disclose to friends with like-experiences and non-disclosure of the family "secret." Benefits and deficits were laid out when posed with a hypothetical intervention of COA groups while highlighting suggestions for improvement of curriculum to include attending to alcoholism in the family. There also was great attention to the challenges or barriers to gaining support that included distress in disclosure and fear of stigma. One important foreseen finding was the emphasized inattention in helping professions to intersectionality for these participants or intersections of disenfranchised groups, of risk factors (e.g., co-morbid caretaker diagnoses, trauma, poverty), and of identities (racial, socio-economic, religious, etc.). Below is an analysis of these key findings.

i. **Experience and roles: long lasting coping and relating** Many participants' experiences could be similarly categorized in the themes presented in Kroll (2003) such as denial, violence, fear, chaos, family roles, impact on attachment, and the long-lasting effects that
were felt in adulthood. An integral finding for this study was how the participants described the impact of living with caretaker alcoholism on navigating relationships—friend, amorous, family or otherwise (Schwarz, B., Stutz, M., & Ledermann, T., 2012; Sher, K. J., Walitzer, K. S., Wood, P. K., & Brent, E. E., 1991). Kroll (2003) pays particular attention to the development of roles in dysfunctional families as described by Wegscheider-Cruse (1989), extending beyond childhood. Eight out of 12 participants described different roles their family members or they played in childhood to mitigate family chaos caused by alcoholism and how it has impacted their adult relationships. Some used specific language such as "scapegoat," "enabler," and "caregiver," terms often used in describing the maladaptive shift for families of alcoholism.

These eight participants confirmed that the roles continued through adulthood. For example, Darla was the hero, playing out perfection in public and private in the face of dysfunction, but riddled with self-doubt (Wegscheider-Cruse, 1989). She commented on how despite looking perfect on the outside as a child with good grades and accomplishments that brought value to her family, no one noticed how her shy perfection could be due to dysfunction in the home. Filled with self-doubt, she continues to question why she "turned out more resilient" than her brothers, experiencing "survivor's guilt" that leads her to mistrust and avoid adult relationships, continuing the isolation that her parents instilled in her. This role was a coping mechanism. It was what developed over time to protect their family from the outside world and allow room for positive family values while her caregivers "created chaos."

It is important to note that the literature argued that though a family affected by alcoholism is strained under normal circumstances creating a maladaptive shift in family roles, development of roles is not atypical in family structures (Black, 1982). When discussing roles they played, many participants made it a point to remind the researcher that the development of
roles in a family is a normal process despite feeling that these roles may have formed through a maladaptive mechanism. Dee emphasized: "This is normal, this is life, this is how families work." In a way, the development of family roles is a relatable adaptation that this population has to their non-COA peers—that is to say that in the face of realizing that alcoholism is not the norm, the realization that all persons play a role in a family is something that is relatable, unpathologized, and "normal" (Vernig, 2011). This notion could be used in interventions for COAs and their non-COA peers—finding relatable aspects can prove to be useful for disclosure and trust as discussed below in camaraderie in like-experiences.

An interesting observation not reviewed in the literature explicitly emerged: how many realized that throughout development, they became attracted to people with addiction. One participant stated why he thought this was so: "It's something like that second ordered effect—I'm comfortable with the behaviors or understandings of people who have been dealing or had alcoholism in their lives." For many of the ACOAs, romantic relationships with addicted persons or with recovering alcoholics had a relatable and familiar comfort, a factor in disclosing in childhood as well. In a way, being attracted to persons with addictions creates space to continue identifying in the roles developed in childhood under the strain of alcoholism. The relationships with addicted persons in adulthood pose no threat to changing characterological aspects of ACOAs, perpetuating what some participants described as unhealthy relationship patterns and what others described as a comfort. Seven participants specifically stated that they have experienced amorous relationships with people struggling with alcoholism and drug use as well as being currently involved with other ACOAs or recovering alcoholics. Kerry married a recovering alcoholic, meeting her husband in Alcoholics Anonymous. Jake married a woman
who identifies as an ACOA: "In some ways my wife and I are able to connect very well because we both have very similar issues with parents, that's a positive out of that."

ii. The importance of friendships

In speaking about roles, friends played specific roles in coping for children of alcoholics, confirming a gap in the literature on the understudied and underutilized population of friends that social work practice needs to attend to (Bagwell, Newcomb, & Bukowski, 1998; Berndt, 2004; Rose, Schwartz-Mette, Smith, Swenson, Asher, Carlson, & Waller, 2012; Schwartz, Stutz, & Ledermann, 2012; Swenson & Rose, 1999). The coded data were broken down into the escape from home, friend as a distraction, comrade in like-experiences, and threat. All participants supported the hypothesis that friendships or the lack thereof has impacted the development of coping and social skills (Berndt, 2004; Berzoff, Flanagan, & Hertz, 2011; Davies, 2011). This is not a new notion, but it does fill a gap in the literature on how to support COAs in the attention to development and use of friends for support.

