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All in the Family: Alcohol and other Drug Problems, Recovery, Advocacy

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Abstract

Families are intimately involved in the dynamics of the alcohol/other drug problems of family members with these problems. Their adaptations to a baffling and devastating disorder of loved ones are viewed as normal and not in terms of psychopathology. Recovery resources for family members are examined, together with the need for advocacy in the part of families, expressed in the new recovery advocacy movement.

Keywords. Alcohol/other drug problems, families, recovery, advocacy

INTRODUCTION

Family members impacted by alcohol and other drug problems have been long-cursed by social stigma, public neglect, and professional misunderstanding. Parents, spouses, and children of the addicted have hidden their most life-shaping experiences behind a veil of silence and secrecy. The personal stories that they eventually shared with professionals were all too often interpreted in terms of personal psychopathology, rather than normal adaptations to a disorder both baffling and devastating. Throughout the history of addiction in America, family members have been castigated more as causative agents and sources of recovery sabotage than as recovery resources or individuals deserving services in their own right.

Given this history, it is not surprising that family members have most often found healing and purpose when they banded together for their own mutual support and political advocacy. In this two-part essay, we will first explore the history of family perspectives on addiction and recovery through the published work of psychiatrists, psychologists, social workers and addiction

counselors. We will then report the results of focus groups held in Connecticut, New York and Massachusetts with family members impacted by addiction. We close this paper with a discussion of the roles family members are playing in the new recovery advocacy movement.

PART I
HISTORICAL PERSPECTIVES ON FAMILY ADDICTION, TREATMENT, RECOVERY, and ADVOCACY

The American Temperance Movement

America's earliest recognition of chronic drunkenness as a disease was accompanied by recognition of the family as a vessel through which alcohol addiction could be transmitted across generations. In 1835, Robert MacNish set forth this emerging view in his book, *Anatomy of Drunkenness:*

> *Drunkenness appears to be in some measure hereditary. We frequently see it descending from parents to their children. This may undoubtedly often arise from bad example and imitation, but there can be little question that, in many instances, it exists as a family predisposition.* (p.61)

The belief that alcoholism was a product of heredity and parental example grew throughout the nineteenth century and added fuel to a rising eugenics movement that called for the mandatory sterilization of alcoholics and addicts (in addition to the mentally ill and developmentally disabled). The passage of these laws was based on the belief that social problems such as alcoholism were a product of bad breeding and could be eliminated by weeding degenerate families from the culture.

The American Temperance Movement was filled with graphic images of the impact of alcoholism on the family. Reformed drunkards filled temperance pulpits, sharing wrenching stories of the pain and havoc they had wreaked on their families. Temperance plays such as *The Drunkard, One Cup More,* and *The Doom of the Drunkard* portrayed the alcohol-related violence, the economic hardship, and abandonment. Women and children played important roles in the Temperance Movement. Bordin (1990), in her study of Woman's Christian Temperance Union membership, noted that many women within the American Temperance Movement had experienced the tragedy of alcoholism in their families. Local temperance society meetings served as therapeutic functions for the daughters, sisters, wives and mothers of alcoholics, and provided a vehicle through which personal pain could be transformed into political advocacy. Beginning with the founding of the Martha Washington Society in 1842, America's early recovery mutual aid societies created auxiliary societies for wives and created junior auxiliaries for children. The "Women's Crusade" and "Children's Crusade" of the 1870s and 1880s brought an unprecedented number of family members into leadership roles in rescue work with alcoholics and the drive for legal prohibition of alcohol.

The Inebriate Asylum Era

Nineteenth- and early 20th-century inebriety literature expressed enormous ambivalence toward the family of the alcoholic and addict. Wives of patients often took up temporary residence in the city nearest the inebriate asylums, so they could provide daily support to their husbands (An Inmate…1869). Wives were viewed as "loyal angels" by the patients, but inebriate asylum staff viewed family members quite differently. While acknowledging the family's role in legally committing the inebriate, taking guardianship of the inebriate's financial affairs, and visiting and supporting the inebriate in treatment; many early treatment professionals saw family

members as hostile interlopers. For example, Palmer, in his 1898 treatise *Inebriety*, had the following to say about wives:

> *The universality of good wives to intemperate husbands suggests an inquiry into the connection they may bear and the influence they may exercise, however innocently, in the downfall of their husbands.* (p. 42)

Nine years later, Cutten in his 1907 *Psychology of Alcoholism* text wrote:

> *The kindest wife and most indulgent parents are very much in the way of numerous cures, and prove to be, instead of the best friends, the worst enemies the alcoholic has.* (p. 325)

Dr. H. H. Kane noted in 1881 that many failed attempts at addiction recovery were due to what today would later be christened family enabling:

> *Very often the relatives, not understanding the meaning of certain symptoms, distressed beyond measure by the pitiful pleadings of the sufferer, will interpose and at once put an end to treatment, thus unwittingly and with well-meaning doing the patient injury of the gravest kind.* (p. 116)

As we will see, there was a thin line between saying that the family could be an obstacle to recovery and saying that the family was a cause of addiction.

Another emerging theme in the nineteenth century is the financial exploitation of family members' anguish and guilt. This was most blatant among the purveyors of bottled and boxed addiction cures, whose advertisements often targeted wives and family members. The most insidious of these claimed that alcoholics could be cured without their voluntary cooperation and, in fact, without their knowledge. Instructions that came with Formula A, for example, directed that 15 to 20 drops of Formula A be surreptitiously placed within the drinker's first drink of the day, and that if this did not induce vomiting, another 15-20 drops were to be added to the second or third drink. These were to be supplemented by sprinkling the contents of Formula A capsules in the drinker's food. Formula A, like many such cures, contained a nauseant-usually fluid extract of ipecac (American Medical Association Health Fraud and Alternative Medicine Collection, Report from Post Office Department, p.3, Box 0030-10). Among the alcoholism-cure products promoted to be secretly administered by family members included the White Star Secret Liquor Cure, The Boston Drug Cure for Drunkenness, Vantox, and Texcum Powders (Helfand, 1996).

There is very little nineteenth-century literature on the impact of addictions other than alcoholism on the family. Most narcotics addicts of this era were white, middle-aged, affluent women whose addictions and their effects on the family were virtually invisible until revealed in occasional literary works, e.g., Eugene O'Neil's autobiographical depiction of his mother's addiction in *Long Day's Journey into Night.*

The Pre-A.A./Al-Anon Years

The opening decades of the twentieth century witnessed the increased influence of psychology and psychiatry upon perceptions of the alcoholic and his/her family. Lay therapy models of alcoholism counseling birthed within the Emmanuel Clinic in Boston dominated thinking about the alcoholic and the alcoholic family. Richard Peabody (1936), the leading lay therapist of this era, believed there were three basic causes of alcoholism: (1) inheritance of a nervous system which was not resistant to alcohol, (2) the effect of the early family environment or (3) the influence of later experiences in marriage, college or work. Peabody emphasized the parental role as a causative agent of alcoholism (his followers were more specific in blaming mothers). In this view,

maternal domination (and a shy, despondent father) led to feelings of inferiority and nervousness, which, in turn, induced alcoholism.

