PART ONE

Introduction

CHAPTER ONE

What Happens When the Drinking Stops?

This is a book about the alcoholic family in recovery. Why the family? Much of the literature on addiction and its treatment still focuses on the drinking alcoholic, with little or no attention to the family as a whole. In seminal works, Joan Jackson (1954, 1962) described the spouse of the alcoholic many years ago, and Steinglass, Bennett, Wolin, and Reiss (1987) outlined the dynamics of the alcoholic family more recently. But neither focused on recovery. And, as was true for the individual alcoholic, coalcoholic, and children of alcoholics 20 years ago, there is still no knowledge base about the family's experience of recovery. All of the attention has been on drinking, with the implication that abstinence would be the answer to everyone's problems. It was incorrectly believed that if the alcoholic stopped drinking and participated in a program of recovery (perhaps professional treatment and definitely Alcoholics Anonymous), the family would heal itself. Not so. We know from years of clinical experience and from the wealth of information now available regarding children of alcoholics that alcoholism affects the entire family, as individuals and as a whole. So does recovery. We wanted to find out how.

We already knew that many marriages and partnerships do not survive addiction. But what about recovery? Is the damage of drinking so great for some that, in their view, they are beyond repair? Or, is recovery itself so full of unexpected change that many couples give up, determining that abstinence has *not* solved the family's problems after

all, and there is no hope for the couple? Who stays together, why, and how do they do it?

As you'll hear from couples and families in recovery, abstinence is as hard or even harder than drinking because it reveals so many problems that were obscured by the family's focus on alcohol. Denial looms as large as ever as the family faces the harsh realities of delusion, illusion, and collusion that predominated during the drinking and that are now laid bare by abstinence. In so many families, the entire system became organized by alcoholism. What is left to organize the family in recovery?

With the knowledge that many couples end their relationships following abstinence, we wanted to know what happens for the couple that stays together. Why are they still together in recovery and how has this occurred? Have they had certain experiences, or completed tasks that have helped and what do they know about the pitfalls?

Is it possible that some couples end their relationships too soon (and others not soon enough) because recovery in the first few years is so hard, and because there is no "map" to chart the way and no other couples with whom to share their experiences? We believe this is so. Not every couple will or should survive recovery. But many more couples might decide to wait with a little more knowledge about what is normal based on the experience of those who have come before. In this book, you'll hear that many of our families are glad they waited; and some don't know yet.

THE RESEARCH

These questions formed the base of the Family Recovery Research Project. We worked with 52 couples and families with lengths of abstinence ranging from 79 days to 18 years. We asked them to participate in a live, 3-hour, audio- and videotaped interview, to take five tests of individual and family function, and to answer a comprehensive demographic questionnaire. In contrast to this one-time interview and testing, we also worked with three couples with long-term sobriety in an ongoing couples group. Meeting once a month for five years, this group gave us data about the process of recovery for the intact couple over time. Finally, we developed a curriculum for families in recovery. Called MAPS (for Maintaining Abstinence Programs), it consisted of 12 weekly meetings for couples and families with more than a year of

abstinence. In these meetings, we outlined the process of recovery for the family, based on our belief that education about what to expect and what is normal following abstinence would be helpful. It was. Participants unanimously valued the information and the experience of sharing with other couples and families. The research interview is in Appendix A, and a summary of the study sample is in Appendix B.

A critical aspect of this research and prior studies involves membership in Alcoholics Anonymous (1955) and Al-Anon (1984). In the original study (Brown, 1985) of the individual alcoholic, all subjects were members of AA. Thus, the model that emerged was a theory of recovery only for people who stopped drinking *and* belonged to AA.

In our Family Recovery Research Project, membership in AA and Al-Anon was not required. It turned out that the majority of self-identified alcoholics did belong to AA and a smaller percentage of their partners belonged to Al-Anon (see Appendix B, Table B.1). A few of our couples used religion and/or therapy as their primary source of support and had no involvement in AA or Al-Anon. Some used all.