Eight participants illustrated the invaluable support system built by having friends and the influence on their coping with dysfunction in the home. Whether through extra-curriculars as with Aly's sports, Brian's friends who helped him escape his home, Lola's camaraderie in abstinence from substances, Kerry's distraction from her own chaos in helping others, and so on, each of these participants made a point to describe how their friends were useful and integral in building the supports that they did not find elsewhere. In tandem with these observations, the eight participants made a point to discuss how the school can be involved in encouraging these friendships, encouraging these supports as a means to cope. Perhaps with an attention to providing groups at the school, friends can be more a part of the intervention process, offering a means for support, not stopping at disclosure. This will be further discussed below.
An interesting observation in looking at the demographics of the population: the four oldest participants were explicit in discussing their lack of friendships and how that impacted their supports later in life—the notion of isolation in childhood continued on in their adulthoods, affecting their friendship and amorous relationships and building a family. There are generational differences in the value of friendships though this study is unable to necessarily specify why. It is a question for further research: what impacts the value that is placed on friendships and encouragement of increased independence when comparing younger and older generations? Was it school policy? Was it a change in societal perspective? Was it development of further research on the value of friendships in developing social skills or in diagnosing? In tandem with the evolution and increase of diagnostic criteria found in the *Diagnostic and statistical manual of mental disorders: DSM-5™* (2013) for peer interactions and social and personal functioning, Bernt (2004) emphasizes the "dramatic increase in knowledge about children's friendships, their development, and their effects" (p. 219) over the last half century. It is difficult to pinpoint exactly why, but it is an interesting finding for this study in representing the differences in generational perspectives.

**iii. Theoretical analysis** As far as gaining support from friends, nine participants confirmed that disclosing to a peer that was able to relate in terms of like-experiences such as caretaker alcoholism or family dysfunction provided comfort, an outlet for consolation, and validation in their sameness. Applying the self-psychology framework, this validation and mirroring of sameness potentially promoted cohesion and internalization of the twinship pole in the face of shame and chaos disrupting the organization of the tri-polar selves (Berzoff, Flanagan & Hertz, 2011; Hadley, Holloway, & Mallinckrodt, 1993; Kohut, 1971, 1977). These data confirm the utility of the theoretical perspective of self-psychology, offering a consideration that
the role of the friend can be a resource to find sameness, balance, and a positive intervention in such things as COA groups. As Darla put it, "I think it takes a very dark soul to understand a dark soul."

An interesting finding in fleshing out the "sameness" factor in disclosing, for the four participants from Texas, there was a "sameness" found in their emphasis on family and geographical culture of active denial. For Dee, the active denial or non-disclosure had to do with having an undocumented caretaker in addition to the normalization of alcoholism around her in her family's Mexican immigrant culture. For Anthony, there was a fear of breaking the "conformity and sort of Southern middleclass bourgeois values" that was described as understanding "that things should look good on the outside in the public and you should have a certain polish when you approach the world." For Cade, denial was a family "sickness" that led to him not even having the thought of disclosure enter his mind. And lastly, for Darla, denial of the problem was hand-in-hand with both her role as the "hero" with the outward perfect appearance and the forced isolation from her caretakers, cutting off extended family and discouraging friendships for fear of exposure to their alcoholism.

Three of these participants actively go to Alcoholic Anonymous groups where they have found support in that sameness. In Anthony's experience, "So many people talk about alcoholism in their families when they were children and so many of those people aren't in ACOA recovery," which led him to develop a ACOA support group that grew from 10 to 50 members over three years, a program for people to share "experience, strength, and hope." These participants found comfort in the sameness of denial in their support groups. Does a Boston COA have a similar experience with denial compared to a Houston COA? What would be interesting
to flesh out in future research are the differences between family, situational, and geographical culture of denial.

Those participants who discussed the lack of friendships in childhood illuminated how a caretaker's alcoholism influenced this lack—Kerry, Cade, Dee, Maureen, and Darla specifically explained how having friends posed a threat to their keeping the family "secret," a threat that could lead to feeling shame, feeling exposed, and feeling as though their part in denying the family experience would be uncovered. Ten participants discussed the active not-telling or non-disclosure of caretaker alcoholism with others. When applying the distress paradox theoretical framework to these experiences, these ten participants confirmed that though disclosure could have had potential benefits in relieving distress, facilitating insight, or affecting interpersonal relationships in a desired way, disclosing could have exacerbated distress, causing feelings of guilt or shame (Kennedy-Moore & Watson, 2001). As Laura put it:

Obviously, looking back now the cathartic and therapeutic benefits of it could have been fantastic, but I don't think I could have seen it as that at the time. And that we could have peer support around. I felt like, I don't know, it wasn't worth it.

In terms of feeling shame, the disclosure of caretaker alcoholism to a peer or friend would mean that the view of alcoholism could not be controlled. The very act of disclosure would be bringing the unpredictable views and actions (potential interventions including removal via child services) of others onto their family, potentially igniting that shame and embarrassment of difference and struggle. When asked about the hypothetical outcomes of friends knowing, many of these participants stated with absolute certainty that judgment would be brought upon their family. The distress paradox accounts for both the very cathartic benefits of disclosure Laura spoke of and also makes note of the risks involved. Active denial and non-disclosure keeps
those risks of shaming, judgment, and embarrassment at bay. The threat that friendships pose to this group involves the potential threat of distress with shame, which greatly outweighed the potential benefits for them. Active non-disclosure and keeping few or no friends left some with a sense of control of the situation that they may not have if others are involved.