The pioneers of the psychological therapies for the treatment of alcoholism that emerged in the 1930s generally viewed the family of the alcoholic as a nuisance or a threat. The views of Strecker and Chambers (1938) are typical. They noted the wounded pride wives experienced as a result of successful therapy, noted wives' efforts to sabotage treatment to reassert their power and control, and complained of having to deal with the wife's "childish resentments." The goal of working with the family in their view was not engaging the family's involvement but obtaining an agreement for noninterference in the alcoholic's treatment.

Psychoanalysts of the 1930s and 1940s shared similar views. Knight (1938), for example, regularly noted the lack of cooperation with and outright sabotage of treatment by the family. Therapist vacillated between including and excluding family members from the treatment process. Some therapists also demanded abstinence from the family members (Jellinek, 1942). Moore and Gray, in a 1937 article on alcoholism, talked about the need for educating the alcoholic's family and noted: "the person with the greatest need of psychiatric treatment is the marital partner who has *not* become alcoholic" (pp. 381-388).

What is striking in the opening decades of the twentieth century is the utter silence of family members. While they are described in great clinical detail, there are few first person voices conveying their vacillation between hell and hope.

Al-Anon

Alcoholics Anonymous began as a family affair, with alcoholics and their family members attending group meetings together, but the voices of family members were heard only indirectly in these early years (the section of the book Alcoholics Anonymous, entitled "To the Wives" was written by A.A. co-founder Bill Wilson). In the 1940s, wives (and later, wives and husbands) of A.A. members began to band together for mutual support in such places as Long Beach California, Richmond Virginia, and Chicago Illinois. A close reading of early editions of the *A.A. Grapevine* reveals the considerable family activity that was underway. Family members of San Diego California A.A. members organized themselves as "Alcoholics Anonymous Associates" in May of 1946. It was there that the practice of spouses joining an A.A.-affiliated support group *before* their partners joined A.A. began. A May 1947 *Grapevine* article noted regular meetings of a Family Groups in San Pedro and Sugar Hill California. The former was noted to have held annual open meetings that were used to educated doctors, judges, and welfare workers. In July of the same year, an article noted the formation of a "Non-A.A. Group" (N.A.A) for family members in Austin Texas. A similar group, referring to itself as the "A.A. Auxiliary" (A.A.A.), was formed in Rome, Georgia in July of 1947. The founding of another "Non-A.A. Group" in Rochester New York was announced in July of 1948. The Rochester group was the first noted in the *Grapevine* to have adapted the Twelve Steps for use by the husbands and wives of alcoholics. Their first step read: "We admitted we were powerless to help the alcoholic." Formal groups of the wives of A.A. members began to spread, meeting under such other names as A.A. Helpmates, Al-Anon, Alono, and Onala (*A.A. Grapevine*, 1947-1963). The growing number of these groups and their request to be listed in the *A.A. Directory* posed a growing question about the relationship between the family groups and A.A. itself (*Living With an Alcoholic*, 1980). To recognize this growing movement and to clarify its relationship to A.A., Lois Wilson and her friend Anne B. set up a service office in 1951 to support the groups. Their announced goals were:

1. To give cooperation and understanding to the A.A. at home.
2. To live by the Twelve Steps ourselves in order to grow spiritually along with our A.A.
3. To welcome and give comfort to families of new A.A.

They chose the name Al-Anon Family Groups and began responding to information requests from family members, requests that were arriving at A.A. headquarters. In the early days, they called themselves the Clearinghouse Committee, and in 1954, they incorporated as Al-Anon Family Group Headquarters, Inc. Just prior to incorporation, Henrietta S. became Al-Anon's first General Secretary/Executive Director (*Al-Anon: Then and Now*, 1986). Responding to the need for more family-oriented literature, Lois began working on a pamphlet that, with the help of Bill Wilson and editorial assistance from Margaret D. and Ralph P., became the book, *The Al-Anon Family Groups*. The first mimeographed copy of this book made its appearance at the 1955 A.A. International Convention in St. Louis.

Al-Anon meetings and literature evolved from a focus on the alcoholic to the emotional and spiritual health of Al-Anon members. As Lois Wilson (1994) has noted:

> *I suppose the seeds of Al-Anon actually germinated when the families of early A.A. members first felt the stirrings of their own regeneration, and began to do something about it* (p. 172).

Another family milestone was the founding of Alateen in 1957, which provided a support group structure for persons 12 to 20 whose lives had been affected by alcoholism.

Al-Anon and Alateen constitute a historical milestone in their focus on the needs of the alcoholic's family members. When pondering the single most important lesson she had learned in Al-Anon, Lois Wilson later stated simply:

> *…we cannot change another human being-only ourselves. By living our own lives to the best of our ability, by loving deeply and not trying to mold another to our wishes, we can help not only ourselves but that other also.* (Wilson, 1994, p. i)

Bill Wilson wrote about the dynamics of the alcoholic marriage at length in the 1952 publication *Twelve Steps and Twelve Traditions*. Here he described how alcoholism turned the alcoholic into a "sick and irresponsible child" and the non-alcoholic spouse into a resentful mother-a method of caring that the alcoholic "alternately loves and hates." Bill went on to describe how this fixed pattern is disrupted by sobriety and how the spouse may resent that A.A. has been able to do what his or her efforts could not and that the marriage in early recovery is often characterized not by grateful bliss but by blame and strain (Twelve Steps and Twelve Traditions, 1981). What Al-Anon provided was guidance through this reconstruction of intimate relationships in the transition from alcoholism to recovery.

While Al-Anon introduced family perspectives that would later exert significant influence on the treatment of alcoholism, family perspectives on and involvement in narcotic addiction treatment during the middle-twentieth century were plagued by problems of distance. Those addicts treated at Lexington and Ft. Worth, the two federal public health hospitals that opened in the 1930s, came from all over the United States. The lack of community-based treatment resources meant that family members were rarely involved in the treatment process. There is a striking absence of family perspective in the addiction literature during this era. References to family in the literature are drawn primarily from addict self-report of his/her family circumstances.

Family Advocacy and the Modern Alcoholism Movement

In 1944, Marty Mann, the first woman to achieve sustained sobriety in A.A., founded the National Committee for Education on Alcoholism (Mann, 1944). Mann's goal was nothing short of changing how America viewed alcoholism and the alcoholic. To achieve that goal, Mann organized local affiliates across the country who provided alcoholism-related information and education, worked to open hospital doors for detoxification, and encouraged the development of alcoholism treatment and convalescent centers. Family members impacted by alcoholism and blessed by recovery played important roles in this advocacy movement that laid the foundation of modern addiction treatment.