Many of the individuals who used both the 12-step recovery program and therapy viewed them as complementary. We heard few, if any, worries that therapy might interfere with the 12-step philosophy, a concern expressed by many of the participants in the research on alcoholics 20 years ago (Brown, 1985). In fact, many felt their 12-step recoveries were greatly enhanced by individual, couple, or family therapy.

We found that the developmental model describes a process of profound change over time, which is very much related to being in AA and Al-Anon but not limited to these programs. The critical mechanisms of change involved the experience of "hitting bottom," the acceptance of "loss of control," *and* reaching *outside* the family for help.

We found significant differences in the experience and the process of recovery depending on whether both partners, one partner, or neither sought outside help. To a very significant degree, the ability to seek help and engage with help outside the family was the most critical factor facilitating long-term change. We will emphasize this paradoxical finding throughout the book.

We state it now because we are very biased. We both believed in the positive benefits and, indeed, the power of AA and Al-Anon before we started, and this belief shaped our work. We still do. In this book, we will confirm "loss of control," the core of AA philosophy

(Brown, 1985, 1993), as the central organizing principle of active addiction, abstinence as the cornerstone of recovery, and the unequivocal value of AA and Al-Anon. We learned something about why these programs are so helpful to the individuals and the family, which we will report.

From our interviews with families, a theory emerged that is consistent with the earlier developmental model of recovery for the individual. We will outline what recovery is like, what to expect, and even what's normal. Abstinence marks the beginning of a new developmental process that has a profound, complicated impact on the whole family.

The theory that emerged from our research confirmed our clinical experience but also yielded unexpected findings. It sometimes shocked the families, and it may also surprise our readers. The necessary, normal process of growth and development goes against some cherished beliefs of what *should* be normal and healthy, and especially how we think people change. It also challenges therapists' principles and ideas about practice: what to do, what not to do.

This model of change is counterintuitive. It goes against the grain of what we tend to think is normal. So, some therapists may well have to shift figure and ground, letting go of *their* ideas of what change should look like and how it occurs; otherwise, what we describe below won't make sense. This turning upside down is exactly what families have to face as well.

It is never easy. In fact, many of our assumptions (based on Brown's prior research) in undertaking the work are still controversial among professionals. Certainly families who are still drinking fight these core principles, sometimes almost literally "to the death." Only from the vantage point of being "in recovery" can they see that their old beliefs, behaviors, and conflicts kept them drinking and kept them locked in pathology. Let us now look at the controversial assumptions and paradoxes that underlie and shape the whole book.

KEY ASSUMPTIONS AND PARADOXES

1.*Abstinence is not recovery.* Abstinence provides a necessary foundation for the beginning of a developmental process of recovery. With the cornerstone of abstinence in place, the entire family may embark on a major process of change that occurs both quickly and slowly over time.

2.*Recovery is a developmental process, not a singular event and not a prescribed outcome.* Becoming abstinent is a process and an event. It is also an outcome—the targeted goal of treatment interventions. Today, since many therapists are strictly problem focused, help can mean fixing people and a belief that therapeutic success should come quickly, with measurable improvements. While a focus on problem resolution can be enormously useful for many kinds of difficulties, it can severely limit the therapist who is working with the drinking or recovering alcoholic family.

With our emphasis on process, we're talking about the big picture, the long haul, and a natural order of change. Time is essential. Much of the process is evolutionary and developmental, rather than prescriptive. Change is incremental and layered. It builds on itself. It is also a process of "fits and starts," as one family described it:

> "We went through a series of crises which pushed us to a new level. Then we'd stabilize until another crisis would push us again."

As an interactive process individuals must accommodate to the changes they are making, which in turn generate further change and accommodation. Several of our families described this process as a "ripple" effect. Change builds upon itself and leads to other changes.

A couple with 8 years of recovery illustrates:

> "The kinds of changes we were making at 5 years simply weren't possible at 6 months, nor did they have the same meaning. Change is the result of the accumulated strengths of the new foundation. The positive energy of recovery gave us different attitudes, which changed the way we related to each other."