Another form of potential theoretical analysis presented in the literature review was DiClemente and colleagues’ (2004) Transtheoretical Model, addressing the process of intentional behavior change in addiction treatment. Reviewing this process of behavior change in addictions treatment, I posed in the review of the literature that this model of change could be applied to children disclosing caretaker alcoholism to a peer. For those who did disclose directly to friends, it was asked if they were looking for specific outcomes of this telling. For some participants it was an act of finding someone to provide an outlet for unburdening or for finding sameness. The act of telling for these five participants was potentially in hopes to gain something different than what they already had in experiencing caretaker alcoholism, though not explicitly stated in the narratives. In a sense, these participants were proactive in the Transtheoretical Model for change, going from pre-contemplation where there was little interest in change, to a contemplation phase where they weighed the risks and rewards of disclosing, to a preparation phase of telling others, to action or implementation of the plan to disclose in order to gain different results than what they were experiencing.

It is important to note, however, that only five participants discussed disclosing directly, playing an active role in changing what they experienced and what they wanted to experience in coping with caretaker alcoholism. The participants did not directly state that they disclosed to friends in hopes of change of their home situation or the addiction their caretakers struggled with; it was more a change in creating a support system around them, offering a change from
internalization of behaviors and chaos to outwardly producing support. The *maintenance* phase is one where there is new normative behavior experienced. This phase could be offered as a framework for those participants who actively changed the normative behavior of "don't talk; don't trust; don't feel" (Black, 1982) by disclosing to their peers. DiClemente et al.'s (2004) framework for addictions treatment could be similarly adapted for children of alcoholics producing change in maladaptive behaviors.

Despite the utility these theoretical frameworks offer in understanding friendships and disclosure for children of alcoholics, it is important to note the importance of active interventions and attending to these findings in curriculum. It should not be up to COAs to increase the number of disclosures to friends or others in order to get support—in the words of Dee: "Again, it's expected for the child to recognize the problem. I didn't know it was a problem until I was a grown up." It is through the practice of social workers and other helping professions to mitigate the challenges, stigma, and the safety concerns faced.

**iv. Make school a safe place** These theoretical observations go hand-in-hand with the current models of treatment, interventions, the hypothetical benefits of COA groups, and improvements offered on school curriculum. Many discussed the benefits of groups found in adulthood such as Alcoholics Anonymous and Adult Children of Alcoholics actively disclosing and being proactive in changing behaviors and responses to outside stimuli—something they argued was more difficult in childhood than adulthood. As Anthony put it, in his organizing the ACOA group in his area, he found it his "mission" to be the supportive element in changing—being part of "that community and be strong and encourage people and let them know that things will get better" as they learn to disclose and process their experiences on a regular, maintained basis. For children, however, there is a need to account for the fear of being judged or fear of
bringing judgment upon their families. Much of this fear of being judged could be accounted for in alcoholism stigma as it is presented in curriculum.

Eight participants expanded upon the lack of curriculum around caretaker alcoholism in their schools, advocating for education as a means to decrease stigma. Those who stated that there were no classes on addiction or alcoholism were of the older age group (40s-70s). Those participants in their 20s and 30s confirmed the reviewed literature around curriculum in schools being limited to talking about avoiding drugs and alcohol rather than promoting education of students, teachers, and professionals on what families with addiction experience, the signs, how to cope, how to communicate, and how to provide support (Kumar, O'Malley, Johnston, & Laetz, 2013).

Avoiding teaching what alcoholism looks like in the families and only presenting how to avoid becoming an alcoholic or drug user elicits stigma outright. The curriculum described by these younger participants only offered a means to avoid becoming part of a struggling population, one that is riddled with harmful effects. Aly described some of this curriculum as "fear mongering" as it presented causation from alcoholism to drug abuse to sexual abuse in the family. It was stigmatizing rather than inclusive of the experiences in the room. Acknowledging that children in the room are experiencing caretaker alcoholism or drug abuse, perhaps not outright, but in a means of intervention that is supportive and less stigmatizing could lead to a decrease in that fear of judgment. Educating peers and educators on how to be active supports in their knowledge of alcoholism and substance abuse in families could lead to better outcomes of interventions and a decrease in stigma.

It is interesting to note that there are generational differences between those who experienced curriculum aimed at drug prevention and those who did not. The history of
substance and addiction curriculum was not reviewed in the literature, though it would be interesting to know when drug prevention education came into or became more prevalent in United States public schools. However, an interesting note: one participant in her 20s and one in her 70s described their Catholic school upbringing as lacking in curriculum on addiction and drug prevention completely. Despite the widespread acknowledgement for the need for drug and substance use prevention programs in the schools, there continued to be a lack of school curriculum around alcoholism or addictions in the home and for some, a lack of curriculum at all.