Understanding the Alcoholic Family as a System (1950s and 1960s)

Family perspectives in the 1950s shifted from looking at the alcoholic and the alcoholic spouse as individuals to looking at the alcoholic couple as a dynamic system. The focus on the alcoholic wife had shifted to a focus on the alcoholic marriage. Of particular interest was the process through which the male alcoholic and his wife struck an "interpersonal bargain" to get personal needs met and maintain some degree of homeostasis in the face of alcohol's assault on the marital relationship. A milestone in this shifting view was the publication of Joan Jackson's 1954 article, "The Adjustment of the Family to the Crisis of Alcoholism" in the *Quarterly Journal of Studies on Alcohol*. Jackson went on to study how alcoholism elicited a wide variety of developmental problems in children of alcoholics (Jackson, 1964). The growing interest in family dynamics during the 1950s and 1960s was evident in the publication of new educational materials such as *Alcoholism: A Family Illness* (a Smithers Foundation publication) and new Al-Anon pamphlets such as *The Stag Line, What's Next? Asks the Husband of an Alcoholic, My Wife is an Alcoholic,* and *Al-Anon IS for Men* that recognized the needs of men married to alcoholic women.

The focus of family studies evolved through several stages: the alcoholic wife, the alcoholic marriage, concurrent group therapy of alcoholics and their wives, multiple couple and multiple-family group therapy approaches, concurrent inpatient/residential treatment of the alcoholic and the alcoholic spouse, and speculations on the nature of the alcoholic family as a dynamic system. What came out of these studies was the concept of "co-alcoholism"-the extension of the disease process to those people, particularly the spouse, who were most intimately involved with the alcoholic.

There are two underlying themes that permeate family studies of addiction in the 1950s and 1960s. The first are studies that document the adaptations that occur within the family in response to addiction and the addiction-related deterioration in role performance of a family member. The second is a suggestion that the marital or family environment is actually an agent in initiating and sustaining addiction. The former studies depict members as innocent victims; the latter depict family members and particularly the wife of the male alcoholic as an "etiological agent" or a factor "complicating the illness." Jackson (1962), and more recently Chaudron and Wilkinson (1988), have reviewed professional literature that not-so-subtly implied that the pathology of alcoholism was rooted not in the alcoholic man, but in his wife. (This literature was strangely silent on the husbands of alcoholic women.)

Alcoholics' wives were increasingly depicted as having chosen alcoholics in order to meet their own dependency needs. Two separately authored articles illustrate this view. In the first article, Thelma Whalen (1944, pp.632-641) described the wives of alcoholics she counseled at a family service agency in Dallas Texas. She noted that "the wife of the alcoholic has as poorly integrated a personality as her husband" and that the wife, as surely as the alcoholic, was responsible for creating the marriage and the "sordid sequence of marital misery" that

followed. Whalen describe alcoholics' wives as falling into one of four styles: (1) Suffering Susan, whose marriage and loyalty to the alcoholic was related to her need for self-punishment, (2) Controlling Catherine, who chose the alcoholic because of his inferiority and her own need to dominate, (3) Wavering Winnifred, who stayed with her alcoholic husband out of her need to be needed, and (4) Punishing Polly, whose relationship with her alcoholic husband was comparable to that of a "boa constrictor to a rabbit."

In the second article, Samuel Futterman (1953) described the prototypical wife of an alcoholic as an inadequate woman who gains ego strength only in relationship to her husband's weakness. Futterman accused the alcoholic's wife of maintaining her "illusion of indispensability" at her husband's expense by inciting his drinking episodes. He noted that it was only through such behavior that the wife could escape the depression she experienced during the periods in which her husband was sober and adequately functioning.

The general profile of the alcoholic wife depicted in this early literature was that of a woman who was neurotic, sexually repressed, dependent, man-hating, domineering, mothering, guilty and masochistic, and/or hostile and nagging (Day, 1961). The typical therapist's view of the wife of the alcoholic was generally one of "I'd drink, too, if I were married to her" (Reddy, 1971, p.1).

Al-Anon not only provided a sustained source of support to family members affected by alcoholism, but also brought together in one place a large enough pool of alcoholic wives to allow researchers to begin to test some of their propositions regarding these women's supposed pathology. By the early 1960s, objective studies began to call into question the 1950s portrayal of the alcoholic wife as having selected and remained with her husband out of her own deep emotional disturbance (Corder, Hendricks, & Corder, 1964).

Wives were not alone in being blamed for the alcoholism of their mates. Day, in her 1961 review of the alcoholism literature also noted a body of opinion suggesting that the etiology of male alcoholism could be found in the alcoholic's family of origin, particularly within the mother-son relationship. This literature emphasized the degree to which maternal domination and overindulgence created the future alcoholic's low tolerance for pain and frustration and stifled his ability to become independent and responsible. Other contributing factors in the family included a stern, autocratic father and conflicting maternal and paternal attitudes toward drinking (Day, 1961). Marking the continuity of this tradition, parents were consistently blamed as their children began illicit experimentation in the 1960s. It was in this context of blame that family therapy emerged as a primary mode of treatment for adolescent substance use disorders (Edwards & Steinglass, 1995; Liddle & Dakof, 1995).

"Family Programs" (1950s-1970s)

Most significant in the 1950s and 1960s were the emergence of explicitly family-oriented alcoholism treatment models, such as the outpatient counseling approach developed at Johns Hopkins Hospital that utilized parallel group therapy processes for alcoholics and their wives. One of the earliest family-oriented inpatient treatment approaches was initiated in 1965 at the Sandstone Hospital in Minnesota. Dr. Charles Cooper created a "Family-In" program in which families of alcoholic patients came to Sandstone for two to three days of residential, family-focused treatment (Richeson, 1978). Two other programs, Lutheran General Hospital in Illinois and Hazelden in Minnesota also experimented with residential "family week" and "family weekend" programs in the 1960s.

At Lutheran General, the original goal was to have family members live in apartments above Lutheran General's Alcoholism Treatment Center (ATC) so that they could fully participate in treatment, but these plans were abandoned when insurance companies refused to pay for the extra expense that was incurred. In spite of this setback, efforts to increase family involvement in treatment at Lutheran

General continued through the early years. An early "family night" program consisted of a lecture/discussion group. In 1978, a half-day Saturday program using Al-Anon volunteers was added, and in 1979 a formal Family Treatment Program was implemented, consisting of a three-day off-site residential retreat. Later iterations included a residential weekend model. Lutheran General's response to the families of alcoholics had two phases. The first phase was to seek family involvement because of the ways in which family members could enrich the alcoholic's treatment experience. The second phase, which began to emerge in the mid-1970s, was the recognition that family members needed and deserved treatment and support services in their own right.