Still, therapists will ask: What kind of success is it when many people feel worse, look worse, and function worse in abstinence than they did when they were drinking? And what kind of outcome is this if everyone is happy about it, or at least philosophical and accepting? What kind of outcome is it if the family says that it's falling apart, that nothing works anymore, nothing makes any sense, and they're all grateful they got here—or that it's so bad they don't know if it's worth it or whether they should stay together? Many therapists, looking for

measurable improvement, will not have an easy time with such outcomes, at least at first.

In a developmental frame, human beings are dynamic, fluid, and changing, rather than static. So are families. Applied to alcoholism and the alcoholic, abstinence is not an end or a static state but the beginning of a new process of development.

In the developmental view, growth and change occur over time and can be defined according to the particular task and stage. Growth is hierarchical in the sense that the early or beginning tasks and stages lay a foundation on which further, more complex development can occur. Problems in the successful completion of any task or stage may be traced to unfinished tasks or missing pieces along the way. Holes in development can contribute to ongoing problems that require intervention and repair.

The developmental view applies to most theories of human growth ranging from the biological (including neurological and psychophysiological) to cognitive, behavioral, and emotional approaches. It also applies to the progression of drinking and recovery. The program of AA, including the 12 steps, outlines a *process* of growth that takes place over time in which each task and stage follows from and builds on the preceding one.

Through "working the program" individuals in AA and Al-Anon learn how to track their ongoing development in recovery, including watching for problems and recognizing holes that need attention and perhaps repair. Many individuals and families in therapy are doing the same thing.

In this longer, comprehensive view, what might be labeled as a problem—to be fixed—in a short-term frame, can be seen instead as part of a stage, part of a process. It may seem and, in fact, it may be very negative in the up-close moment, but a wide-angle lens casts a different view. It gives context and perspective. We may then decide whether or not to intervene. We do not assume the family is headed in the wrong direction, although we assess the possibility. It is just as likely that they are actually moving toward a more positive way of relating. We might tell them, for example, that the disruption and turmoil they are experiencing at 6 weeks' or 3 months' abstinence is normal, that they do not need to try to stop it, or fix it. Families do need support in living with it, however, which we would address directly. Are they going to meetings, sharing with others? At this point in time, we assess structural support rather than targeting symptom reduction as the goal.

What does this mean for therapists? Being in recovery is not itself a problem to be treated, though unfortunately it is sometimes seen this way. That's because recovery is often just as traumatic as drinking, but in different, paradoxical ways. Many changes that are necessary to move to abstinence and to set a recovery foundation in place are themselves traumatic. Thus, individuals and families are faced with the dilemma that what is absolutely necessary to establish and maintain recovery can *also* cause problems and even damage, without awareness and support. Years into recovery, families may go back to remember and resolve the trauma of "what it was like" and "what happened" in drinking *and* recovery.

Being in recovery is a normal process, with clearly defined, predictable tasks and stages. It is absolutely vital for therapists to know what is normal over time in the process of recovery or they may inadvertently try to treat, stop, or fix what is normal and necessary to growth. It is the therapist's job to stay out of the way of the natural healing process, to monitor progress, and to recognize past or current roadblocks that might interfere with people's ability to remain abstinent and engaged in recovery. It is also the therapist's job to know the path, to anticipate the seemingly unresolvable conflicts families will face, and to help them cope with these challenges in ways that will minimize secondary trauma. The complicated task for the therapist is to constantly assess what is part of growth—for this person and this family—and what is a sign of difficulty that requires intervention. The individuals and the family hopefully are doing the same thing.

It is the therapist's task to listen, interpret, advise, educate, and coach all along the way. It is not the therapist's job to dictate what change should be. For example, the therapist is not approaching the family with a goal of helping people express their feelings more or less, based on the therapist's idea of what constitutes good therapy. The therapist instead wonders how the expression of feeling *at this point in time,* in this particular family, will facilitate or inhibit the developmental process of recovery. The therapist is always guided by a focus on the organizing principles of loss of control, abstinence, and the long-term, developmental process.