In addition to this limiting curriculum, the many participants who argued for treatment groups to occur in the school system confirmed the literature findings that providing curriculum and groups in the schools could mitigate many detrimental effects of caretaker alcoholism (Arman & McNairm 2000; Dore, Nelson-Zlupko, & Kaufmann, 1999; Price & Emshoff, 1997). Similar to the findings of Dore, Nelson-Zlupko, and Kaufmann (1999), participants agreed with the notion "that there are so few institutional resources and supports for children with these psychosocial needs is a national tragedy" (p. 188). It appears that the school would be a safe space for providing these groups as discussed below, however there has to be an increased awareness of alcoholism stigma if children participate in these groups. These data call for revisions for more attention to de-stigmatizing alcoholism and drug addiction and increasing awareness of families of alcoholism and addiction in drug prevention curriculum and resources.

Participants defined the benefits of hypothetical COA groups: providing room to process; space to discuss; validation; a creation of a support system that can relate to feelings of isolation and shame; the promotion of healthy behaviors; and providing a de-stressing environment away from home life. These are similar concepts as promoted by National Association of Children of Alcoholics (NACoA) as mentioned in the literature review (offering psychoeducational
pamphlets for children, early childhood professionals, social workers, etc.), findings of Arman and McNair (2000) and Price and Emshoff (1997) and described by Jerry Moe and Dan Pohlman's 7 C's (1989): I didn’t cause it; I can’t cure it; I can’t control it; I can help take care of myself by communicating my feelings, making healthy choices, and celebrating me. Some participants also described their experiences in attending groups at treatment centers with their families, to which they offered a suggestion in attending school treatment groups as opposed to a treatment centers that may have stigma attached (Price & Emshoff, 1997). The findings go to show that there is benefit in including school interventions and the education of professionals on the signs to look for as NACoA provides.

The findings also suggest the great benefit in educating children and peers about alcoholism in the family while also providing an outlet for treatment and disclosure within the schools. If curriculum only attends to drug and addiction prevention, it plays into the denial that a caretaker's alcoholism can affect a child in the home. The recognition of alcoholism and addiction in the family is the next step in curriculum reform, which may also lead to decrease in such things as intergenerational alcoholism and substance use. It can also provide a foundation for the peers attempting to support their COA friends. Knowledge of the disease can lead to active support if the school system is equipped to handle disclosure through such things as treatment groups. The majority of time spent outside the home is in the school—if children have a means to recognize signs of alcoholism in the family, a means to provide support for COAs via peer disclosure and interventions with school professionals, and treatment in the same space, it could be greatly beneficial in mitigating the challenges faced by this population.

v. Pay attention to stigma and intersectionality Other key findings in this study include confirming the multitude of challenges in gaining support, one being due to secrecy and stigma.
As Mehta and Farina (1988) describe in the concept of associative stigma, a majority of participants discussed the conflict of disclosure and gaining support was due to a fear of stigma, feelings of embarrassment and shame, and for some, the threat of bullying from peers due to their caretakers' struggles (Harlow & Roberts, 2010). For other participants, the concept of intersecting identities led to a confusion or internal conflict in gaining support—confirming what much of literature reviewed stated in implications for further research (Berndt, 2004; Dore, Nelson-Zlupko, & Kaufmann, 1999; Eiden, Ostrov, Colder, Leonard, Edwards, & Orrange-Torchia, 2010; Harlow & Roberts, 2010; Vernig 2011).

The shame, judgment, and embarrassment described by the participants could be attributed to how alcohol is portrayed in our society: a means to relax, have fun, enjoy relationships, and it is sexualized a great degree. Alcoholism, however, is stigmatized, portrayed as a choice, a failure to gain control and composure, pathologized as a nuisance and a form of abuse in the family. These contrasting portrayals leave children of alcoholics stuck in coping with dysfunction in the family—to disclose it is a problem is both denying the "cool" and corroborating the "nuisance." Marianne grew up in a generation where liquid lunches were the norm, were "cool," but when one of her friends called to say she saw a woman drunkenly walk down their street that looked a lot like her mother, Marianne just listened silently. She could not confirm that it was her mother "staggering down the street" for fear of embarrassment. Around the time when Brian's friends were an escape from his mother's alcoholism, they also began drinking together out of his mother's house, a paradox that he noted in the interview.

Dee, Laura, Anthony, Jake, Aly, and others described how difficult it is to recognize, even in retroactive observations, where the challenge of gaining support came from outside of experiencing stigma—whether it was the normalization of alcoholism due to family culture,
socio-economic status, or community representation; the co-morbidity of some of their caretakers' addictions; the multiple areas of marginalization in their identities; or otherwise. These participants made it clear that there was confusion in how to approach these intersections. Dee was fearful that if she disclosed, authorities would become involved and uncover her father's undocumented status. Laura experienced marginalization as a first generation immigrant family, which compounded the challenges of gaining support. Throughout the interview, Anthony continued to return to the intersection of both his father's alcoholism and his father's views on Anthony's sexuality—both caused physical conflict between the two and emotional challenges for Anthony in reaching out. Aly described her father's struggle with multiple substances and depression, a co-morbidity that attaches different stigma to both.

Intersectionality is not a phenomenon; it is a concept that is gaining more recognition in social work practice, needing improvement in the mediums of intervention. An improvement for the resources that should also be considered in tandem with school interventions is paying attention to the intersectionality in this population labeled COAs—perhaps becoming more specific with resources, more educated on compounded factors that are challenges for gaining support, can better serve this population.