A key source of family advocacy was the staff hired to work in the ATC who had extensive prior Al-Anon experience. The initiation of a formal alcoholism counselor-training program increased the involvement of Al-Anon members in the ATC. A.A. and Al-Anon members, many of them volunteers, enrolled in the training program and formed a pool from which new counselors could be hired. As the number of people with Al-Anon experience and a family-oriented perspective on alcoholism recovery increased at Lutheran General, these perspectives became integrated into Lutheran General's clinical training and public education programs.

The conceptualization of addiction as a "family disease" opened the door to exploring how this disease altered family structure (roles and subsystem interactions), family rules, family rituals, and the family's boundary transactions with the outside world. Studies of how alcoholism disrupted family rituals (e.g., meals and holidays) concluded that the disruption of such rituals increased the likelihood of intergenerational transmission of alcoholism (Wolin, Bennett, & Noonan, 1979).

The popularization of transactional analysis (TA) theory and techniques in the 1970s again shifted the focus from the effects of alcoholism on the family to the role of the family in the etiology of alcoholism. Within in the TA framework, alcoholism is the product of disordered family and social communication. Steiner (1971) posited three alcoholic roles or games: "Drunk and Proud," "Lush," and "Wino." Each of these games, as described by Steiner, involved manipulating others into the roles of persecutor, patsy, connection or rescuer. The games provide a guilt-free means of expressing aggression, an avoidance of overt anger, a projection of blame, and social attention. It was Steiner's belief that such roles could be revealed and changed through the process of therapeutic self-examination.

Denial, Enabling and Family Intervention (1970s)

A major corollary of the proposition that alcoholism is a family disease was that family homeostasis was maintained through the mechanisms of denial (portrayed metaphorically as the elephant in the living room that no one acknowledges) and enabling (any actions which prevent the alcoholic from experiencing the consequences of their drinking behavior). A further corollary was that acknowledging the problem and adopting a pattern of tough love could speed up the day when the alcoholic "hit bottom" and initiated recovery. Reverend Vern Johnson felt there had to be a better way to intervene in alcoholism than to sit and wait for the alcoholic to hit bottom. He developed a technology of family intervention through which the bottom could be raised to meet the alcoholic. He pioneered the use of a loving confrontation between the alcoholic and those who cared for the alcoholic to precipitate a crisis that most often resulted in the alcoholic's entry into alcoholism treatment. This concept was spread through a charitable foundation (the Johnson Institute) and through Johnson's publications, e.g., *I'll Quit Tomorrow* (1973/1980), which sold more than 100,000 copies.

The Family/Children of Alcoholics and the Codependency Movement (1980s)

Two overlapping movements emerged in the 1980s. The first focused on the special needs of children of alcoholics- an exploration that led to the concept of "co-alcoholism" or "para-alcoholism" (Greenleaf, 1981). During the early to middle 1980s, the work of Claudia Black and Sharon Wegscheider-Cruse graphically depicted the psychological and developmental consequences of parental alcoholism on children and catalogued how these consequences continued to affect children of alcoholics in their adult lives (Black, 1982; Wegscheider-Cruse, 1985). This marked a significant shift, in which the alcoholic's family members were viewed, not simply as sources of support for the alcoholic's recovery, but as patients in their own right, who suffered from a condition that required treatment and support services. This transition gave rise to a new clinical specialty within the psychotherapy and addictions fields-counseling children and adult children of alcoholics- and gave rise to a broader social-support movement. Adult Children of Alcoholics (ACOA) groups were formed within Al-Anon-some 1,100 by 1986-and the National Association for Children of Alcoholics (NACoA) organized more than 1,500 local groups between its founding in 1983 and 1990 (Brown, 1995).

As this movement took off, the extension of these findings to children and adult children who had been raised in other types of dysfunctional families marked a transition between the concept of co-alcoholism and the newly emerging concept of "codependence." The writings of Karen Horney, Erich Fromm, and other psychologists were used to create the concept of codependency (Melody, Miller & Miller, 1989). Dr. Timmen Cermak (1986a, b) conceptualized codependency as a "disease," proposed criteria for its medical diagnosis, and advocated that the major insurance carriers reimburse treatment of this disease. Addiction treatment programs began offering codependency treatment tracks and extending stays of alcoholics and addicts in treatment because of their "ACOA issues" or "codependency issues." Melodie Beattie launched a veritable social phenomenon with the 1987 publication of her book *Codependent No More.* She later defined five "core symptoms" of codependency: (1) difficulty experiencing appropriate levels of self-esteem, (2) difficulty setting functional boundaries, (3) difficulty owning our own reality, (4) difficulty acknowledging and meeting our own needs and wants, and (5) difficulty experiencing and expressing our reality moderately (Melody, Miller and Miller, 1989). Adding fuel to this movement was the publication the following year of John Bradshaw's *Healing the Shame That Binds You* and his highly popular PBS television series that was based on the book. A whole nation seemed to be riveted on the exploration of the "dysfunctional family" and on the extension of this concept to the workplace, and to society as a whole. This new movement also spawned its own Twelve-Step adaptation, Co-Dependents Anonymous, which by 1990 had more than 1,600 registered groups (Makela, Arminen, Bloomfield, Eisenbach-Strangl, Bergmark, Kurube and others, 1996).

The ACOA and codependency movements left many legacies. For the first time, children and adult children of alcoholics were admitted as primary patients and given a primary diagnosis as well as their own individualized treatment. These movements gave many people a heightened understanding of their own family-of-origin experiences. If there is a clear legacy from the ACOA movement it is the experiential understanding that childhood trauma can unfold developmentally within three domains of adult life: emotional turmoil, disorders of perception and thought, and self-destructive behaviors. The codependency movement did bear unanticipated fruit via an ideological and financial backlash that hurt the movement itself and the broader addiction treatment community from which it had been spawned.

The Codependency Backlash (1990-1995)

The backlash against the concept of codependency and its commercialized applications came from many quarters (Katz & Liu, 1991; Kaminer, 1992; Travis, 1992). The most strident criticisms included the following:

- The definitions of codependency are so inclusive as to lack any clinical utility.
- The symptoms of codependency inordinately target women have been raised to cultivate; codependency turns social pathology into psychopathology. Energy is turned toward inner healing rather than political activism and environmental change.
- By defining the problem of "women who love too much" as one of psychopathology, we fail to hold abusive men accountable for their neglectful, demeaning and violent behavior.
- The movement sets up a milieu in which women bond out of their weakness rather than their strength (Kasl, 1992).
- The movement infantilizes its members as "Adult Children" and traps them at an immature stage of development.

In the end, it was not philosophical debate but economics that doomed the codependency movement. An aggressive system of managed behavioral health care led to a rapid erosion of first the length of treatment and then an erosion of the number of private and hospital-based addiction treatment programs. In that change, many family programs disappeared. Insurance companies, observing the ever-widening conceptual net of codependency, reasonably concluded that it would be financial suicide to provide coverage for a disease that apparently almost everyone had. These companies backed away from coverage of codependency treatment during the same period in which they began to impose severe restrictions on coverage for the treatment of alcoholism and other addictions.