3.*Recovery is an interaction and an interactive process, meaning that there is no predetermined end or goal to achieve.* It's an interaction of the individual's relationship to self and other and family members' relationships with one another. It's an interaction that builds on itself, reinforcing and strengthening the foundation that will hold and later

shape healthy couple and family relationships. Recovery is the result of the individuals' and couples' participation in it.

4.*This interaction creates a constant, what some might even call a chronic, tension within the family: the tension between the focus on the individuals and the focus on the family as a whole.* Both are vital, though the primary focus changes depending on the particular stage and task at hand. In the beginning, confusion about what is necessary and what is desirable often causes serious difficulties.

Couples need to tolerate ongoing ambiguity as part of this tension. They need to tolerate not knowing much about anything, which is often so frightening it pushes people to premature action and closure. Recovery in the beginning is so new and so shocking, and reality is so different from everyone's dream, that it is sometimes hard to find a basis for hope. It is also hard to trust in the natural process and to follow a path, usually AA and Al-Anon, when the impulse is to seize control, carve out one's own plan, and end the state of "not knowing" and uncertainty.

This is why it is essential for therapists to know what is normal over a long period of time. They can help the couple and family tolerate all the unknowns by literally mapping out the terrain, offering support and suggestions for coping, as well as tracking progress and pitfalls.

5.*AA, Al-Anon, and other 12-step programs are valuable sources of help for people who are facing addiction.* Unlike most professional therapies, the "message" of recovery is carried through an apprentice model. That is, people who have come before share their "experience, strength and hope" with those who are following (Alcoholics Anonymous, 1955). Through this supportive, reassuring chain of shared experience, individuals learn how to maintain abstinence and build sobriety. We will emphasize and illustrate how membership in a 12-step program helps people tolerate all the tension, ambiguity, and "not knowing," and literally "holds" (Winnicott, 1953) the family through the recovery trauma of massive disruption, change, and new development.

6.*Therapists can also be valuable sources of help for people who are facing addiction.* In tracking the normal process of recovery, therapists will stand ready to intervene at behavioral, cognitive, psychodynamic, and systems levels, based on the stage and task of recovery and the needs of *this particular family.* As noted above, intervention is guided by a focus on maintaining abstinence and the organizing principles of the developmental model, particularly loss of control. It is not deter-

mined by a therapist's preferred treatment modality, a shift in frame that is often difficult for therapists. Having been trained to specialize in one school—behavioral, cognitive, psychodynamic, or systems—therapists may impose their preferred approach on all patients, expecting them to fit. In many cases, because of a too-specialized, limited theoretical frame and a focus on problem resolution, the therapist ends up ignoring the patient's experience and the known stages and tasks of recovery. Many therapists are as impatient as the family to finish up with this nasty business of addiction and get on with the "real work." Nothing could be more off base.

Frequently, therapists believe that recovery, or change, comes from the therapist rather than the patient. Much of experimental research and some theories of change rest on these premises: what can the therapist *do* to a patient, or what "intervention" can the therapist bring that will *cause* the patient to change? This thinking can increase the danger that the therapist will fall into the exact "thinking disorder" that the alcoholic is struggling with: the therapist assumes the faulty belief that he or she is the agent of change and is thus responsible for figuring out how to *get* the patient to stop drinking. In essence, therapists get caught in the faulty belief that they must control the patient, the same distorted logic of the alcoholic and family. If there's a problem, someone else is responsible for solving it. The same kind of distortion occurs in recovery. Everyone, including the therapist, wants to fix this disaster as soon as possible. Accepting that it can't be fixed and, in fact, that all is going well is very difficult.

While directed interventions are frequently helpful, therapists must accept their own limitations in being able to *make* anybody change. This truism is often a major source of countertransference: therapists have as much distaste for the idea and reality of "loss of control" as the patients they are treating.