An overwhelming response was the recognition that friendships or the lack thereof were incredibly vital in terms of coping and not-coping even in the face of these intersecting identities and struggles. The participants who stated that they had a lack of friends also acknowledged the isolation and loneliness they felt in that process. What was greatly acknowledged in the data was the overwhelming benefits friends could offer for children and how greatly underutilized they were in terms of interventions. The outcomes described by the participants of friends knowing were described as stopping at the disclosure or friends offering space to process in the
moment. No one stated that if a friend found out, the outcome of that knowing went further into such things as involving a professional in the school, family, or social work practice. As the literature suggests, it is clear that friends and peers are the greatly understudied and underutilized population for children (Bagwell, Newcomb, & Bukowski, 1998; Berndt, 2004; Rose, Schwartz-Mette, Smith, Swenson, Asher, Carlson, & Waller, 2012; Schwartz, Stutz, & Ledermann, 2012; Swenson & Rose, 1999).

In combination with data presented on the improvements for curriculum, placement of interventions and resources, call for attendance to intersectionality of experiences and identities, the role of the friend in terms of disclosure and gaining support for children of alcoholics is greatly ignored in current systems of support for this population. The potential of these data is very promising in promoting more effective interventions and supportive elements in approaches for treatment with children of alcoholics. As Darla greatly put it: "Finding someone in your life like that is a godsend because it allows you to unburden yourself even for a moment."

II. Limitations, biases, and strengths

The limitations of the study include generalizability of the study sample and personal bias that may have shaped the execution of the interviews and interpretation of that data. These are not unusual in qualitative studies, however it is important to recognize where the limitations may fall so as to understand the vulnerabilities of this study and infer the needs for possible revisions in future research.

My limitations as a novice researcher and my personal biases have affected this study. Ethical concerns in consultation with my research advisor brought me to the conclusion that it would be important to interview adults of alcoholism due to the vulnerability of the population of children these issues affect and the difficulties of obtaining the informed consent for child
participants. As discussed in the potential biases of the researcher section, my point of view is that there are not enough resources and services available or feasibly able to be utilized due to secrecy and stigma, which may have biased my results; I know that my bias is towards pushing for understanding of support from peers and adults or resources to help children affected by alcoholism feel safe in their disclosures.

The sample limitations include the inability to generalize due to the small size and lack of representative sample. Other limitations in execution might include: recruitment of sample being perhaps biased with potential for having received treatment as recruited through Adult Children of Alcoholics support groups; the self-reporting bias of memory and hindsight; the possibility that the questions formulated from the literature reviewed, the consultations with my advisor, HSR support, and professional experiences may have shaped participants' responses or could have led to my own personal expected findings unknowingly; and the design and recruitment of highly motivated participants resulted in a non-probability, non-representative sample as described as integral by Tinnfält, Eriksson, and Brunnberg (2011)—this sample did not have a specific intersectionality in mind nor did it limit the sample in terms of qualifiers (such as race, gender, religion, culture, community).

A strength that may be found in this study is the space it provided for participants to reflect upon their experiences. The interview with the multitude of questions and follow-ups/clarifiers provided freedom for both the interviewer and interviewee to have a conversation that was open to narratives of all kinds—reflections on their processes of disclosure, their processes of acceptance and denial, their childhood and adulthood factors that may have been impacted. The rich narratives were greatly appreciated by this researcher, giving faces and names to experiences rather than numbers on a scale. Despite the requirement/constraint to maintain
feasibility with 12-15 interviews rather than a highly desired larger sample, these 12 interviews offer great insight on experiences and improvements, and provide deeply moving narratives that voice a need to attend to this population in more attainable, accountable, and inclusive ways.

This execution was to better benefit the researcher in the feasibility of finishing this project. Tinnfält, Eriksson, and Brunnberg (2011) make note of the need to look into gender, race, religion, culture, and community specific responses to disclosure of children of alcoholics in order to account for the great intersectionality of identity in a single vulnerable population. The findings support this recognition and will be further discussed in the implications for future research and social work practice section. The acknowledgement of these limitations is important in determining the validity of this study.

**III. Implications for future research and social work practice**

The overwhelming findings of this study include: the need for social work practice to utilize friendships in supporting the coping of adverse childhood experiences; an improvement of curriculum development and policies for inclusion of educating factors of addictions in the home and how to support peers; and the need for future research to attend to and recognize the intersectionality of identities and experiences when it comes to assigning findings to populations.

In order to create a better foundation of support for the utilization of friendships, further research is needed. Specifically, the recruitment of a more diverse sample or a more specific sample is needed—potentially sampling for reflections on a certain age range to analyze latency vs. adolescent uses of friendships or researching specific socio-economical, gender, religious, community, and cultural responses to alcoholism, as examples.

What are difficult to mitigate in researching this population are the challenges of gaining support that were confirmed by participants and in the literature reviewed. If sampling children
currently experiencing their caretakers' alcoholism would not pose ethical challenges in
disclosure of a family "secret" or needed parental consent, needed data could be collected.
However, these challenges makes note of the interworkings of all responses to alcoholism,
family dysfunction, and intersecting marginalized identities—policy, school, familial, cultural,
community, socio-economic responses—and the prevalent stigma that continues to create
barriers to disclosure and gaining support. Future research must attend to this stigma specifically
and a formulation of mitigating resources to this stigma.