Family Recovery Research: The New Frontier (Late 1980s-1990s)

Since 1989, Drs. Stephanie Brown and Virginia Lewis have worked to construct the developmental stages of family recovery from addiction. Their preliminary findings challenge the prevailing expectation that families can rapidly move toward health with the initiation of alcoholism recovery. They found in their research that the emotional turbulence within the family produced by addiction continues well into the first three to five years of recovery. Family recovery begins with what are, in essence, individual recoveries of its members. Without "holding environments" to sustain these individual recoveries until couple and family relationships can be reconstructed, the risk of collapse and disintegration of the family is quite high. Children older than twelve may have great difficulty participating in this family-making at a time they are moving toward individuation and separation from the family. A major implication of this research is the notion that children and families go through a "trauma of recovery"-a readjustment of expectations required by their continued psychological isolation from the addicted parent going through early recovery (Brown, 1994). Continued research on families in recovery is likely to reveal the diversity of family addiction and recovery experiences. The response of families to alcoholism and other addictive diseases is not a homogenous one that can be depicted in a single reductionist model. The diversity of family life is as wonderful in its capacity for resilience as it is sometimes horrifying in its capacity for cruelty. Each family must be its own model. Intervention into families must by characterized by gentleness and humility rather than by clinical arrogance born of knowing THE truth about the impact of addiction and recovery on the family.

Evolution of Family-Oriented Treatment

Family treatment evolved through several overlapping stages in the modern era: referral of wives to Al-Anon, groups for wives of alcoholics, conjoint marital therapy, residential or outpatient family education, and primary treatment for family members that focused on their individual recovery. Another nuance that emerged in family programming in addiction treatment programs in the past 20 years was the effort to break intergenerational patterns of alcohol- and other drug-related problems. These efforts, particularly those that emerged in programs designed to treat addicted women with histories of child neglect and child abuse, began with simultaneous but separate interventions with addicted mothers and their children, then focused attention on enhancing the health of the family as a unit. Combining treatment services for parents and children, parenting training, and family therapy, they sought to decrease the likelihood that the children of today's clients would recapitulate these problems as they moved into their own adolescence and adulthood (White, Woll, & Webber, in press).

PART II
FAMILIES AND THE NEW RECOVERY ADVOCACY MOVEMENT

The 1980s and 1990s witnessed significant changes in the cultural perception of people with severe and persistent alcohol and other drug problems. Such problems were re-stigmatized (positive images of addiction and recovery, e.g., First Lady Betty Ford, were replaced by images that evoked fear and pessimism), demedicalized (redefined as moral problems rather than medical problems), and recriminalized (persons with these problems were transferred from systems of compassion and care to systems of control and punishment). In response to these new changes, grassroots recovery advocacy organizations began to again organize to change how America viewed addiction and those addicted. The strength of this movement, which is led by people in addiction recovery and their family members, continues to reside in its work in local communities, although efforts to forge a national-level movement are underway.

The Experience of Family Members as Advocates

To develop a better understanding of the role of family members in this new recovery advocacy movement, the authors conducted and analyzed the results of five focus group meetings of individuals whose families had been impacted by addiction and/or recovery. The meetings were hosted by the Connecticut Community for Addiction Recovery. The focus groups were conducted in the communities of Hartford, CT, Wethersfield, CT, New Haven, CT, Springfield, MA, New City, NY between the summer of 2002 and the spring of 2003. A total of 56 family members participated in the focus groups. Each focus group lasted approximately 2 hours. The members of each focus group were asked to respond to the same set of questions related to family experiences with addiction, recovery and recovery advocacy.

In the remainder of this paper, we will explore the experiences of family advocates in this new movement and end with a discussion of the future of family members as recovery advocates.

The Lived Experience of Stigma

Focus group members often opened with accounts of what it was like to live with the shame and stigma of addiction. Most striking in these accounts were repeated references to the silences that pervaded their lives-silences that grew out of a larger cultural silence about addiction.

> *I grew up in a small, French Canadian town in Northern Maine. There were and are so many alcoholics. Everybody knew our family and our situation (alcoholism), but yet nobody talked about it.*

We were very good at keeping the secret (alcoholism). There was the shame and it was very powerful.

For some this shame was magnified by cultural stereotypes of who was and was not supposed to have alcohol and drug problems.

The problem wasn't alcohol; it was crack cocaine. Where we lived this was viewed as a problem of the intercity ghetto. When our own college-educated son in the suburbs developed this problem, it was really hard to talk to others about it. This was not something our family and friends could see happening in their world. It was our shameful secret.

Such cultural silence made it very difficult for family members to come to grips with the reality of what was happening within their own families.

I thought, "My son can't be a heroin addict." When he went through treatment the first time, I thought, "Now he's fine." After treatment, I thought, "Okay, now we can all go back to normal." I didn't have a clue. I thought my son had a little problem-a little problem that went on to kill him.

My son made something very clear to me some time before he died. I had always thought of junkies as these depraved guys on the streets, and my son said to me one day, "Mom I am that junky. Don't you understand that there isn't a difference between me and that guy?" That's when it really hit me! Today when I see some poor person strung out on the street, I remind myself that this lost soul has a family like mine somewhere. It is sad that people don't understand this.

People would come to my house and see my son's picture, my son that passed away, and they couldn't believe it when I told them that he died last year of a drug overdose. They couldn't believe that he was a normal boy who went fishing and grew up to have two children and a loving family. People think of junkies as people who don't have families that care about them. What no one understands is that these junkies are our sons and daughters and brothers and sisters.

The shame attached to female addiction was greater than that for males.

Maybe this gender thing is old fashioned, but for my mother, it was so much more treacherous for her. She only went to women's meetings. A lot of people knew because when things were bad with her, it wasn't the kind of thing you could hide. But there still wasn't the same kind of openness you see with male family members in recovery.

I am proud of my father's addiction and recovery, but I have had a hard time discussing my mother's addiction and recovery, and my sister's addiction-related death.

There were also differences noted between family experience and disclosure of that experience based on whether the addicted family member was in recovery or still using.

There is a big difference between talking about a family member in recovery and one who's active. When my sister was actively using, the shame was overwhelming. I didn't really want to get into it at all. Once there is the success of recovery, it is a whole lot easier. Then you feel you can share in the pride and success of recovery. But when it's going on, it's very hard. With all the things that addicts do, even with people who are close to you, you don't want to disclose the gory details.

It was often in encounters with professional helpers that family members had to first confront the reality of addiction within their families. Yet focus group members repeatedly talked about the shame they were made to experience within these same institutions.