As in any other clinical work, therapist beliefs can be a major source of help and hindrance. For example, therapists may feel frustrated when alcoholism is identified and yet the family rejects the whole idea. The therapist expects everyone to go along with abstinence. Or the therapist and family may agree to behavior changes that will support abstinence, but no one looks at the family's beliefs about alcoholism. Later, after several relapses and great family resistance to change, it becomes clear that no one in the family wants Mom to be an alcoholic and they don't want to be an "alcoholic family." The failure to explore the family's beliefs, values, and wishes interferes with behavioral change. The therapist, having grown up with an alcoholic

father, unconsciously supported the resistance. He or she didn't want to be part of an alcoholic family either. Finally, another therapist may see that "good psychotherapy" involves a focus on the transferential relationship between the patient and the therapist. This clinician sees the newly abstinent patient's attention to concrete behavioral change and intense engagement in AA as resistance to engagement in the therapeutic dyad and pushes the patient to focus more on the therapist, transference, and uncovering psychotherapy. The patient may respond in any of several ways: she or he complies but feels more conflict; or the patient ends the therapy; or the patient drinks. These examples characterize the ongoing challenge for the therapist: how to integrate complex mental health theories of psychotherapy and change with addiction knowledge. As we outline the stages and tasks of therapy for the alcoholic family, we will also comment on the difficult task for the therapist.

7.*The model of recovery is transformational* (Tiebout, 1944, 1946, 1949, 1953). Individuals who belong to 12-step programs speak about conversion, about surrender, and giving up, which involve a radical rupture in deepest belief—there is no alcoholism in this family and no one has lost control—followed by a starting-from-scratch process of development organized by the opposite belief—there is alcoholism in this family and everyone has lost control. The alcoholic has lost control of drinking, the partner cannot control the alcoholic, and everyone has lost control to the power of a drinking, pathological family system. Within this system, everyone's best efforts to "fix" the problem reinforce it. The transformation process involves two separate experiences: the individual(s) accept the loss of control *and* reach outside the family for help.

8.*The developmental model of addiction and recovery is organized by core beliefs about control.* Drinking is maintained by a false belief in control; recovery is organized by the deep acceptance of loss of control. As therapists working with drinking families, we are not trying to plug holes or help families regain control. We work to help them widen the holes so the defensive structure, based on the faulty belief in control, can collapse and the new building process of recovery begin. This is an ongoing dilemma for the therapist: how to facilitate increasing disruption knowing that the result will not be a "fixed" family. In most cases, individuals and families will feel worse and look worse. This goes directly against the grain of what many patients, therapists, insurers, and employers think ought to happen.

Individuals and families "in recovery" have undertaken what

some might call a bone-breaking process of change. This is a radical shift in paradigm, not an adjustment or fine-tuning within the same organizing structure of belief. That is why it is transformational and counterintuitive. According to family systems theorists, the recovering family has made a shift from first- to second-order change (personal communication from V. Lewis to S. Brown, 1997).

9.*Recovery takes time*. There is nothing about recovery that is brief, or a quick fix. It is tough but necessary to relinquish the hope for a magical "fix" because the notion of a short-term cure is antithetical to the slower, healing-building process of recovery. Family members often struggle with this reality as they continue to hold onto the belief that the family's problems were caused by the drinking (and therefore by the alcoholic alone) and should be solved by abstinence (and therefore by the alcoholic alone). As long as abstinence is seen as the end of the problem, which is convenient for all, rather than the beginning of a new growth process that can involve all, the myth will continue: recovery should bring a reversal of trauma and much improved family function and relationship in a very brief period of time. All of these changes do occur, but not quickly. There is more disruption and turmoil that comes first—what we call the "trauma of recovery."

KEY DEFINITIONS

One of the most controversial areas of theory and practice in treating the alcoholic and the family is that of definitions. We will define some of the most critical terms and concepts here. A more detailed glossary is at the end of this book.