What also should be noted here is the affect evoked throughout these interviews. The
participants volunteered for a study with a risk of unearthing affect and experiences that could be
painful to acknowledge, remember, or talk about and were willingly forthcoming with someone
whom they had just met for 30-45 minutes. Painful narratives of isolation, fear, abuse, sexual
violence, regret, chaos, and anger colored some parts of the interviews and led to moments of
reflection between interviewer and interviewee. Many were tearful; many were angry; many
were thankful that this study was occurring; many made note to state that though caretaker
alcoholism affected them, they continue to be grateful for the life they have. For Kerry: "And I
know what grateful is. Whenever the topic comes up, I say I have absolutely no business not
being grateful for waking up and putting my feet on the ground. If I can't be grateful for that—I
just gotta." Perhaps that is the positive reframe for the strong affect encountered—the study
provided cathartic space for participants to process how they were affected and how they have
dealt with it all, but also provided a medium for people to contribute positively to future
generations of children of alcoholics. It provided a medium where there is great potential for
others to be grateful for the participants' voices.
In terms of implications for social work practice, what this research study confirms is the need for this profession to attend to: 1) including addiction in the families and de-stigmatization of alcoholism in education policy as a means to provide support for school-aged children; 2) including treatment programs within schools and resources that are easily accessible in the face of stigma and secrecy; 3) addictions treatment and resources for the entire family—not just the caretakers—including work around attention to the roles of caretakers and children; 4) attention to intersectionality as a compounded challenge in receiving support and resources; 5) including friends and peers in the education and support from professionals around experiencing caretaker alcoholism such as in the NACoA resources. There is much work to be done in terms of providing more of a foundation in research for the work implied in these findings—however this study offers rich data on the benefits of support this population could gain if more attention was given by social work practice.

IV. Summary

Participants of this study offered rich narrative accounts of their experiences, providing a deeper examination of the role of peers in the face of caretaker alcoholism. The aim of this study was to gain perspective and examine the experienced effects and the processes of disclosure to and support gained from friends in childhood for adult children of alcoholics. It was in hopes of better providing a foundation for the utilization of friends in social work practice. The experiences with friends serving as support for children of alcoholics are missing in the current literature—friendships in general are an underutilized and understudied element of support for children of alcoholics (Bagwell, Newcomb, & Bukowski, 1998; Berndt, 2004; Rose, Schwartz-Mette, Smith, Swenson, Asher, Carlson, & Waller, 2012; Schwartz, Stutz, & Ledermann, 2012; Swenson & Rose, 1999). It has become clear through this study that not only does caretaker
alcoholism have a profound effect on children, but also that friendships, or the lack thereof, profoundly impact coping, communication, and the provision of support for children of alcoholics.

The participants' multifarious experiences with caretaker alcoholism and gaining support from friends, social work practice, schools, and helping professionals reflect the incredibly unattended challenges for this population. Caretaker alcoholism is something that impacts 17 million children in the United States alone. It is hard to believe that one in four children in this country experience caretaker alcoholism; in the Boston metropolitan area alone, the one organization providing COA groups can only organize two meetings per week. Much more needs to be done to account for this lack of resources and the underutilized population of friends.

With future steps in research and social work practice to mitigate challenges, eradicate stigma, and improve education, perhaps the role that friends can play becomes less of a threat and even more integral part in coping with caretaker alcoholism. Gayle succinctly puts it as:

"Everybody wants to be heard. And it's awesome and scary at the same time." For Aly:

I always have a ton of friends, but there's only a few people in the world I actually trust. I think that's a function of survival and recognizing that you really do (pause) it takes a lot. You really don't want to get hurt. It takes a lot to find people you really, really believe in.

In a way, friends play the role professionals in social work practice want to offer—a means of support and listening. Taking arms with these friends, mitigating challenges of disclosing, and paying attention to how this population is supported are necessary actions in social work practice.
REFERENCES


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January 6, 2014

Erica Cormier

Dear Erica,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Carolyn Mak, Research Advisor
Dear All,

Are you or someone you know an adult child of an alcoholic? Someone who grew up with an adult who had an alcohol/alcohol and other problem? If so, you or they may be interested in being involved in my research study.

My name is Erica Cormier. I am in the final year of a Masters in Social Work program at the Smith College for Social Work. In order to graduate, I have to complete a Master’s thesis or paper. For this paper, I am exploring 1) how children who grew up with an alcoholic caretaker talk to their childhood friends; 2) what supports they need from childhood friends; and 3) how social workers can better understand and support these childhood friendships.

If you grew up with an adult you relied on, such as your father, mother, grandparents, foster parents, older brothers or sisters etc. who struggled with alcoholism or alcoholism and other drugs, 21 years of age or older, you grew up and went to school in the United States, and you're not being treated for substance use, you qualify to participate in this study.

If you are interested in being interviewed by phone, Skype, or in person (Boston area) as part of my study please contact me at [cell phone number] or [email] to hear more.

Please also forward this email to those who may be interested or know those who may be interested in contributing to this study. Thank you for considering to take part in this study, and I look forward to hearing from you.