> *You feel dirty when you're standing in the emergency room and your child is there for a drug overdose.*

> *Interacting with some professionals is like a belly punch. One of them said to me, "I know what to do with addicts: you should put them on an island like Alcatraz and drop food and guns to let them take care of themselves." He said this in front of me. I just wanted to go into another room and cry.*

> *If someone had died in a car accident, they would take the arriving family members to a room and talk to them in a comforting way. When we arrived after being told my son had died of an overdose, they said you better hurry and say your good-byes because the Medical Examiner is coming to pick up his body at midnight. It was like he was nothing-my 24-year-old baby. Nobody walked me in. Nobody got my mother a chair. There was no social worker. They didn't ask if they could call a priest. They didn't ask what funeral home we wanted contacted. Nobody was there to help. There was no privacy-we were out in the middle of the lobby. Nobody took us into a private room. There was nothing.*

One focus group member noted that procedures designed to protect those who are addicted even reflects this stigma.

> *Sometimes I get so angry at the system. One of the things that I think is so detrimental is that the professionals can't tell me whether my daughter is in treatment or not. You don't have to tell me personal information that she has disclosed; I just want to know that she is there and is okay. I don't know where she is. She may be dead on the street. I've been concerned for 6 or 7 days. There is no other medical condition in which family members are so shut out and deprived of information. This is the only disease that even professionals can't talk about. I hope the removal of stigma will make it easier for those in my situation to get information about the status of our family member.*

During such interactions, family members reported hearing more therapeutic pessimism than hope.

> *A number of professionals that know my daughter and about her addiction have told me that she is hardcore and that she will never recover. I can't say I don't believe them, but I refuse to believe them.*

Toward Family-Inclusive Recovery Language

People recovering from addiction have evolved a language (e.g., recovering/recovered) and rituals (e.g., sobriety birthdays) to describe and celebrate their experience. Language and rituals for family members is much less defined. Some refer to themselves as "families in recovery" or a "family member in recovery," even though some focus group members felt such terms were ambiguous and confusing.

> *The term recovery is so broad it is hard to get handle on what we mean by it. The term doesn't capture the diversity of ways families experience addiction and the ways family members restore their own disordered health. I wish we could come up with a better term.*

> *I think my family members would be offended if they were known as a "family in recovery." It has a pejorative connotation.*

We could refer to ourselves as survivors of a family member's addiction or perhaps we could all wear a nametag that says "Caution: Family in Renovation."

Other family members found it difficult to apply the term when their loved one was still actively using.

The only time I'm in recovery is when my daughter is in rehab. That's because I sleep well and I know that she's being taken care of and doing something.

In the end, most focus group members felt comfortable with the term recovery but also felt family members should be able to select the term that best depicts their experience. They clearly see themselves as being in recovery, and they can pinpoint or approximate when they started on the road to recovery. They are interested in being equal partners with their formerly addicted loved ones in a recovery process and feel that use of recovery as a term for their experience enhanced understanding and acceptance by those in direct recovery from addiction. For some family members, the term recovery implies a retrieval of what was lost through addiction (e.g., trust, economic security, intimacy, laughter). For others, such as those whose family member died an addiction-related death, the term recovery implies the long process of grieving and healing.

Persons recovering from addiction use the date that they stopped drug use as their point of recovery initiation and often celebrate that date similar to a birthday. Family members have much greater difficulty pinpointing the initiation of their own recovery process. Some use the recovery initiation date of their family member while others note a particular milestone in their own healing or growth.

It's a long time before you believe it's for real. My father used to celebrate his sobriety anniversary with coins and all that stuff, but it wasn't until he got 7 or 8 years in that we started to believe it. I am not sure I can mark the date for me as a family member, but there clearly was a date when he stopped.

You could pinpoint the period when you understood and stopped enabling, but I think that process is gradual. It's hard to pick a date. It's cumulative.

Marking recovery by enabling alone would be difficult. Enabling is one of the hardest words to deal with. One day you think you're enabling and the next day you do the same thing and you're helping out.

For me events have more of an impact than a date. His last rehab was very eventful for the both of us. I saw a change in him. The return of his soul is the only way I can describe it. The new place that he was at means more to me than any date. It's a developmental process.

Another approach to defining recovery initiation for family members is to focus on the stage at which the member stopped reacting to the addicted family member and focused instead on their own needs and aspirations.

The Decision to Keep or Break Silence: Responses to the Family Addiction/Recovery Story

Family members have three levels at which silence can be broken regarding their experiences with an alcohol- or other drug-addicted family member. These levels mark the stages between personal recovery and political advocacy.

Breaking silence to others cannot occur until there is a breakthrough of insight that allows one to reconstruct the perception of the addicted family member. Many focus group members noted the importance of

such breakthroughs. What this revealed was that silence must be broken within the self before it can be broken to others.

> *I talk to myself. There was a point at somewhere maybe 15 or 20 years ago that I really started to delve into what is this alcoholic family that I grew up in? I reached a point where I accepted the fact that my father was an alcoholic, and I started to get involved in a lot of different things. There was a clear point at which how I saw him and myself started to shift. That was when I decided I wasn't going to be ashamed any more.*
>
> *You have to make sense of what happened and heal yourself before you can carry a message of hope to others. I came to realize that my son had a disease. You can forgive somebody for having cancer; why can't you forgive them for having the disease of addiction? The terrible things they do are part of their disease. My son did a lot of terrible things, but it never meant that he wasn't a good person or that he didn't love me.*

The helpfulness of these new insights opens the doorway for disclosure to others. One of the most difficult arenas for such disclosure involves other family members. The second level of silence-breaking occurs within the family itself. Even some of the most articulate advocates-persons who have championed recovery in all manner of public forums-confessed the difficulty they had talking with other family members about the experience with addiction. Few topics generated such lengthy and detailed responses.

> *I found it easier to talk to people outside of my family…my son is an addict, and I've never even to this day expressed those words to my family. When he was 17 and he started drinking they said it was just a stage and not to worry about it. They know he's been in rehab and on probation, but we've never discussed these things in detail. Part of the reason that I never told them about his addiction was that I felt it would change how they acted towards him and I didn't want that to happen.*
>
> *I have a problem talking about all this with certain members of my family. They have a different outlook on life. They have to shop at Bloomingdales. They just can't shop anywhere else. With certain people, you just can't go there with this subject.*
>
> *I was given an award, not too long ago, and my siblings attended. After my talk on my involvement in the recovery advocacy movement, my wife asked me why I hadn't mentioned my father's alcoholism. I didn't dare broach this subject then for fear of upsetting my siblings. I was silent because I didn't want to have my whole family teed off at me for acknowledging that my father was an alcoholic. This was fifty years of stigma and shame still influencing my behavior.*
>
> *I think we had a harder time with this because it's not a parent who is addicted but our own child. With a child, it is hard not to feel responsible. You are seen as having failed in a vital part of your life. People think that you somehow allowed your kid to become addicted. I have not shared this with some of my own siblings. I have four siblings, but have only talked about my son's addiction with one.*
>
> *The risk that I face is alienation of my siblings, especially with my sister, which is interesting since her husband died of alcoholism. Our relationship has developed in a unique way and I don't want to ruin that. Besides, protecting the alcoholic is still ingrained in me after all those*

years. When I first spoke about my father's alcoholism at a CCAR meeting, I started crying. I didn't realize I would react that way. So there is also the risk of embarrassment in the presence of one's family. My brother is coming down shortly and this obviously won't be a topic. My family knows what I'm doing but I don't push it too far.