1.*What is alcoholism?* We define alcoholism as a physical, psychological, social, emotional, and spiritual disease, characterized by continuous or periodic loss of control of drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, particularly denial. Although there has always been controversy about whether or not alcoholism is a disease (Marlatt, 1983; Pendery, Maltzman, & West, 1982; Jellinek, 1960), there is less disagreement that the term "alcoholism" denotes "loss of control." Abstinence is essential. Other schools of opinion do not use this term, preferring instead "problem drinking" and the currently popular "substance abuse." Both of these terms hold the possibility that control has not been lost or that it can be regained. In our model, we use the term alco-

holism (or addiction, to include drugs besides alcohol), the organizing principle of "loss of control," and the requirement of abstinence in order to qualify as a "family in recovery."

2.*What is recovery?* "Recovery" is now a common term, popularized by the chemical dependency field in the 1980s and long associated with AA literature. Despite its common usage, it's a complex term that actually has multiple meanings. Although we too will use the word "recovery" in this text, the dictionary definition is not what we mean.

In *Webster's* view (1961/1981), to recover means "to get or win back; . . . to bring oneself back to normal balance." In the case of the individual alcoholic, the term "recovery" has long implied a "return" to health, sanity, and well-being that presumably existed before the individual became alcoholic. In this sense, recovery is seen as a "restoration" of something lost.

This may be true for some—take away alcohol and indeed people are better and "restored." But for most, recovery is a new process of development. It involves not restoration of a prior state but dramatic changes over a long period of time that will lead to new health and well-being. Recovery has thus come to mean growth and fundamental change rather than restoration or going back; the word in this sense implies not just a "correction" within the same system, or paradigm, but an alteration of the fundamental worldview. The changes we are going to report involve a radical transformation, with a new paradigm, forming the foundation for a new developmental process.

3.*What is an alcoholic family?* An alcoholic family refers to a family in which the environment or context of daily life becomes dominated by the anxieties, tensions, and chronic trauma of active alcoholism. Alcohol, or someone's drinking, becomes the central organizing principle of the family system, controlling and dictating core family beliefs and influencing all aspects of behavior as well as cognitive and affective development.

There is considerable dissonance in the alcoholic family. What is often most visible and problematic, the alcoholism, is most vehemently denied. The denial operates to say to the world, "This doesn't happen here. This doesn't exist." Members of the family are engaged in a continuing crusade to make the alcoholic well or to simply enable the family to survive despite what is really happening. They are coping, trying to hold things together. When the consequences of the alcoholism become more visible and difficult to resolve (illness, job loss,

physical abuse, and drunk driving arrests), the need for secrecy grows and the family becomes a closed system, cutting itself off from other sources of input and help.

Individuals within the family develop the same behavioral and thinking disorders as the alcoholic: they are controlled by the reality of alcoholism, and they must deny it at the same time. Individual development may be sacrificed to the greater needs of the unhealthy drinking family system.

4.*What is an alcoholic family in recovery?* The recovering alcoholic family is one in which one or both parents has stopped drinking and the family, as a whole or in parts, is actively engaged in a process of growth and change. Our research families identified themselves as "recovering families" in very different ways. But most agreed that "recovery" and "being in recovery" from alcoholism organized to a greater or lesser degree their identity as a family and the process of change.

Families with long-term abstinence speak about recovery as a process. They have a backward lens, a view of life since drinking that is a history, a story of change. Families with shorter-term abstinence do not yet have the perspective of time away from alcohol and often have no story of change except the new unknown state of abstinence. We will describe both.

5.*What is pathology?* When we use this word, we are referring to the defensive accommodations people make to adjust to and maintain active alcoholism. These defenses may mask other serious emotional problems, and/or they become the problems that drive people to seek help. Often, in a clinical setting, what we will work to define as unhealthy, or pathological, also represents the family's best efforts to cope with the reality that must be denied. In recovery, pathology may include the underlying problems that were masked by alcohol as well as the consequences of drinking and the family's adjustments to maintaining it. In a general way, we define pathology as the behavioral, cognitive, and affective processes that defensively narrow one's internal and external view of self and the world. Recovery involves an expansion in these capacities (Brown, 1988).

Let's look next at the major conclusions we drew from this research.