Sincerely,

Erica Cormier
Do you identify as an adult child of an alcoholic or someone who grew up with an alcoholic caretaker?  
✓✓✓

Are you over the age of 21?  
✓✓✓

Did you spend the majority of your childhood in United States and in United States schools?  
✓✓✓

I am currently completing my master’s thesis in Clinical Social Work. I would like to learn about your experience with growing up with caretaker alcoholism and the role of your friends. If you answered yes to the three questions above and are not currently in treatment for alcoholism and substance abuse, you qualify to take part in this research study. In person, phone, and Skype interviews are available.

If you would like to be a participant in my research study or have any questions, please contact me at [email] or call [cell phone number].
APPENDIX C

Informed Consent

Consent to Participate in a Research Study

Smith College School for Social Work • Northampton, MA

Title of Study: How Do We Do No Harm? Exploration of Adult Children of Alcoholics’ Perspectives on Disclosures and Support from Childhood Peers

Investigator(s): Erica Cormier, [cell phone number]

Introduction

• You are being asked to be in my research study. This study is about what people who grew up with caretakers with an alcohol problem think about their childhood experience of telling friends and getting support from friends.

• You were selected as someone who may be able to participate because: 1) you grew up with an adult you relied on, such as your father, mother, grandparents, foster parents, older brothers or sisters etc. who had an alcohol or alcohol with other drugs problem, 2) you are 21 years of age or older, 3) you grew up and went to school in the United States, and 4) you're not being treated for substance use.

• Please read this form. Feel free to ask any questions you may have. You may participate in this study if you agree and sign this form.
Purpose of Study

• The goal of this study is to explore the childhood experiences of adults who grew up with a caretaker(s) who had an alcohol problem. The study aims to understand the role of the childhood friend in growing up in this way. I hope that the study will explore the specific experiences of how or why children tell their friends about the caretaker alcoholism. Was this telling supportive? Why or why not? Your perspective on this experience will help social workers understand how to support both children of alcoholism and their friends who may want to support them.

• This study is being conducted as a research requirement for my Master’s in Social Work degree.

• At a later date, this research may be published or presented at professional conferences or workshops.

Description of the Study Procedures

• If you agree to this study, you will be asked to do the following things: 1) read and agree to this informed consent form. 2) Sign and mail this form back to me in an envelope provided if the interview is over Skype or by telephone. 3) If it is an in-person interview, be prepared to sign this form at the interview.

• The interview will last approximately 45 minutes. It may take place by telephone or Skype in a private and safe space. In-person interviews will be in a safe, public place if we are in the same geographical region.

• I will make contact to set up a good interview time for both of us only when you have read and agree to this form for in-person interviews. When it is mailed back to me or signed for
Skype or telephone interviews, I will make contact to set up the interview at a good time for both of us.

**Risks/Discomforts of Being in this Study**

- The study has some risks. The interview may bring about feelings of discomfort or feelings of being exposed because your experiences may be painful to share. This is a high likelihood because of the general topic.
- I will give you a list of resources for adult children of alcoholics that may be able to provide support before the interview takes place.

**Benefits of Being in the Study**

- The benefit to being in the study is helping children of caretakers with an alcohol problem. Sharing your experience on the subject will help people understand how to support these children, families, and friends. It may also be a chance to reflect on your childhood.
- The benefit to social work and society is adding to the current studies on this topic. Current studies show the risks for children growing up with alcoholism in a family. This study aims to improve the current interventions. It also aims to better understand the role of the friend for children of alcoholism and how to support both.

**Confidentiality**

- Your participation will be kept confidential. If the interview is over phone or Skype, it will take place in my private room in my apartment during a good time for both of us. It will also be at a time where you can have private space to speak freely. If you are in a geographical area close to me and would like an in-person interview, we can set one up. It will have to occur in a public space with private rooms such as a library meeting room, a safe location that works for both of us.
• Your identity and all information collected from the interview, including any recordings or notes will be kept confidential and safe. My research advisor will have access to the information collected from the interview only after your name has been replaced with another name. This also goes for publication or presentations. If any quotes or names are included, they will be disguised.

• In addition, the records of this study will be kept strictly confidential. All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. I will not include any information in any report I may publish that would make it possible to identify you.

  **Payments/gift**

• You will not receive any financial payment for your participation.

  **Right to Refuse or Withdraw**

• The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up to the date noted below) without affecting your relationship with the researcher of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone prior to 10
days after our interview, which I will remind you of at the interview. After that time, your information will be part of the thesis, dissertation or final report.

**Right to Ask Questions and Report Concerns**

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Erica Cormier at [email address] or by telephone at [cell phone number]. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

**Consent**

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep. You will also be given a list of referrals and access information if you experience emotional issues related to your participation in this study.