I've talked to my mother about my advocacy work, but she's not too excited about it. I've tried to talk to all my brothers and sisters about what I'm involved in and they have provided ambivalent support for my going public with our story.

A person in our group wanted to speak publicly but her daughter was very upset and thought it was simply an airing of the family's dirty laundry in public. It took this woman almost three months to explain to her daughter and have her daughter come around to the fact that what she was doing was very important.

We have CCAR members who are active with us but will not speak publicly because their addicted family members refuse to let them do so.

Going Public

The decision to go public with one's family story of addiction or recovery is a highly personal one. Perhaps the first obstacle to overcome is the anticipation of judgments that others will make.

I think the risk that you face, is what people are going to think. When I tell them what happened to my son, they give me a look and just roll their eyes. I can see that they really don't believe me. I can hear their minds saying that my son was no good and that I must have done something wrong. I risk those judgments for the sake of my son and every other family that could face the nightmare I have lived through.

When I considered going public, all I could think of was my neighbors. I knew I would run this risk of them judging me and having them wonder what I did wrong. I wanted to be thought of as a good parent, but there were several instances when my son acted up in our neighborhood. I had to get past the thought of those people judging me.

I don't care what people think: I will tell the truth of our experience. I loved my grandson, and I hope I can help other people by telling them our story. I don't care if it's in the newspaper. It is the truth of what happened in our life. We went through a lot of pain and we're still recovering.

Most focus groups members talked about having passed through the stage of their concerns about the judgment of others to a place where the message was more important than their potential embarrassment. The first element of that message was that addiction could touch any family and the devastating impact of addiction upon the family as a whole. The second element was about the potential for recovery and the process of recovery for the individual and the family. The potential benefit of this message to others eventually outweighed concerns about personal privacy. There was also in the decision to go public a dimension of anger: anger that their pain could have been lessened if addiction had not been so shrouded in shame and silence.

Family advocacy is important due to the demoralization and anger families often experience through multiple episodes of recovery initiation and relapse. Families need to know that there are permanent solutions to addiction and that there is hope for their loved one and their family. Families telling their stories of survival, forgiveness and reconciliation are powerful antidotes to

the hopelessness that so often pervades the perception of addiction in this culture.

Parents who have lost children to addiction face a special challenge working in recovery advocacy. It is sometimes hard for these parents to work with individuals and families in sustained recovery. Through these relationships they must face the question of why their family was not included among the success stories. For our focus group members, the potential value of their stories to other parents and the larger community overcame such questioning. Most committed their work in advocacy to the loving memories of their lost children.

What family members do is shine a light on the shrouded world of addiction and recovery.

> *When family members speak out, they normalize the addiction experience. When I publicly declare, "I'm a member of a family that has been wounded by addiction," I'm saying that this problem can touch anywhere, that I'm not different than you are. What we can do as family members is try to help others understand what they are dealing with. Our job is to take some of the stigma off being a family touched by addiction and take away the guilt and shame that comes with that.*

When people openly talk about stigmatized issues and experiences to others, there is no cultural etiquette to define what is expected from those hearing this account. The inclination is for people to offer advice about how the problem can be solved.

> *If I tell you my lawn is bad and you tell me to put Scotts on four times a year and then I don't do it, you're going to be upset with me because I didn't take your advice. Sometimes we don't talk because we don't want the advice. We just want them to listen to what we are going through. We need to be honest with people and tell them we are not asking for advice. We need to tell them we have had advice from all quarters, that what we need now is a sympathetic ear and understanding.*

One of the issues that arises following the decision to put a public face and voice on the family experience of addiction and recovery is how to tell one's story as a family member without bringing embarrassment to the addicted or recovering family member.

> *Our son lives and works in the area where we live. I've always been conscious of how my public disclosures could affect him and his business. So I don't say anything unless he says it is all right, or I know he has talked about it. I feel very protective about that. He is in business for himself and he's doing very well, but it's an occupation that requires people's trust. I wouldn't want to do anything to hurt that. It is very important that you have the support of the member, if you are going to speak out, otherwise it could have an adverse effect.*
>
> *This is our son's private place and we've decided that it is not our privilege to talk about that in forums that would bring embarrassment to him. He's part of our local community and we feel we don't have the privilege to publicly tell his story here. We can support him and this movement in ways other than our story.*
>
> *The way I handle this is to not go into a lot of details about his* [addicted family member's] *experience. I try to keep the story to what I experienced.*
>
> *It's not the concerns for myself but for my children, if one of their peers finds out their dad is an alcoholic. How much do I say as a parent and where do I draw the line to keep their life private? I don't stop myself in saying*

what I have to say but I kind of watch it sometimes because of them.

I think we have to be discrete. If I'm going to disclose my story in a public forum, I'm not going to give all the details. I certainly have to take into consideration how disclosing this story will affect my family. Otherwise, I am back to being a self-centered person.

Not everyone is suited to tell their story to a local newspaper or speak before a group of legislators. The personal vulnerability of such disclosure is a reality, but many focus group members talked about how the risks of recovery advocacy were diminished when they stood with large numbers of other people in recovery.

I go to Legislative Day and to the Recovery Walks where there are hundreds or thousands of other people. Those activities are less personally vulnerable because of the sheer number of people who are there.

Some family members expressed concern about potential embarrassment brought to children within the family. The following comment underscores just how personal is the decision and timing of recovery advocacy activities.

Our children are at an age where they want to be like everyone else. They don't want to stand out in any way. So we have been careful to talk to them about when and how we tell our story at a public level. We could even reach a period where we don't tell our story publicly for a while if we decided that it would make our children too uncomfortable.

The fear of potential embarrassment is often overcome by pain, grief, anger, or gratitude.

I refuse to let my son die with that stigma over his head. If it takes to the day I die, I'm going to fight to get rid of the shame and stigma attached to addiction.

There was Al-Anon, but there was nothing there for parents who have lost their sons or daughters to addiction. That's what I committed myself to change.

The women in this group have all lost children to drug overdoses. If we don't speak out, our children will have died in vain.

Recovery Mutual Support and Recovery Advocacy

Family members made several key points related to the roles of mutual support and advocacy.

1. The functions of mutual support and recovery advocacy should be kept separate. While advocacy may have certain therapeutic benefits, it is not a program of personal recovery and should not be thought of as a substitute for such a program.

2. When one is a member of a mutual support group and a member of a recovery advocacy organization like CCAR, these roles should be kept separate. Recovery advocacy activities should not spill into one's mutual support activities, and one's advocacy activities should be done as an individual and not as a representative of a mutual support group.

3. The anonymity tradition of Twelve Step programs should be respected in advocacy activities via no references to one's personal affiliation with a Twelve Step program at the level of television, radio or the print media.

There was a man in the audience at the first presentation I made for CCAR who as I spoke got redder, redder, and redder. Finally, he said, "You can't speak out publicly like this because of the anonymity tradition." But there was another younger man

who explained that you could disclose your recovery status and story as long as you didn't identify yourself as a member or attempt to speak on behalf of A.A. or other Twelve Step programs. It triggered a very lively discussion. Some said CCAR would never grow because of this issue of anonymity, and yet we grew because there were and are people willing to put a real face on recovery.

4. Not everyone is cut out to do recovery advocacy at a public level. Many people may have personal or family circumstances that preclude such activity. Recovery advocacy organizations like CCAR, and the larger new recovery advocacy movement, are not asking all individuals and families in recovery to step into public view, but they are calling upon a vanguard of recovering people and their families to take such action.

Family members in our focus groups talked a lot of how to separate and balance their personal needs and their advocacy activity. The following response is typical.

Family members need to understand that at times one's own needs come first. Even if you have been involved in advocacy work at one point, you may need to move in and out of advocacy work depending on how balanced your life is. This moving in and out of advocacy work is OK. Ultimately, the decision to do public advocacy with your own story comes down to what you need to do and how to minimize that impact on others close to you. At CCAR, we try to have this conversation about the risks involved in advocacy before people get extensively involved.

Members of our family focus groups did feel that family members had a unique contribution to make in the advocacy arena.

Our personal stories have not been heard in our communities. They are stories that can influence other family members and policy makers. The family experience adds to the total story of addiction and puts a positive face on recovery. They help deal with the part of the stigma that is uniquely experienced by the family member. They help members in direct recovery have a better understanding of the impact they had on family members and how to deal with those issues in respect to their own recovery. And they help their own personal recovery by giving back.

5. Involving family members in recovery advocacy provides a venue to address policy issues and conditions that are most paramount to family members. When asked for examples of such issues, focus group members most frequently noted the following:

- Exploration of the impact of stigma on family members and the need for programs that reduce such stigma at the local and national levels
- Assistance and support in talking about addiction and recovery even within one's own extended family
- Availability of treatment and recovery support resources (There were nightmarish stories about families in crisis encountering waiting lists and various procedural barriers to getting help.)
- Assistance in navigating a complex and often fragmented treatment system
- Availability of information on the relative quality of treatment agencies
- Inclusion of family members in addiction treatment (Focus group members lamented the loss of family programs as an integral component of addiction treatment.)
- Access to information about the presence of their family member in treatment (Focus group members noted that confidentiality regulations designed to protect the individual often harm the family by denying them information, not about the details of

treatment, but the presence or absence of their family member in treatment.)

Focus group members felt very strongly that community education that focused on the family experience of addiction and recovery would have diminished their own difficulties with these experiences. Such education would have given them more information and would have also created more informed and supportive social networks. Without such education, family members must either be silent or try to answer questions such as:

- How did he/she become addicted?
- Why doesn't he/she just stop?
- Why do you continue to go to those support meetings if he/she is no longer drinking?

For many family members, silence is easier than struggling to formulate answers to such questions.

Focus group members also felt cheated that they had been denied knowledge about addiction and its impact on the family. The wounds to their families not only from addiction, but also from the ignorance and stigma that surrounded it. Those wounds were also created by a lack of knowledge about what the family could expect within the recovery process. Focus group members spoke with great animation about what they did not understand about the family recovery process.

> *There is so much we don't understand about the problems of recovering families. My wife has a black belt in Al-Anon and we seem to have competing programs. We have what amounts to an ongoing angersarial relationship when it comes to programs and I don't know why. I think I've encountered more stigma inside my family than outside, and that stigma is the source of a lot of beefs that plague my marriage and my family.*

The Blessings of Advocacy

The other theme that resounded within the focus groups was the personal benefits that members had experienced from their advocacy activities.

> *Today, I am a messenger of family recovery. Somehow my experience of family recovery came up in a recent job interview. The woman who was interviewing me said, "I have a daughter who is addicted, and I don't know where to go." After she talked for some time, we both had the feeling that fate had brought us together to have this conversation.*
>
> *By speaking out, we have helped reduce the stigma that families experience as a result of having a family member addicted to alcohol and other drugs. By giving back, we have sped the progress of our own recovery. We have learned things and felt a sense of purpose that has helped us in dealing with other aspects of their life. We have helped shape policies and legislation. We have honored our family members in recovery and the family members we lost to addiction.*
>
> *I know there is power in the individual person in recovery telling his or her story publicly, but the power of the family member telling their story is potentially far greater in terms of system change. This is because of the magnitude of people in this culture who have been touched by addiction. Having the opportunity to turn our wounds into that kind of potential influence is a true gift.*

The Future of Family Members as Advocates

For two centuries, families have been as likely to be blamed for the addiction of one of their members as offered support in responding to that addiction and its impact

on themselves. And yet through this period family members have played an important role in advocating for more enlightened attitudes and social policies related to alcohol and other drug-related problems. As a new recovery advocacy movement seeks to define itself locally and nationally, we believe that is it time to honor the historical legacy of family members by embracing them as co-leaders of this movement. It is also time to define the family as the basic unit in the design of addiction treatment and sustained recovery support services.

One of CCAR's primary purposes is to put a positive face on the Recovery Community, which includes persons in direct recovery, family members and friends. A second and equally important purpose is to provide support to the recovery community to help sustain recovery and improve the quality of life for recovering people. Over the past few years, CCAR has devoted a considerable amount of work in these two areas and has started to see positive changes at the legislative, state policy and local community levels. A similar effort needs to be launched for families who have family members who are or were addicted. A vanguard of family members is needed to tell their story to legislators, policy makers, other family members and the community at large. Family members are needed to advocate for the support they need and for other family members still needing help. Telling their story will help provide a better understanding of the impact that addictions has on the family, help give permission for all families to speak about these issues, and help make it more acceptable for families to seek help for an addicted family member.

Recovery community organizations like CCAR provide training and the opportunity for family members to come together as a group to achieve things that could not be done on their own. Working as a group to put a positive face on family issues and provide support to families can provide a sense of community and purpose and provide a venue for service to other family members still suffering. To the family members who are reading this, we encourage you to seek out recovery advocacy organizations in your area and help support them in ways that will benefit you and the larger community. It is time family members became full partners in this new recovery advocacy movement.

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