…………………………………………………………………………………………………………………………

Name of Participant (print): _______________________________________________________________

Signature of Participant: _____________________________ Date: _____________

Signature of Researcher(s): _____________________________ Date: _____________

…………………………………………………………………………………………………………………………
[if using audio or video recording, use next section for signatures:]

1. I agree to be [audio or video] taped for this interview:

Name of Participant (print): _______________________________________________________

   Signature of Participant: ________________________ Date: ___________

   Signature of Researcher(s): ________________________ Date: ___________

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): ___________________________________________________

   Signature of Participant: ________________________ Date: ___________

   Signature of Researcher(s): ________________________ Date: ___________
APPENDIX D

Interview Guide

Part I: Demographic and Standardized Questions

1. How old are you?

2. If you are willing to answer, how do you describe your sex and gender? Male? Female? Queer?

3. What is your race and ethnicity?

4. As a child, was your family poor? Well-off? Somewhere in the middle?


Part II: Open-Ended Questions

1. What was your relationship to the caretaker or caretakers who struggled with alcoholism or alcoholism and other drugs? Potential follow up/expanding questions:
   a. Was it a biological or non-biological relationship?
   b. What was the quality of relationship in your mind?
   c. If there was a caretaker that did not struggle with alcoholism, what was your relationship with them? Did they talk about the problem? Ignore? Participate?

2. As a child, what did you feel/know about alcohol in general? Potential follow up/expanding questions:
   a. How did you first come to know that it was alcoholism affecting your family? Did this cause any positive or negative feelings?
   b. What are your thoughts on peer pressure, school curriculum/classes on alcoholism?
3. What were relationships like growing up—including family and friends? Potential follow up/expanding questions:
   a. What relationships were significant and why?
   b. Did these significant relationships know about the alcoholism? Why or why not?
   c. How were significant relationships formed—through extended family, school, extra curricular activities, other?

4. As a child, did you ever disclose or tell a friend about the alcoholism explicitly? (if not, skip to question 7). If so:
   a. To whom?
   b. How or why did you decide to tell this person or these people?
   c. How did you tell them?
   d. If this person was not a friend that was around your age, but an adult, who was this? Same questions as above.

5. Why did you decide to tell this person or these people? What were you hoping to gain or what did you think would be the outcome of telling them?

6. Were there any outcomes to telling a friend or someone about the alcoholism, positive and/or negative? Potential follow up/expanding questions:
   a. Did these people whom you told support you? How did they react to you telling them?
   b. Did other friends ever become involved? Adults?
   c. Were any school members like teachers, counselors, principals, etc. involved? What was the school members' reaction?
d. Did any form of telling cause a more supportive reaction than other ways of telling?

7. If you did not tell anyone as a child, why was that? Potential follow up/expanding questions:
   a. Did you not tell because of some specific or general reason? Family reason? Personal reason?
   b. What do you think may have happened if you told someone about caretaker alcoholism?
   c. Would you say there are specific outcomes of not telling someone about your caretaker alcoholism? Was this a positive, negative, so-so experience?
   d. Does anyone know now as an adult that your childhood caretaker struggled with alcoholism? Why or why not?

8. What do you think you could have used or needed as a child growing up with caretaker alcoholism? Potential follow up/expanding questions:
   a. Were there any specific interventions discussed in school or outside/inside the family such as peer/friend groups? Were there any groups in your area that you could have joined?
   b. What do you think about peer or friend groups such as Children of Alcoholics or Adult Children of Alcoholics and Al-Anon in dealing or supporting children with caretaker alcoholism?
   c. Did you or do you know anyone who have found these types of groups helpful or not helpful? Why or why not?
9. Would you say that growing up with someone who had a problem with alcohol has affected your life in any way such as your beliefs? Your career? Your feelings of safety? Yourself? Your relationships? Why or why not?
APPENDIX E

Referral List

Resource Referrals for Participants

**National Association of Children of Alcoholics** The National Association for Children of Alcoholics (NACoA) believes that none of these vulnerable children should grow up in isolation and without support. NACoA is the national nonprofit 501 (c) 3 membership and affiliate organization working on behalf of children of alcohol and drug dependent parents. Our mission is to eliminate the adverse impact of alcohol and drug use on children and families through many means such as publishing periodic online and print newsletters, creating videos, booklets, posters and other educational materials to assist natural helpers to intervene and support children, hosting this site on the Internet with information about and ways to help children of alcoholics and other drug dependent parents, sending end information packets to all who ask, and maintaining a toll-free phone available to all.


CONTACT: 10920 Connecticut Avenue, Suite 100 Kensington, MD 20895 Phone: 888-55-4COAS or 301-468-0985

**Adult Children of Alcoholics—World Service Organization (WSO)** WSO is the World Service Organization of Adult Children of Alcoholics. It acts as the central agency of the program, gathering and disseminating meeting information; creating and distributing literature for use in the Family Groups and provides information to the general public. Adult Children of Alcoholics is a recovery program for adults whose lives were affected as a result of being raised in an alcoholic or other dysfunctional family. It is based on the success of Alcoholics
Anonymous and employs its version of the Twelve Steps and Twelve Traditions.

http://www.adultchildren.org/

CONTACT: ACA WSO, P.O.Box 3216, Torrance CA 90510 USA 562-595-7831

Books


Internet Resources


* Boston Area MEETING of Adult Children Of Alcoholics: Wednesday 7:30P.M. K Thru 12” - K-Street (fenway), 74 Kilmarnock St. Open to all, Discussion, Steps, Non Smoking, English Speaking. (MA031) ACA.KStreet@gmail.com

* Boston Area MEETING of Adult Children Of Alcoholics: Tuesday, 6:00P.M. Emmanuel Church Upstairs In Library Room, 15 Newbury St., Open to all, Discussion, Book Study.